

## BUPRENORPHINE (SUBOXONE) TREATMENT AGREEMENT

As a participant in buprenorphine (Suboxone) treatment for opioid use disorder, I agree to the following:

1. To keep all my scheduled appointments or change the appointment in advance, except in case of emergency. \_\_\_\_\_
2. I agree not to sell, share, or give any of my medication to another person. \_\_\_\_\_
3. I agree not to deal or buy drugs at GIMC, or in its parking lots or property. \_\_\_\_\_
4. I agree that my medication/prescription will 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. \_\_\_\_\_
5. I agree that the medication I receive is my responsibility and I agree to keep it safe and secure. I agree that lost/ stolen medication will not be replaced regardless of why it was lost/ stolen. \_\_\_\_\_
6. I agree not to obtain buprenorphine (Suboxone), other opioids, or benzodiazepines (for example, lorazepam, diazepam/Valium, clonazepam, alprazolam/Xanax, etc.) from any other healthcare providers, pharmacies, or other sources without telling my treating physician. \_\_\_\_\_
7. I understand that mixing buprenorphine with other medications, especially benzodiazepines (as in #6) can be dangerous. I understand that several deaths have occurred among persons mixing buprenorphine (Suboxone) and benzodiazepines. There is also a risk of overdose death from mixing buprenorphine (Suboxone) with large amounts of alcohol or other types of sedatives, such as barbiturates. \_\_\_\_\_
8. I understand that buprenorphine (Suboxone) by itself is not enough treatment for my addiction, and I agree to participate in counseling/support groups as discussed and agreed upon with my healthcare provider. I understand that if my attendance at these groups is not confirmed then I will not be able to continue to receive buprenorphine (Suboxone). \_\_\_\_\_
9. I agree to provide random urine samples for drug testing and have my healthcare provider test my blood alcohol level whenever I am asked to do so. \_\_\_\_\_
10. I agree that my goal is to stop using addictive drugs, and that I will work to stop using all addictive and illegal drugs during my treatment with buprenorphine (Suboxone). \_\_\_\_\_
11. I agree that violating this agreement may result in my no longer receiving treatment with buprenorphine (Suboxone). \_\_\_\_\_
12. I understand that if I decrease my use of opioids (stop using heroin, pain pills) or substitute buprenorphine for these drugs, I have a higher risk of dying from an overdose if I relapse. I understand that if I relapse, I need to use small doses of opioids until I learn what my body can tolerate. \_\_\_\_\_
13. I understand that if I relapse when I have been taking buprenorphine, at first I may not get high from the other opioids because buprenorphine blocks their effect. I understand that if I keep using larger and larger amounts to try to get high, I could stop breathing and die. \_\_\_\_\_
14. I understand that buprenorphine (Suboxone) is extremely dangerous for infants and children. They can stop breathing and die after taking in tiny amounts of this medication. I agree to keep my supply of this medication locked securely away from others, especially infants and children. \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart # \_\_\_\_\_

I consent to the above terms and to begin treatment with buprenorphine (Suboxone).

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Provider name & signature \_\_\_\_\_ Date \_\_\_\_\_