☐ I received information on treatment with buprenorphine, buprenorphine/naloxone (suboxone) as well as other options.

☐ We discussed possible side effects including the risk of overdose and death especially if not taken as prescribed.

☐ My treatment team has answered all my questions regarding the medication.

☐ My treatment team has offered me naloxone to prevent overdose.

* I will do my best to arrive on time or call the clinic if I need to reschedule my appointment.
* If I miss my appointment, I will call the clinic immediately.
* In an emergency, and if the clinic is not open, I understand that the LAC urgent care center may be able to refill my medications.
* I agree to treat everyone in the clinic with respect and I expect to be treated with the same respect.

For my safety, I understand that:

* By law, my team is required to check where I fill my prescriptions. I will only fill my prescription at one pharmacy. If I need to change pharmacies, I will tell my team.
* I will need to provide urine screens from when requested.
* I will bring my medicine to all my visits and my provider may count my pills.

I also know that:

* I should not share or sell my medications and I should not get medications from others.
* Mixing my medications with other drugs such as alcohol, sedatives or muscle relaxants can be dangerous.
* I need to keep my medications in safe place so they are not lost or stolen. If there are children in the house, I will make sure my medication is kept out of reach in child-tamper-proof bottles.

Finally, I will tell my doctor right away if

* My medications are not working, or I am experiencing more cravings.
* I become pregnant or start breast feeding.
* I start taking a new medication including over-the-counter or natural medications or if I am prescribed a new medication by a provider at another facility such as a dentist or a psychiatrist.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**Doctor/Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**