Medication-Assisted Treatment Agreement

Suboxone/Naltrexone/Vivitrol, and buprenorphine containing products are used to help people treat substance use disorders (SUD). These are the requirements and responsibilities you must follow in order for you to successfully participate in medication assisted treatment (MAT).
In order to receive Suboxone and/or buprenorphine from Life Balance Mental Health Clinic, you must fully agree to the terms of this Treatment Agreement.

Your initials mean you have read, understand, and acknowledge the information and if the paragraph calls for an agreement from you, your initials indicate agreement to accept responsibility for these terms throughout your Medication Assisted Treatment. Failure to abide by any of these requirements/agreements may result in treatment termination.

1._____**Information regarding Suboxone and/or buprenorphine therapy.** My Provider has discussed with me various options for treatment of my substance use disorder, including non-pharmacological options. He has explained, and I understand, the risks and benefits of buprenorphine, including potential side effects. I understand that in order to be a satisfactory candidate for Suboxone/buprenorphine I must follow certain safety precautions for the treatment and comply with the treatment schedule prepared for me by my Provider. This includes recommended lab tests, which will typically be liver tests every 6 months for sublingual products, every month for subcutaneous injections, and may include recommendations on screening for hepatitis and HIV. Additionally, my Provider and his staff have discussed this agreement with me and explained what is expected of me in the program. Having taken all of this information into account, I desire to enter into MAT and agree to comply with the requirements described herein.

2._____**Attendance at all scheduled appointments.** I agree to keep and be on time for all of my scheduled appointments. After induction and when the appropriate Suboxone dose has been achieved, appointments will be scheduled on a 28 to 36-day rotation as deemed appropriate by my Provider. Missed and rescheduled appointments will require a drug screen within 24 hours. I understand that “No Show” and/or repeated cancelled appointments will be considered positive drug screens and may be grounds for discharge from the MAT program. I understand that if I miss an appointment and did not notify the clinic in advance to cancel my appointment, I will be dismissed from the MAT Program and I will not be given any refills for my medication. If I miss or reschedule an appointment for a later date, I understand that my medications will not be refilled until the time of my next scheduled appointment with my MAT provider.

3._____**Induction transportation.** I agree that I will not drive a motor vehicle or use power tools or other dangerous machinery during my first days of taking Suboxone/ Buprenorphine, to make sure that I can tolerate taking it without becoming sleepy or clumsy as a side-effect of taking it. I also agree to arrange transportation to and from the clinic during my first days of taking Suboxone, so I am not required to drive myself during this time, thus reducing the danger to myself and others.

4._____**Walk-in visits.** I understand that Suboxone can only be prescribed by a specially licensed physician. I can only get Suboxone refills during scheduled office visits with my Provider and I will not be able to obtain Suboxone/buprenorphine refills during walk-in visits, after regular clinic hours, on weekends, or holidays. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my prescription until the next scheduled visit.

5. _____**MAT Conduct Policy.** I agree to conduct myself in a courteous manner while in the clinic as well as any other place of business associated with the clinic including but not limited to my Pharmacy of choice, any testing facility where I may be requested to have a drug test completed, or any treatment center or therapy group I may attend in accordance with my agreed upon treatment plan. Once I have asked a question and received and answer or am told an answer is pending per what my Provider prefers, I will not badger, continue to call, or become a nuisance to any person involved in my treatment plan. Any adverse behavior (including but not limited to that mentioned above) that may be deemed detrimental to my treatment plan and Treatment Program Team, may be cause for my discharge from the program.

6._____**Abuse of any persons involved in my MAT program.** I will refrain from any verbal or physical abuse to any clinic, pharmacy, or drug testing facility staff member or any person involved in my treatment plan. Any reported abuse by me may result in my discharge from the Treatment Program with no recourse or appeal.

7._____**Arrival at any MAT Program Facility under the Influence.** I agree not to arrive at the clinic or any facility involved in my treatment plan while intoxicated or under the influence of any alcohol, prescription medications not prescribed in my name, or any street drugs that are illegal to use, possess, or distribute. My arrival in this state will result in not being seen by my Provider and not getting my medication refilled until my next scheduled appointment, or complete discharge from the MAT Program without recourse or appeal.

8._____**Illegal activities while in or around any facility in my MAT Program.** I agree not to deal, steal, or conduct any illegal or disruptive activities in the clinic, the pharmacy where my prescription is filled, or any other facility involved in my Treatment Program. Any observed or suspected behavior of this sort will be reported to my Provider and may result in my discharge from the MAT Program without recourse or appeal.

