TREATMENT CONTRACT FOR SUBOXONE (BUPRENORPHINE) THERAPY

PROGRAM REQUIREMENTS AND PATIENT RESPONSIBILITIES

Suboxone (also known as Buprenorphine/Naloxone) is used to help people treat addiction to narcotic drugs. These are the requirements and responsibilities you must follow in order for you to successfully participate in addiction treatment therapy which includes Suboxone. In order to receive Suboxone from Marquette General Health System, you must fully agree to this Treatment Contract and place your initials next to each item and sign this Treatment Contract. Your initials mean you read, understand and acknowledge what is said in the paragraph next to your initials, and if the paragraph calls for an agreement from you, your agreement to fully live up to that agreement, throughout your therapy using Suboxone which we call the Treatment Program in this Contract for Treatment.

1. I read this and acknowledge this is true: _____ Initials	**Information regarding SuboxoneTherapy.** My attending physician has discussed with me various options for treatment of my addiction, including non-pharmacological options. He or she has explained, and I understand, the risks and benefits of Suboxone, including potential side effects. I understand that in order to be a satisfactory candidate for Suboxone I must follow certain safety precautions for the treatment and comply with the treatment schedule prepared for me by my attending physician and/or my substance abuse counselor. Additionally, my attending physician has discussed this agreement with me and explained what is expected of me in the program. Having taken all of this information into account, I desire to enter into Suboxone Therapy and agree to comply with the requirements described herein.
2. I read this and acknowledge this is true and agree to doing this: _____ Initials	**Attendance at all scheduled appointments.** For my health and safety, I will attend all scheduled appointments with my attending physician. In the event that I am required to cancel an appointment, I understand that I may be provided only enough of a Suboxone refill to last me until the next available opening in the physician's schedule. I understand that repeated "No-shows" or a pattern of cancelled appointments will be grounds for discharge from the Suboxone Therapy program.
3. I read this and acknowledge this is true and agree to provide proof: _____ Initials	**Substance abuse counseling.** I understand that in order to be prescribed Suboxone I am *required to be actively involved in substance abuse counseling*. If my substance abuse counselor is located outside of Marquette General Behavioral Health Service Area, I will *provide proof of regular substance abuse therapy attendance (which may be in the form of a note from my substance abuse counselor) at each visit with my attending physician.*

4. I read this and acknowledge this is true and agree to doing this: _____ Initials	**Releases of information.** I hereby agree to release and agree to sign any additional releases of information which will permit all physicians from whom I may receive care at Marquette General Behavioral Health Service**,** including my attending physician, any counselors or therapists I see with regard to substance abuse counseling, the pharmacy at which I shall obtain Suboxone prescriptions, access to my medical records for use in my treatment. I understand that Marquette General Behavioral Health and its affiliated providers will keep my medical information confidential.
5. I read this and understand this and agree to do this: _____ Initials	**Abstinence from alcohol and drugs.** I understand that in order for my participation in Suboxone Therapy to be meaningful, and in order to promote my health and safety, it is necessary for me to agree to and actually abstain from drinking alcohol or taking drugs that have not been prescribed to me. I am aware that random drug and alcohol screens will be a necessary part of my participation in the Suboxone Therapy program as further explained below.
6. I read this and acknowledge this is true and agree to do this: _____ Initials	**Notify in Case of Relapse.** I will notify the office immediately in the event that I relapse, or if I otherwise take any drugs which have not been prescribed to me. I recognize that the office understand that relapse may be part of the disease process, and that honest communication between myself and my attending physician regarding a relapse is essential to my relationship with the physician and my treatment. Additionally, I recognize that it is important for the office to be aware of any relapse BEFORE a positive drug screen is obtained and I will let the office know.
7. I read this and acknowledge this is true and agree to do this: _____ Initials	**Store Medication Properly**. I understand that use of Suboxone can be dangerous to those who do not have a prescription. I will store my medications, including Suboxone, where they may not be accessed by children, or used inadvertently or intentionally by other adults. I will not "share" my medication with anyone.
8. I read this and acknowledge this is true and agree to do this: _____ Initials	**Take as Prescribed.** I understand that use of Suboxone in a manner other than as prescribed may be dangerous to my health. I will take Suboxone exactly as it is prescribed and shall comply with the directions of my attending physician for its use. I will not adjust the dosage myself. If I feel that the dosage of Suboxone prescribed to me is not working correctly, I will contact my attending physician and schedule an appointment to discuss potential alterations in the dosage.

