El Dorado
Community Health Centers
Placerville • Diamond Springs • Cameron Park
Case Management • Podiatry • Support Services • Behavioral Health • Primary Care • Dental • Pharmacy
Medical (530) 621-7700 • Dental (530) 497-5016
www.edcchc.org

MEDICATION ASSISTED TREATMENT AGREEMENT

Patient Name: **MR#:**

As part of my participation in the program I am requesting that my doctor provide buprenorphine/naloxone treatment for opioid use disorder. I freely and voluntarily agree to accept this treatment as described below.

1. **I agree to keep, and be on time to, all my scheduled appointments with the doctor, behavioral health, and the care team.**

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

3. I agree to submit Urine Drug Screens whenever required by my doctor, this includes random, scheduled and/or observed drug screens. I agree to have a negative drug screen. (A negative drug screen will only show medication that is being prescribed by a physician). I understand that if I have more than one positive drug screen, it will require me to meet with the team to update the treatment plan, evaluate the level of treatment.

4. I agree to bring in my bottle of buprenorphine/naloxone for random pill counts within 24 hours that this request is made by my doctor. I understand that this medication and all prescribed controlled medications must be kept in the bottle in which they came from the pharmacy. (This is required by law.)

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

6. 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 without recourse for appeal.

7. I understand that the use of buprenorphine/naloxone by someone who is addicted to opioids could cause them to experience severe withdrawal.

8. I agree not to deal, steal, or conduct any other illegal or disruptive activities in the vicinity of the doctor's office or anywhere else.

9. I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.

10. 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.

11. **I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine/naloxone 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 the doctor has instructed, and not to alter the way I take my medication without first consulting the doctor.

13. I understand that medication alone is not sufficient treatment for my disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my recovery.

14. I understand that my buprenorphine/naloxone treatment may be discontinued and I may be discharged from the clinic if I violate this agreement.

15. I agree that if at any point in this program, it is recommended by my doctor and MAT team that I enroll in Outpatient Treatment, Intensive Outpatient Treatment or Residential Treatment that I will do so. I understand that my success in recovery depends on my willingness to engage in the recovery process.

16. I understand that there are alternatives to buprenorphine/naloxone treatment for opioid addiction including:
    a. medical withdrawal and drug-free treatment
    b. naltrexone treatment
    c. methadone treatment
    d. My doctor will discuss these with me and provide a referral if I request this. Not all of these options are available at this clinic.

17. I agree to keep all contact numbers up to date so that my providers can contact me quickly. If my numbers change, I am required to inform the clinic.

18. I also agree to (patient specific) _____
    _____

19. I agree to participate in outpatient treatment at: _____
    _____
    _____

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Date