CelebrityCare MEDICAL CLINIC
Promoting Lifestyle Medicine

PATIENT TREATMENT AGREEMENT

Patient Name: _____ **Date:** _____

As a participant in medication treatment for opioid dependence and/or abuse, I understand the following:

1. I agree to use one physician to prescribe and monitor all medications used in the treatment of my condition.

2. I agree to use one pharmacy to obtain all my medications prescribed by my physician.

   Pharmacy: _____ Phone number: _____

3. I agree to bring all medications in their original bottle to each appointment for pill counts and I understand that pill counts may be done randomly at any time and I must comply within 24 hours of a request.

4. I agree to keep, and be on time to, all my scheduled appointments.

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

6. I agree to conduct myself in a courteous manner in the doctor's office.

7. 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 any recourse for appeal.

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

9. 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 medication 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.

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

11. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.

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

13. I understand that mixing this medicine with other medications, especially benzodiazepines (for example, 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 administration other than sublingual or in higher than recommended therapeutic doses).

14. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine). Failure to do so may result in a change to my treatment plan, including safe discontinuation of medications when applicable or complete termination of the doctor/patient relationship.

15. I agree to provide random urine samples and have my doctor test my blood alcohol level.

16. I agree to read the Medication Guide provided by the pharmacist for each medication and consult my doctor should I have any questions or experience any adverse events.

17. 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.

18. 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.

19. I agree to establish an overall treatment goal and work towards the eventual discontinuation of all mood-altering medications if appropriate.

20. I agree to allow my physician to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if my physician feels it is necessary

21. I agree to a family conference or a conference with a close friend or significant other if the physician feels it is necessary.

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

23. Other: _____

_____

_____

_____

The above agreement has been explained to me by _____

I agree to its terms so that _____ can provide quality medication management of my condition.

Patient's Signature _____ Date_____

Witness's Signature _____ Date_____

Agreement Reviewed:

Date: _____ Initials _____

Date: _____ Initials _____

Date: _____ Initials _____

Date: _____ Initials _____