9. I read this and acknowledge this is true and agree to do this: _____ Initials	**Pill Counts**. I understand that in order to ensure that I am taking Suboxone as prescribed, my attending physician or other participants in the Suboxone Therapy program may ask me to bring in my Suboxone medication for a pill count, either in conjunction with a scheduled appointment or at any other time when confirmation of my compliance with the program requirements is desired. I will come to the office within 24 hours of receiving such a request. I understand that my lack of transportation is NOT a valid excuse for failure to report to the office for a pill count. If I live outside of Marquette County, or if I otherwise cannot come to the office within the 24 hour time period, I shall arrange to have the pill count completed by my substance abuse counselor within the original 24 hour time period. In the event it is necessary for me to have my substance abuse counselor perform a pill count, I will alert the office to my inability to come in, my reasons for not coming to the office and my intention to have my substance abuse counselor perform the check.
10. I read this and acknowledge this is true and agree to do this: _____ Initials	**Loss or theft of medication.** In the event I misplace my medication, or if I believe it has been stolen, I will immediately notify the office. I understand that this notification is necessary to protect my continued participation in the program, to ensure me compliance with any pill counting tests, to permit refill prescriptions to be written and to promote good communication between me and my therapy team.
11. I read this and acknowledge this is true and agree to do this: _____ Initials	**Drug Testing.** I understand that in order to ensure that I am abstaining from non-prescribed drugs I will be asked to come to the office for random drug tests. I understand that such drug screens will be "supervised," and that a staff person will be required to be present in the restroom with me in order to ensure that the test specimen is coming from my body. I will come to the office within 24 hours of such a request. I understand that my lack of transportation is NOT a valid excuse for failure to report to the office for a drug screen.
12. I read this and acknowledge this is true and agree to do this: _____ Initials	**"Out of town."** In the event that I am contacted for a pill count or drug screen and cannot report to the clinic because of being out of town, or otherwise unable to travel to the office within the 24 time period (for instance, if I live outside of Marquette County or am hospitalized at the time of the request), I understand that I will be required to provide documentation that proves this at my next scheduled visit with my physician. At the time I report that I am unable to make it to the office I will explain why I am unable to come and indicate the form of written proof I will be bringing to my next appointment. In the event that I will be out of town and require an early refill I must present written evidence showing my travel plans to my attending physician in order to obtain such early refill.

13. I read this and agree to do this: _____ Initials	**Contact information.** I will provide the office with my current contact information, and will update that contact information as necessary. I will notify the office immediately in the event I change my address or phone number.
14. I read this and understand this and agree to this: _____ Initials	**Discharge from program.** I understand that failure to comply with the requirements described above and/or any of the violations listed below may serve as grounds for my discharge from the Suboxone Therapy program: a. A failed drug screen; b. Any attempt by me to alter, substitute, or tamper with a urine specimen obtained for a drug screen; c. A failed pill count; d. Failure to report for required drug screen or pill count, inability of program staff to contact me to request a drug screen or pill count, or a failure to provide documentation verifying that I was "out of town" during a drug screen or pill count request; e. Distribution of Suboxone to any other individual; f. Alteration of my prescription or failure to comply with prescribed use; g. Repeated failure to show for scheduled appointments; h. Any illegal activity related to Suboxone or other drug use; i. Any other breach of the terms of this treatment contract; or j. Dangerous or inappropriate behavior that is disruptive to the clinic or to other patients. This includes coming to the clinic intoxicated or high.
15. I read this and acknowledge this is true and agree to this: _____ Initials	**Discharge.** I understand that I have the right to appeal a decision to discharge me from the Suboxone Treatment Program and that I may do so by contacting the Director of Clinical Services at 225-3985. I may also contact the Patient Advocate at 225-3183 to request assistance or additional information.
16. I read this and agree to this: _____ Initials	**(Women Only) Pregnancy.** I understand that if I become pregnant while taking Suboxone, my baby may experience withdrawal symptoms upon or shortly after birth, as a result of my taking Suboxone. If I become pregnant while I am in the Treatment Program, I shall immediately notify the office. I understand that if I become pregnant while I am not in compliance with other Treatment Program requirements that I will be discharged. I further recognize that if in the judgment of Marquette General Behavioral Health Staff I became pregnant in order to secure participation in the Suboxone/Subutex Treatment Program, I will not be allowed to participate in the Treatment Program. Marquette General Behavioral Health Service is under no obligation to initiate or continue the Treatment Program or to provide me with Subutex Therapy for any pregnancy.

I understand that if I agree to the Treatment Program requirements of this Treatment Contract for Suboxone Therapy, and I have been approved by the Treatment Plan Review Committee, that I will be permitted to participate in the Treatment Program so long as I satisfy Marquette General Behavioral Health Staff that I am continuing to comply in every way with this Treatment Contract.

Prospective Treatment Plan Patient Signature: _____
Prospective Treatment Plan Patient Name Printed: _____
Street Address: _____
Email Address:_____
Personal Phone Numbers:_____
Date:_____

If signed below, the prescribing physician and the Program, the person above is accepted into the Treatment Program conditioned on full and continuing compliance with the terms of this Treatment Contract:

By: _____ By: _____
Director of Clinical Services Prescribing Physician
Marquette General Behavioral Health
Date: _____ Date: _____

My initials here indicate that I have been given a copy of this contract: _____