WESTBROOK MEDICAL CENTER

7328 MIDDLEBROOK PIKE
KNOXVILLE, TN 37909
(865) 769-2600

BUPRENORPHINE TREATMENT CONTRACT

Patient Name_____ **Date**_____

As a participant in buprenorphine treatment for opioid addiction, I freely and voluntarily agree and understand this treatment contract, in its entirety, as follows:

___ 1. I agree that I have been informed that buprenorphine is a treatment designed to treat opioid addiction --- not addiction to other classes of drugs. If I am actively addicted to other substances, I will need to be treated by other methods for those addictions.
___ 2. I agree that medication management with buprenorphine is only one part of the treatment for my addiction and I agree to participate in a regular program of professional counseling while in treatment with buprenorphine.
___ 3. I agree to provide proof of counseling at every visit.
___ 4. I agree to abstain from **all** illegal drugs, alcohol and other addictive substances while in treatment with buprenorphine.
___ 5. I agree that I will be subject to random drug screens and/or pill counts. I understand that I am responsible for the cost of a nurse visit. This sample will be referred to an outside lab from whom I and/or my insurance company will receive a bill. I agree to report to this office for random pill counts or drug screens within two hours of being called. Should I be out of town when called for a pill count or drug screen, I understand that I must bring in proof of my whereabouts at the time of the call (a credit card receipt which is time and date stamped with my name on it or a notarized statement from an official entity).
___ 6. I agree to keep and be on time for all my scheduled appointments.
___7. I agree to immediately notify the office of any change of address and/or telephone number. All patients must be accessible to this office at any time when this office needs to contact them.
___8. Voice mail MUST be set up. If this office cannot reach the Patient within two hours, this office has a right to discharge the Patient without further notice.
___ 9. I agree that a network of support and communication is an important part of my recovery. I **will be asked for my authorization** to allow contact, as appropriate, between my doctor and/or his staff and outside parties, including physicians, therapists, probation/parole officers, and other parties. Contact will only be made when the doctor has determined that communication is necessary for effective treatment and recovery.
___ 10. I agree to adhere to the payment policy outlined by this office.
___ 11. I agree that I have a means to store my medication(s) safely where it cannot be taken accidentally by children or stolen by others. I further agree that if my buprenorphine is swallowed by anyone besides me, I will call 911 or the Poison Control Center at 1-800-288-9999.

___ 12. I agree not to sell, share, or give any of my medication(s) to another person. I understand that such mishandling is a serious violation of this contract and will result in my treatment being terminated without any recourse for appeal.
___ 13. Medication lost, stolen, or damaged ***will not*** be replaced. It is my responsibility to protect my medication. I understand that the consequence of not protecting the medication is that I may be without prescribed medication for a period of time.
___ 14. I agree that if the doctor recommends that my medication(s) should be kept in the care of a responsible member of my family or another person, I will abide by such recommendation.
___ 15. I agree not to conduct any illegal or disruptive activities in or around the doctor's office and/or pharmacy and to treat all office and pharmacy staff with respect. I understand that should such behavior occur, I will be terminated from treatment without recourse for appeal and the appropriate authorities will be notified.
___ 16. I agree that my medication/prescriptions can only be given to me at my regularly scheduled office visits. No medication will be called in to any pharmacy.
___ 17. I agree not to obtain medication(s) from any other doctors, pharmacies, or other sources without informing the doctor.
___ 18. I agree that I have been informed that it **can be dangerous to mix buprenorphine with alcohol or other sedative drugs such as Valium, Ativan, Xanax, Klonopin or any other benzodiazepine drug_----- so dangerous that it can result in accidental overdose, over-sedation, coma or death.**
___ 19. I agree to take my medication(s) as the doctor has instructed. I understand that only the doctor can change the way I take my medication(s).
___ 20. I agree that I will not drive a motor vehicle or operate heavy or dangerous machinery during my first two weeks of treatment to ensure that I can tolerate my medications without becoming sleepy or clumsy as a side-effect.
___ 21. I agree that I will be open and honest with my doctor and treatment team about my addiction and overall health history and will inform my doctor about cravings or unhealthy situations in which I am involved, specifically about any relapse that has occurred before a drug test result confirms it.
___ 22. I understand that I may be witnessed by a staff member when giving urine samples. I also understand that attempts to alter my urine or bring in urine from others will result in termination from treatment without recourse for appeal.
___ 23. I understand that, if I am prescribed the Suboxone film, the empty packets MUST be returned to Westbrook Medical Center to be counted and destroyed. I further understand that if I fail to return these packets, I will not be seen and could possibly be discharged from the program.
By signing 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 termination of treatment without recourse for appeal.

_____
Patient name (print)

_____ _____
Patient signature Date

_____ _____
Witness signature (employee) Date