Cornerstone Behavioral Healthcare Acehelosu, a division of Cornerstone

Therapeutic Agreement for Treatment with Buprenorphine

Client#

This agreement is being undertaken between _____ (*the patient*), and _____ (*the Licensed Independent Practitioner*), to define the responsibilities of the patient during treatment with buprenorphine.

1. **You agree to keep and be on time to all scheduled appointments.**
2. **You agree to the payment policy outlined by this office.**
3. **You agree to fill all prescriptions at only one pharmacy.** This will allow the medical provider to coordinate care with a pharmacist.
   Pharmacy Name: _____City, State: _____
4. **You agree to store medication properly.** Medication may be harmful to children, household members, guests, and pets. If anyone besides the patient ingests the medication, the patient must call the poison control center or 911 immediately.
5. **You agree to take the medication only as prescribed.** The indicated dose should be taken daily, and the patient must not adjust the dose on his or her own. If the patient wishes a dose change, he or she will call the clinic for an appointment.
6. **You agree to comply with the required pill counts and urine tests.** For suboxone, it is the client's responsibility to keep all empty medication wrappers and return them to the nurse at their next appt. Urine drug testing is a mandatory part of the program, as well as pregnancy testing if you are of childbearing age and ability. The patient must be prepared to give a urine sample for testing at each clinic visit, as well as to show the medication bottle for a pill count as requested.
7. **Females of child bearing age and ability:**
   - You should use some form of birth control during treatment due to the unknown safety of buprenorphine.
   - The medical provider may have to discontinue your treatment or consider alternative medications if you become pregnant.
   - If you are or become pregnant, it is important to inform the medical provider right away so you can receive the appropriate care and referrals.
   - There are ways to maximize the healthy course of your pregnancy while in opioid pharmacotherapy.
8. **You agree to maintain a working phone number so that you can be contacted.** Notify WHW if you change your phone number. If you do not have a phone yourself, provide the name and number of a person who will serve as a contact and who will reliably get messages to you.
9. **You agree to notify WHW immediately in case of lost or stolen medication.** Medicine will not be prescribed earlier than scheduled and a police report will be required in the case of stolen medication.
10. **You agree to notify the office immediately in case of relapse to substance use.** Relapse to opiate drug use can be life threatening, and an appropriate treatment plan has to be developed as soon as possible. The medical provider should be informed about a relapse before any urine test shows it.
11. **You agree to abstain from using any illicit drugs, including marijuana.** The only exception is if you have a Medical Marijuana card.

12. **You understand that it is important for you to inform any medical provider who may treat you, that you are enrolled in medication assisted treatment** so that the provider is aware of all the medications you are taking, can provide the best possible care, and care avoid prescribing medications that might affect your opioid pharmacotherapy or my chances of successful recovery from substance use disorder.
13. **You understand that you will need to sign releases for my primary care physician, med management, counselor, and case manager** so that we can communicate with them about your treatment.
14. **You understand that the Prescription Monitoring Program (PMP) will be used** to identify all medications prescribed.
15. **You have reviewed the Program Description.** This description includes the hours, the phone numbers, the fees, the requirements for participation such as treatment attendance, and WHW's responsibilities for patient care.
16. **Do not interfere with another's recovery** in any way.
    - No selling or diverting medication.
    - Understand that such conduct is a serious violation of this agreement and will result in treatment with buprenorphine being terminated immediately.
17. **Respect privacy and confidentiality** of all participants including the fact that they are in treatment.

My initials below show that I have reviewed each of the following documents with staff, asked questions, and had my questions explained to me in terms I understand. I understand the patient information about buprenorphine/Suboxone. A copy of each of the following documents has also been provided. **(Please initial each line below.)**	
	Therapeutic Agreement for Treatment with Buprenorphine
	MAT Program Client Informational Handout

My signature below indicates my informed consent to receive this medication.	
Client Signature	Date
Licensed Independent Practitioner Signature	Date
Witness Signature	Date