SNA MEDICAL

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Treatment Contract

As a participant in buprenorphine treatment for opioid dependence, I freely and voluntarily agree to accept this treatment contract as follows:

I agree to keep, and be on time to all my scheduled appointments with the doctor and his or her assistant.

I agree to conduct myself in a courteous manner in the physician's office.

I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the doctor will not see me, and I will not be given any medication until my next scheduled appointment.

I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated at this office without recourse for appeal.

I agree to cooperate with urine drug testing whenever requested to detect whether I have used alcohol, prescription drugs or street drugs. I will tell the SNA Medical staff if I have used alcohol or street drugs before a drug test result shows it. Please be aware that presence of substances in the urine other then Buprenorphine may result in your insurance company not extending the coverage for your medications

I agree not to deal drugs, steal or conduct any other illegal or disruptive activities.

I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication 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 physician who is prescribing buprenorphine. I understand that mixing Buprenorphine 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 persons mixing buprenorphine with benzodiazepines.

I agree to take my medication 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 illness, and I agree to participate in the patient education and relapse prevention programs, as provided, to assist me in my treatment.

If you insurance policy requires us to obtain Prior Authorization for your medication, participation in the substance abuse rehab program may be the requirement for medication coverage. In this case you will have to provide us a proof of participation.

Patient Name_____

Signature_____Date_____