PLACE LABEL HERE

FAMILY HEALTH CENTERS
OF SAN DIEGO

MAT Treatment Agreement for Buprenorphine

As a participant in buprenorphine treatment for opioid use disorder, I agree to the following:

1. I have read, understood and signed a Family Health Centers of San Diego (FHCSD) Patient Consent for Buprenorphine Treatment.
2. I agree to complete and sign all necessary releases of information for my health records with FHCSD to permit coordination of my healthcare within FHCSD and with outside treatment providers, when necessary.
3. I agree to participate in an assessment of my needs for substance use treatment, medical and/or mental health services.
4. **I agree to participate in weekly group refills during the Induction and Stabilization phase of treatment.**
5. I agree my goal is to stop misusing addictive and/or illicit drugs during my treatment with buprenorphine (Suboxone).
6. I agree to arrive 30 minutes early for all scheduled appointments or notify FHCSD in advance to reschedule, except in case of emergency. I understand that appointments with providers may need to be rescheduled if I arrive late.
7. I agree to submit urine screens prior to each scheduled medication appointment. I will submit to scheduled and/or random testing including observed urine screens upon request. Failure to comply will result in notation of a positive urine screen in my health record.
8. I understand buprenorphine without counseling is not sufficient treatment for my substance use disorder. I agree to participate in counseling, as discussed and agreed upon with my healthcare provider(s). I understand my participation in counseling is required to continue to receive buprenorphine.
9. I agree to establish an individualized treatment plan and regularly assess progress towards goals with my primary counselor.
10. I agree to attend sober support meetings, if assigned, such as Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery®, religious affiliations, etc.
11. **I understand my buprenorphine will only be given at scheduled appointments.** A missed appointment may result in my waiting until the next scheduled visit to get my buprenorphine. I understand early refill of my buprenorphine is not possible.
12. I agree the buprenorphine I receive is my responsibility. I agree to keep it safe and locked securely away from others, especially infants, children and animals. I understand buprenorphine is extremely dangerous for infants, children and animals. They can stop breathing and die after taking in tiny quantities of this medication. I understand that I can call Poison Control at 800-222-1222 if a child is exposed to buprenorphine. I understand that I can call ASPCA Poison Control at 888-426-4435 if an animal is exposed to buprenorphine (an ASPCA consultation fee may apply). I agree if my buprenorphine is lost, stolen, destroyed or damaged, I will attend an appointment with my physician to discuss the possibility of replacement.

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13. I agree not to obtain buprenorphine, other opioids or benzodiazepines (for example, Valium®, Klonopin®, or Xanax®) from any other healthcare providers, pharmacies, or other sources without telling my treating physician.
14. I understand taking buprenorphine with benzodiazepines (for example, Valium®, Klonopin® or Xanax®), can be dangerous. I also understand death has occurred among persons taking buprenorphine with large quantities of alcohol or other types of sedatives, such as barbiturates and benzodiazepines.
15. I agree not to sell, share, or give any of my buprenorphine to another person.
16. I agree not to sell, share, give or buy illicit drugs at any FHCSD facility, parking lot, or surrounding neighborhood.
17. I agree not to sell, share, give or buy illicit drugs at any pharmacy, its parking lot, or surrounding neighborhood where I obtain my buprenorphine.
18. I agree to adhere to random pill/film counts to confirm treatment compliance whenever asked to do so.
19. I agree violating any part of this treatment agreement may result in no longer receiving treatment with buprenorphine and/or I may be referred to another level of care.
20. I agree to follow all FHCSD policies and I understand violations of FHCSD policies may result in my discharge from the MAT program and/or FHCSD.
21. I understand that if I take other opioids while taking buprenorphine, I may not get high from the other opioids because buprenorphine blocks their effect. I understand that if I keep using larger amounts of other opioids to try to get high, I could stop breathing and die (opioid overdose).
22. I understand my success in treatment may include, but is not limited to, freedom from intoxication, improved physical and psychosocial functioning, and adherence to the treatment plan.
23. I understand once I have reached the maintenance phase of the program, I may be referred to another FHCSD location to receive my medication and substance use disorder counseling.

I consent to the above terms and to begin treatment with buprenorphine.

_____ Date_____
Patient Signature

_____ Date_____
Print Name

_____ Date_____
Physician Signature

_____ Date_____
Print Name