INSTITUTE FOR ADVANCED PSYCHIATRY

TRANSCRANIAL MAGNETIC STIMULATION & BRAIN MUSIC THERAPY

PATIENT TREATMENT CONTRACT: Buprenorphine

Patient Name: _____ Date of Birth: _____

As a participant in the Buprenorphine protocol for treatment of opioid abuse and dependence, I freely and voluntarily agree to accept this treatment agreement/contract, as follows:

PLEASE INITIAL ALL STATEMENTS

_____ I agree to keep and be on time to all of my scheduled appointments.

_____ I agree to adhere to the payment policy outlined by this office.

_____ I agree to conduct myself in a courteous manner in the doctor'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 an would result in my treatment being terminated without any recourse for appeal.

_____ I agree not to deal, steal or conduct any illegal or disruptive activities in the doctor's office.

_____ I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine prescription is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.

_____I understand that Suboxone is a powerful drug. People who want to get high or sell Suboxone for a profit may want to steal my take-home prescription supplies. My medication must be protected from theft or unauthorized use. If my medications are stolen, I will file a report with the police and bring a copy to my next visit.

_____ I agree that my medication/prescription can only be given to me at my regular office visits. Any missed office visits may result in my not being able to get my medication/prescription until the next scheduled visit.

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_____ I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I understand and agree that lost medication will not be replaced regardless of how/why it was lost. I understand that if I run out of my medication before it is time for a refill I could end up experiencing symptoms of opiate withdrawal.

_____I understand that Suboxone must be stored safely, where it cannot be taken accidentally by children or pets, or stolen. If anyone else takes my Suboxone I will call 911 or Poison Control at 1-800-222-1222 immediately.

_____ I agree not to obtain medications from any doctors, pharmacies or other sources without telling my treating physician.

_____ I will report any change in my medical history, such as becoming pregnant or developing hepatitis C.

_____ I understand that mixing buprenorphine with other medications, especially benzodiazepines (Valium®*, Klonopin®** or Xanax®***), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician using routes of administrations other than sublingual or in higher than recommended therapeutic doses).

_____I agree to abstain from all drugs, including alcohol, marijuana and other street drugs. I understand that continued use of drugs can interfere with my attempts at recovering from opioid dependence. I also understand that buprenorphine (as found in Suboxone) is designed to treat opioid dependence, not addiction to other classes of drugs. Therefore, I will work with Dr Ghelber and my therapist to design an individualized treatment program to assist me in discontinuing the use of other drugs.

_____ I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.

_____ I understand that medication alone is not sufficient treatment for my condition and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.

_____ I agree to abstain from alcohol, opioids, marijuana, cocaine and any other addictive substances, with the exception of nicotine.

_____ I agree to provide random urine samples and have my doctor test my blood alcohol level. I agree to comply with all lab orders within 24 hours of their issue.

_____I agree that the support of loved ones is an important part of recovery, and I agree to invite significant persons in my life to participate in my treatment

_____I agree that a network of support is an important part of my recovery, and honest communication among people within the network is important for my treatment. I will provide authorization to allow telephone, email, or face-to-face contact, between Dr Ghelber, therapist, probation officers, and parents, spouse to discuss my treatment and progress.

_____I am not pregnant, and I will not have unprotected sex or attempt to become pregnant while taking Suboxone, because the safety of this medication during pregnancy is unknown. If I accidentally become pregnant I will inform the doctor as soon as I am aware so that she can refer me to a methadone clinic or for other appropriate treatment.

_____ I understand that violations of the above may be grounds for termination of treatment.

SIGNATURE OF PATIENT PRINTED NAME DATE

SIGNATURE OF WITNESS PRINTED NAME DATE

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