AGREEMENT FOR THE TREATMENT OF ALCOHOL USE DISORDER
SOBER SOLUTIONS OF NORWALK

Pt. Name_____ DOB_____ Date of visit_____

I am requesting that my doctor provide medically assisted treatment for my overuse, tolerance or dependence upon alcohol. I freely and voluntarily agree to stop taking all drugs/substances that can cause dependence to include alcohol, opiates, benzodiazepines, stimulants marijuana and "club drugs and psychedelic drugs.

I accept this treatment in accordance with the agreement as follows:

(1) I agree to keep, and be on time to, all my scheduled appointments with the doctor and/or 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 the cost of medication will be my own/insurance policy expense. I agree to be drug tested at least on a per visit basis and also randomly; and agree to be responsible for the payment of random drug testing at the time of testing ($35.00 fee). Point of service drug tests will be confirmed by a forensic/toxicology lab and those tests will be billed to the patient's insurance. Fees for lab services are solely the responsibility of the patient.

(4) I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the physician and/or 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 would result in my treatment being terminated without recourse for appeal.***

(6) It is my responsibility to protect the medication that I am prescribed. Closely controlled substances that may be prescribed to me must be locked up and kept away from children. A lock box or cupboard is the most appropriate place for such storage.

(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.

(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 prescriptions for controlled substances that are lost 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.

(10) I agree not to obtain medications from any physicians, pharmacists, or other sources

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without informing my treating physician. I understand that mixing alcohol with other medications, especially benzodiazepines (sedatives or tranquilizers), such as Valium

(diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and/or other drugs of abuse, 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 physician in this office, Dr. Sterling 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 alcohol and drug abstinence and compliance with this program.

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

(15) I understand that there are alternatives to medically assisted treatment for alcohol use disorder which may consist of:

a. medical withdrawal and drug-free treatment
b. one on one counseling
c. group therapy following various evidence based protocols
d. relapse prevention groups
e. Alcoholics Anonymous

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

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Date