

## PATIENT TREATMENT AGREEMENT

As a participant in the Buprenorphine/Vivitrol program for treatment of Opiate/Alcohol abuse and dependence or for treatment of chronic pain, I **freely and voluntarily agree to accept** the patient treatment agreement as follows:

- To conduct myself in a polite manner in the physician's office.
- To be present on time for all my scheduled appointments.
- To attend weekly group sessions and be present 15 (fifteen) minutes before the scheduled time to complete urine test.

*I understand that being late more than 5 minutes for a scheduled group will exclude me from entering group and will be considered as failure to attend. [ ] Initials*

*I am informed and understand that if a group is not attended, a urine for toxicology testing must be provided within 24 hours of the scheduled group time. [ ] Initials*

*Failure to attend a scheduled appointment/group, or positive urine result, will be considered as non-compliance and will be recorded in the patient chart. [ ] Initials*

*Any 3 (three) incidences of non-compliance will be grounds for discharge at the discretion of the provider. [ ] Initials*

- To take my prescribed medication as the doctor has instructed and not to change/modify the way I take my prescribed medication without first consulting the doctor.

*The prescribed medication I received is my responsibility and must be kept in a safe, secure place. [ ] Initials*

*I understand that lost prescriptions for Suboxone will not be replaced regardless of the reasons for such loss. [ ] Initials*

- Not to obtain prescribed medication from any physicians, pharmacies, or other sources without informing my treating physician at Connecticut Addiction Medicine, LLC.

*I understand that mixing buprenorphine with other prescriptions, especially benzodiazepines, opioids, and other drugs of abuse, can be dangerous. [ ] Initials*

*I am informed and understand that deaths have been reported among persons mixing buprenorphine with these other drugs. [ ] Initials*

*Stolen medication will be replaced only after supplying the appropriate police report. [ ] Initials*

- Not to sell, share, or give any of my prescribed medication to another person.

*I understand that such mishandling of my prescription is a serious violation of this agreement and will result in my treatment being terminated without recourse for appeal.*

*[ ] Initials*

- To provide random urine tests, witnessed or unwitnessed, for verification of compliance with the treatment program.

*I understand that falsifying my urinalysis in any way will result in immediate termination from the program without recourse for appeal. [\_\_\_\_\_] Initials*

- To avoid over-the-counter agents that may give a positive urine result (e.g. poppy seeds, cough/cold medicines containing ephedrine or pseudoephedrine; agents containing alcohol such as some sleep aids, mouthwashes, and after shave lotions).
- To abstain from alcohol, opiates, marijuana, cocaine, and all other substances of abuse, excluding nicotine.
- To provide the medication from active prescriptions for med counts if requested.

**I understand and agree that Connecticut Addiction Medicine Office reserves the right to obtain observed urine tests at any time.**

**I understand and agree that violation of any of the above are grounds for termination of treatment.**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_