NORTH AMERICAN MENTAL HEALTH SERVICES

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Suboxone Patient Treatment Contract

Patient Name: _____ Date: _____

As a participant in Suboxone Therapy, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep, and be on time to all my scheduled appointments. If I have an emergency, I agree to call at least 12 hours in advance to notify the office.
2. I agree that I will arrive 15 minutes early to my scheduled appointments and be ready to submit a urine sample for urine toxicology screening.
3. I agree to conduct myself in a courteous manner in the clinic.
4. I agree to report my history and symptoms honestly to my provider and the office staff. I will inform my provider about any medications (prescription and non-prescription) that I am taking. I will report any changes in my medical history, such as becoming pregnant.
5. I agree to not sell, share, or give any of my medications to another person. I understand that such mishandling of my medication is a serious violation of this agreement and will result in my treatment being terminated without any recourse or appeal.
6. I understand that my medication must be stored safely, where it cannot be taken accidentally by children or pets, or stolen. If anyone else, including a child takes my medication, I will call 911 or Poison Control at 1-800-222-1222. If my medication is stolen, I understand that I must provide a police report to my provider.
7. I understand that if dealing or stealing of 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.
8. 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.
9. I will be careful with my medication/prescription. If I report that my medication/prescription have been lost or stolen, my provider may not provide me with a make-up supply.
10. I understand that at every visit, my doctor may ask me to bring my unused supply of medication for a medication count and that I may not get a refill if I do not bring my medication with me.
11. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my provider.
12. I agree that I will attend all scheduled group or individual counselling sessions that are scheduled for me.
13. I agree to keep confidential the content of group sessions.

Signed: _____ Date: _____

Witness: _____ Date: _____