THERAPEUTIC CONTRACT – SUBOXONE/VIVITROL

Client Name _____ **Date** _____

As a participant in the Suboxone/Vivitrol Program, 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 and to check in and out at the front desk. I understand that I am to wait in the lobby until called by staff.

2. I agree to conduct myself in a courteous manner while in the facility or on the facility grounds.

3. I understand that payment is due PRIOR to receiving services. If I do not have payment, including my co-pay (as applicable) I will not be seen by the physician or counselor.

4. 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.

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

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

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

8. I understand that use of alcohol or other drugs with Suboxone/Vivitrol is dangerous and may be life-threatening. I agree to remain abstinent from alcohol and other drugs not prescribed specifically for me. I understand that use of other substances may result in the physician referring me to a higher level of care/treatment or discontinuing my treatment with the program. I have been informed that deaths have occurred among persons mixing Suboxone (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).

9. I agree to take my medication as my doctor has instructed (place under the tongue until dissolved) and not to alter the dose or the way I take my medication without first consulting my doctor.

10. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in the recovery program as discussed and agreed upon with my doctor and specified in my treatment plan. I agree to attend a **minimum of five (5) AA/NA/MARS meetings and a minimum of two group therapy sessions per week, as well as a minimum of one individual therapy session per month.** I understand that my AA/NA meeting lists must be signed by a chairperson at the meeting. I also understand that the Suboxone Program physician or therapist may require that I attend more than four AA/NA meetings or therapy sessions each week and that failing to follow through on my meeting or therapy attendance may result in termination of my treatment in the Suboxone/Vivitrol Program. Misrepresenting my participation in treatment activities – including AA/NA/MARS – may result in my discharge from the Program.

11. I have been informed of the nature of the treatment and it has explained to me the risks of possible side effects of the medication, including sedation. I have been informed that operating machinery or operating a vehicle is a risk and could have serious consequences i.e. accidents, DUI, etc.

12. I agree to report immediately to Program staff any concerns or problems related to my medication or Program participation.

13. Women of childbearing potential - I agree to tell my Physician if I become pregnant or even think I may be pregnant. I understand that I must submit to bimonthly pregnancy tests throughout the duration of the Program.

14. I agree to provide random urine samples, breathalyzers, and pill/film counts. Failure to submit to any of these upon request may result in my discharge from the Program.

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

I have been informed of the nature of treatment including the risks of possible side effects of possible side effects of the medication including sedation. I have read and understand the above contract. My questions have been answered. I have received a copy of this contract.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date