[redacted] SUBOXONE TREATMENT AGREEMENT

Suboxone Treatment Agreement Patient Name _____

MRN_____

As part of my Suboxone treatment, I freely and voluntarily agree to accept this treatment agreement/contract, as follows:

I agree to keep, and be on time to, all my scheduled appointments with the doctor, counselor, nurse, and other providers.

I agree not to sell, share, or give any of my Suboxone to another individual. I understand that such mishandling of my medication is a serious violation of this agreement.

I understand that Suboxone can be given to me only at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.

I understand that the Suboxone I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost Suboxone will not be replaced regardless of the reasons for such loss.

I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treating physician. I understand that mixing Suboxone with other medications, especially benzodiazepines such as valium and other drugs of abuse can be dangerous. I also understand that a number of deaths have been reported among individuals mixing Suboxone with benzodiazepines.

I agree to take Suboxone as the doctor has instructed and not to alter the way I take my medication without first consulting the doctor.

I understand that medication alone is not sufficient treatment for my opioid dependence, and I agree to participate in counseling and other treatment.

I understand that urine drug screens are a necessary component of Suboxone treatment.

I understand that staff may have to verify my Suboxone supply and obtain urine drug screens on a random or urgent basis. I agree to come to clinic, upon request from my physician or other staff, within 24 hours with my supply of Suboxone for a pill count and urine drug screen.

Patient Signature _____ Date _____

Staff Signature _____ Date _____