

The Mathers Recovery Buprenorphine Treatment Program Contract

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 and sign below):

APPOINTMENTS

- INITIAL HERE
- I agree to **keep and be on time** to at least 10 appointments per year with my doctor.
 - I agree to **make a follow up appointment** with the receptionist after each and every appointment I attend.
 - I agree that my medication (or prescriptions) can **only** be given to me at my regular office visits and that if I miss my office visit I will not be able to get my medication until my next scheduled office visit.

BEHAVIOR

- INITIAL HERE
- I agree to conduct myself in a **courteous** manner in the physician's office.
 - I agree to not arrive at the office **intoxicated** or under the influence of drugs. If I do, I understand that the doctor **will not see me**, and I **will not be given any medication** until my next scheduled appointment.

MEDICATION

- INITIAL HERE
- Voluntary participation in MAT after review of other treatment options and review of risks and potential side effects on this medication.
 - I **will not sell, share or give any of my medication** to another individual. I understand that such mishandling of my medication is a serious violation of this agreement and will result in my treatment being terminated without recourse for appeal.
 - I agree and understand that my prescriptions will not under any circumstances be filled in between appointments and will **only be filled at my scheduled appointment**.
 - I agree that the medication I receive is my responsibility and that I will keep it in a safe and secure place.

MEDICATION (continued)

- I agree to **take my medication exactly as the doctor has instructed** me to and not to alter the way in which I take my medication without first consulting the doctor. I agree that the medication I receive is **my responsibility** and that I will keep it in a **safe and secure place**. I agree that lost medication will not be replaced regardless of the reasons for such loss. I understand that if my medication is lost or stolen it is my responsibility to file a police report.
- I agree not to obtain medications from any physicians, pharmacists or other sources without informing my treating physicians. I understand that mixing buprenorphine with other medications (especially benzodiazepines such as Valium and other drugs of abuse) can be extremely dangerous. I also understand that a number of deaths have been reported among individuals mixing buprenorphine with benzodiazepines.

DRUG SCREEN

- INITIAL HERE
- I understand that I will be requested to provide urine screens at any and all appointments and that the specimen confirmations will be performed and billed by an outside laboratory or Mathers Clinic.

PREGNANCY (if applicable)

- INITIAL HERE
- Patients must agree to notify prescribing physicians if they are or plan to become pregnant.

RECOVERY PROGRAM PARTICIPATION

- INITIAL HERE
- I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education and relapse prevention programs, as provided, to assist me in my treatment.

Printed Name of Patient or Legal Guardian

Date

Signature of Patient or Legal Guardian

Date

Witness of Signature

Date



ELGIN: 420 Airport Rd, Ste C, Elgin, IL 60123
FOX LAKE: 101 Towne Centre Ln, Fox Lake, IL 60020

phone: 847.462.6099 fax: **847.628.6064**
phone: 224.908.3005 fax: **847.531.1296**