9._____**Selling or sharing Suboxone/Buprenorphine.** I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication or alteration/forging of the prescription is a serious violation of this agreement and will result in my immediate discharge from the MAT Program without recourse or appeal.

10._____Theft of my Suboxone. I understand that Suboxone is a powerful drug. People who want to get high or sell Suboxone for a profit may want to steal my take-home prescription supplies. My medication must be protected from theft or unauthorized use.

If my medications are stolen, I will file a Police Report and bring a copy to my next appointment, fully understanding that my medication/prescription may not be refilled until my next scheduled appointment, thus resulting in the increased chances of experiencing opiate withdrawal symptoms if I run out of my medication.

11._____**Loss of Suboxone.** I will be careful with my take-home prescription supplies of Suboxone and agree that I have been informed that if I report that my supplies have been lost or stolen, that my Provider will not be requested or expected to provide me with make-up supplies. This means that if I run out of my medication supplies it could result in my experiencing symptoms of opioid withdrawal.

12._____**Suboxone Storage and accidental ingestion.** I have a means to store take-home prescription supplies of Suboxone safely, where it cannot be taken accidentally by children or pets or stolen by unauthorized users**. I agree that if my Suboxone tablets/films are taken by anyone besides me, I will call 911 and the Poison Control Hotline at** 1-800-222-1222 **immediately and see that the Person is transported to the nearest appropriate medical facility for treatment.**

13._____**Third party control of Suboxone.** I agree that my home supplies of Suboxone should be kept in the care of or monitored by a responsible member of my family or another third party, I will abide by such recommendations.

14._____**Pill Counts.** I understand that in order to ensure that I am taking my Suboxone as prescribed, I will bring my remaining Suboxone to each appointment for a count to be sure that I have the appropriate amount remaining. My Provider may also call me at random, requesting that I give him a verbal pill count at that time. I may also be required to present to the clinic within 24 hours of notification for a count of my medication strips or tabs. In the case that there is a message left on my voice mail I only have 24 hours to respond, or it will be grounds for my discharge from the MAT Program.

15._____**Take as prescribed.** I understand that the use of Suboxone in a manner other than as prescribed may be dangerous to my health. I will take my Suboxone exactly as it is prescribed and shall comply with the directions of my Provider for its use. I will not adjust the dosage myself. If I feel that the dosage of Suboxone prescribed to me is not working correctly, I will contact my Provider to discuss changes, or if necessary, schedule an appointment to discuss potential alterations in the dosage.

16._____**Abstinence from alcohol and drugs.** I understand that in order for my participation in the MAT Program to be meaningful, and in order to promote my health and safety, it is necessary to agree to and fully abstain from drinking alcohol or taking drugs that have not been prescribed to me. I also understand and have been made aware that mixing Suboxone with other medications, especially benzodiazepines **(including but not limited to Diazepam [Valium], Clonazepam [Klonopin], Alprazolam [Xanax], Lorazepam [Ativan], Chlordiazepoxide [Librium], Oxazepam [Serax])**, can be dangerous and has been associated with severe adverse events including: ***ACCIDENTAL OVERDOSE, OVER-SEDATION, COMA, or DEATH***. The use of alcohol with Suboxone can produce ***Decreased Respirations, Impaired Thinking, or Impaired Behavior***.

17._____**Other prescription medications.** I agree to inform my Provider and all other medical care providers I am seeing of all medications that I am taking including over-the-counter supplements. I understand this is important for my safety and to assure that another medication is not prescribed which may lead to harmful side-effects. I will report ***any*** new prescription given to me by ***any*** other provider Dentist, Dermatologist, Psychiatrist, Pharmacy, or ***any*** other sources to my Program Provider so he can assess them for adverse interactions with my Suboxone.

18._____**Random Drug Testing.** I understand that in order to ensure that I am abstaining from all non-prescribed drugs, street drugs, or alcohol, I will be required to complete random drug screens. I will have 24 hours from the time I am contacted (this does include the time that the message was left on my phone or with my family) to supply the name, phone number, and fax number of a facility near me that can do a 9 to 12 panel drug screen and send any positive results for confirmation, and have the test done with the results faxed to Life Balance Mental Health Clinic at (662)-638-8285. I understand that I may be witnessed by a staff member when giving urine samples. I also understand that any attempt to alter my urine or bring in urine from others will result in immediate dismissal from the MAT Program without any recourse or appeal.

