Robert E. Sterling M.D., DABAM,
120 East Avenue, Suite 1 E
Norwalk, CT 06851

BUPRENORPHINE/NALTREXONE TREATMENT AGREEMENT

Patient Name:_____ Date of Birth:_____
Date of Intake:_____

I am requesting that my doctor provide buprenorphine/naloxone treatment for opioid addiction to_____. I freely and voluntarily agree to accept this treatment. {list drug(s)}
agreement, as follows:

(1) I agree to keep, and be on time for, all my scheduled appointments with the doctor and his/her assistant.

(2) I agree to conduct myself in a courteous manner in the physician's or clinic's office.

(3) I agree to pay all office fees for this treatment at the time of my visits. I will be given a receipt that I can use to get reimbursement from my insurance company if this treatment is a covered service. I understand that this medication will cost between $5-$10 a day just for medication and that the office visits are a separate charge.

(4) I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me and I will not be given any medication until my next scheduled appointment. ***I also agree to avoid the use of all illegal drugs and otherwise non-prescribed controlled substances.***

(5) 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 the law and would result in my treatment being terminated without recourse for appeal.***

(6) I understand that the use of buprenorphine/naloxone by someone who is addicted to opioids could cause them to experience severe withdrawal.

(7) I agree not to deal, steal, or conduct any other illegal or disruptive activities in the vicinity of the doctor's office or anywhere else. Knowledge of this will cause an abrogation of this agreement.

(8) I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit. I understand that early prescriptions will not be written for business travel, trips, vacations or other exigencies planned or unplanned. Therefore plan your schedules accordingly. **MAKE SURE THAT YOU FILL YOUR PRESCRIPTIONS AT THE SAME PHARMACY. THIS WILL PERMIT THE PHARMACIST TO KNOW YOUR PARTICULAR NEEDS.**

(9) I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss. I further agree to report all lost medication to the police and obtain a police report stipulating report of stolen narcotic medication. ***Further, I understand that if I do carry my medication on my person, it must, by law, be in a container that the prescription comes in. I understand that I should not carry all of my medication with me since its loss will not be replenished until my next scheduled appointment.***

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(10) I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine/naloxone with other medications, especially benzodiazepines (sedatives or tranquilizers), such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and/or other drugs of abuse including alcohol, can be dangerous; that the mixing of such medications has caused death by respiratory depression. I also understand that I should not drink alcohol while taking this medication as the combination could produce excessive sedation or impaired thinking or other medically dangerous events as well as respiratory depression.

(11**) I agree to take my medication as the doctor has instructed, and not to alter the way I take my medication without first consulting the doctor.**

(12) I understand that medication alone is not sufficient treatment for my disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my recovery. Such programs consist of AA, NA, psychological counseling in relapse prevention, CBT, Motivational Interviewing, IOP's and other programs. **ADDITIONAL RELAPSE PREVENTION CARE IS NOT OPTIONAL, IT IS REQUIRED. PROOF OF ATTENDANCE WILL BE REQUIRED.**

(13) I freely permit the physicians in this office, (Dr. Sterling or others), to contact those physicians, analysts, counselors, social workers and/or other drug counselors, parole board and similar workers for the purposes of continuity of care for drug abstinence and compliance with this program.

(14) I understand that my buprenorphine/naloxone treatment may be discontinued and I may be discharged from the clinic if I violate this agreement.

(15) I understand that if, in the course of my treatment, I am prescribed other controlled substances (e.g. stimulants such as Adderall, Vyvanse, Concerta, Focalin or any other controlled substance,) I will take that medication as directed without altering or changing the frequency, dose or manner in which they are to be taken. Failure to adhere to this stipulation will result in immediate discharge from the program.

(16) I understand that there are alternatives to buprenorphine/naloxone treatment for opioid addiction including:

a. medical withdrawal and drug-free treatment
b. naltrexone treatment, (both oral or injectable)
c. methadone treatment
d. behavioral therapy without medically assisted treatment

My doctor will discuss these with me and provide a referral if I request this.

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Date