MEDICATION ASSISTED TREATMENT AGREEMENT

Patient Name: **MR#:**

As part of my participation in the Medication Assisted Treatment program at Alliance Medical Center, I am requesting that my Provider prescribe Buprenorphine for my opioid use disorder and/or pain management. I freely and voluntarily agree to accept this treatment as described below.

1. _____ I agree to keep, and be on time for, all of my scheduled appointments with the doctor and the care team, including support groups. I agree to conduct myself in a courteous and respectful manner in the clinic.
2. _____ I agree to provide urine samples for Drug Screens whenever required. This includes random and scheduled drug screens. I agree to have a negative drug screen. (A negative drug screen shows ONLY medications prescribed by my Provider.) I understand that if I have more than one positive drug screen, I will be required to meet with the care team to update my treatment plan and evaluate the level of care I need to be successful.
3. _____ I agree to bring in my container of Buprenorphine for random pill/ film counts within 24 hours that this request is made by my Provider. I understand that this medication (and all prescribed controlled medications) must be kept in the containers in which they came from the pharmacy. (This is required by law.)
4. _____ I agree to not be intoxicated or under the influence of drugs when I come to the clinic. If I am, the care team will not see me, I will need to arrange a sober drive home, and I will not be given any medication or refills until my next scheduled appointment.
5. _____ 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 will result in my treatment being terminated without appeal.
6. _____ I understand that the unplanned use of Buprenorphine by someone who is addicted to opioids will cause severe withdrawal symptoms.
7. _____ I agree not to deal, steal, or conduct any other illegal or disruptive activities in the vicinity of the clinic.
8. _____ I agree that my medication (or refill prescriptions) can only be given to me at my regular office visits. Missed office visits, including behavioral health visits, can result in my not being able to get medication until the next scheduled visit.
9. _____ 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.
10. _____ I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating Provider. I understand that mixing Buprenorphine with other medications, especially benzodiazepines (sedatives or tranquilizers), such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing Buprenorphine with benzodiazepines. I also understand that I should not drink alcohol while taking this medication as the combination could produce excessive sedation or impaired thinking or other medically dangerous events.

12. _____ I agree to take my medication as my Provider has instructed, and not to alter the way I take my medication without first consulting my Provider.
13. _____ I understand that medication alone is not sufficient treatment for a substance use disorder and, if applicable, I agree to participate in the recommended Behavioral Health therapy, patient education and relapse prevention programs to assist me in my recovery.

Patient Signature _____ Date _____