19._____**Random Suboxone Testing.** I understand that to be assured that I am taking my Suboxone in the manner prescribed, I will be required to complete random urine drug screens for Suboxone. I further understand that in the event my Suboxone drug screen result is negative (meaning no Suboxone was found), it is cause for immediate dismissal from the MAT Program without any recourse or appeal.

20._____**Out of Town.** I understand that being “out of town” will not suffice as a reason for being unable to obtain a random drug screen or a random Suboxone screen. I will still be given the 24-hour time frame to find an appropriate testing facility and complete the test as previously described.

21._____**Notify in Case of Relapse**. I will notify the MAT Clinic and my Provider immediately in the event that I relapse, or if I otherwise take any drugs that have not been prescribed to me including illegal drugs obtained from the “street”. I recognize that my Treatment Program Provider understands that relapse may be part of the disease process, and that honest communication between myself and my Provider regarding a relapse is essential to my relationship with my Provider and treatment. Additionally, I recognize that it is essential that my Provider is aware of any relapse BEFORE a positive drug test is obtained. I understand that this is not a guarantee that I will not be discharged from the MAT Program for continued relapses to opiates or any other drugs of abuse that, I have in this agreement, or verbal agreement with my Provider been instructed not to use.

22._____**Counseling.** I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in all recommendations made by the Life Balance MAT Program staff, including counseling, etc.… I will provide written documentation of attendance of all meetings recommended to my Provider at each of my scheduled appointments.

23._____**Pharmacy of Choice.** I will fill all of my Suboxone prescriptions at the same pharmacy, and should the need arise any pharmacy change will be noted in writing with pharmacy name, address, phone, and fax numbers. My pharmacy of choice at this time is:

Pharmacy Name: _____City: _____State: _____

Phone: _____ Fax: _____

24._____**Contact Information.** I will provide the clinic with my current contact information and will update that contact information immediately as necessary. I will notify the clinic immediately in the event that I change my address or phone number. I will be accessible to this clinic at all times in the event the clinic needs to contact me. I understand that my phone must have an answering machine or voice mail that is set up and kept clear for messages. I understand that if the clinic is unable to reach me within 24 hours I may be discharged from the Treatment Program.

25._____**Pregnancy (Females Only).** I am not pregnant and will not attempt to become pregnant without discussing this with my Provider. I will not have unprotected sex and will continue my birth control while I am taking Suboxone. I understand that if I become pregnant I will be transitioned to buprenorphine. If I become pregnant I will inform my Provider, so I can be treated in the safest way possible for me and my unborn baby.

26._____**Discharge from the Program.** I understand that failure to comply with the requirements described above and/or any of the violations listed below may serve as grounds for my discharge from the MAT Program:

a. A failed drug screen without advising my Provider of the lapse prior to the test.

b. A failed Suboxone screen may result in my immediate discharge without recourse or appeal.

c. Any attempt by me to alter, substitute, or tamper with a urine specimen obtained for a drug screen will result in my immediate discharge without recourse or appeal.

d. Failure to report for a required drug screen.

e. Distribution of Suboxone to any other individual will result in my immediate discharge without recourse or appeal.

f. Any alteration, tampering, forging, etc… of my Suboxone prescription will result in my immediate discharge from the program without recourse or appeal.

g. Failure to comply with prescribed use of my Suboxone.

h. Repeated requests to re-scheduled appointments.

i. Not showing for scheduled appointment without calling ahead of time to let staff know that I will not be able to make it will result in my discharge without recourse or appeal.

j. Any illegal activity related to drug or alcohol use will result in my immediate discharge.

k. Any dangerous or inappropriate behavior that is disruptive to the clinic or to other patients (This includes reporting to the clinic or any other facility involved in my MAT Program) will result in my discharge without recourse or appeal.

l. Any other breach of the terms of this agreement.

Emergency Contact Information:

Printed Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

With my signature I give my consent for my medical information involving my treatment in the Life Balance MAT Program to be discussed with my Emergency contact listed above.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

With my signature below, I attest that I have read and understand the above contract and that I have had the opportunity to ask questions and have them answered to my understanding. I also understand that violations of this contract may be grounds for my discharge from the MAT Program without recourse or appeal.

Patient Name: _____ DOB: _____
(**Please Print** First, Middle & Last Name)

_____ _____ _____
Patient Signature: (or Authorized Representative) Relationship to Patient: Date: (MM/DD/YY)

_____ _____
Physician Name: Date: (MM/DD/YY)

_____
Physician Signature: