SC Professional Services, LLC
d/b/a Hope Integrative Medicine
775 Saint James Avenue, Suite B
Goose Creek, SC 29445
Phone: 843.779.7718

Patient Treatment Contract

I, _____ a patient of Hope Integrative Medicine, have been informed that it is necessary to observe strict rules pertaining to the treatment journey I am about to embark on. I agree to the terms and procedures described in this agreement, as a condition of the willingness of the physician whose signature appears below to prescribe or continue prescribing, control substances.

1. Patient visits will be seen weekly for the first month, bi-weekly for the second month, and then monthly after that, unless otherwise specified by physician. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life, and the ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy. Continued participation in the treatment program is contingent on whether my physician believes that the medication use benefits me. I will comply with all treatments as outlined by my physician.
2. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any immediate family member.
3. I agree that I will be subject to voluntary evaluation and subsequent treatment by a psychologist/psychiatrist at my own expense. I will provide Hope Integrative Medicine with any and all copies of psychologist/psychiatrist encounter with date and time of any and all appointments. Any prescriptions for Benzodiazepines or any of the sedative-hypnotics are to be initiated and maintained by a psychiatric consultant.
4. All controlled substances must come from my physician at Hope Integrative Medicine. My controlled substances will come from the physician whose signature appears below, or during his or her absence by the covering physician.
5. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform the Physician's office immediately so my record can be updated.
6. I will inform Hope Integrative Medicine of any new medication or medical conditions, or of any adverse effects l experience from any of the medications that I take.
7. I will inform any and all other of my healthcare providers that I am in a MAT treatment program and inform them of the existence of this agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.
8. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with other healthcare providers, pharmacists, or other professionals, who will provide my healthcare regarding my use of controlled substances for purposes of maintaining accountability.
9. I <u>will not</u> allow anyone else to have, use, sell, or otherwise have access to the medications. The sharing of medications with anyone is absolutely forbidden and against the law and will be grounds for immediate dismissal from the practice.

10. I understand that controlled substances may be hazardous or lethal to a person who is not tolerant of their effects, especially a child, and I must keep them out of reach of such people for their own safety.
11. For female patients of childbearing age, birth control/contraception is mandatory while in treatment. Patients who became pregnant during treatment will be referred immediately to their OB/GYN for further treatment and continuation of their buprenorphine.
12. I understand that tampering in any way with a written prescription is a felony and I will not change or tamper with my doctor's written prescription. I am aware that attempting to obtain controlled substance under false pretense is illegal.
13. I agree not to alter my medication in any way, and I will take my medication as prescribed. I will take my medication as instructed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by my Hope Integrative Medicine Physician.
14. I understand that this drug should not be stopped abruptly as withdrawal symptoms may develop.
15. I will cooperate with all requests for urine drug screens, as well as any random pill/film counts of medication. Failure to comply may result in immediate discharge from the practice. I understand that urine screenings will be done at each and every visit. I understand that the presence of unauthorize and/or illegal substances in the screening described previously may result in prompt discharge from the practice.
16. I understand that medications <u>will not</u> be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request and early refill of my medication, a copy of a filled police report will be required before additional medication is considered.
17. I understand that a prescription may be given early if the physician or patient will be out of the town when the refill is due. The prescriptions will contain instructions to the pharmacist that the prescription may not be filled until the appropriate date.
18. If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I have obtained medications from several pharmacies, all confidentiality is waived, and these authorities may be given full access to my records of controlled substance administration.
19. I will keep my scheduled appointments in order to receive medication renewals. If I need to cancel my appointment, I will do so with a minimum of 24 hours' notice prior to my scheduled appointment. Failure to give the office the necessary notice will result in a cancellation fee of $25.00 per missed appointment. I understand that if I miss my appointment, I will have to be rescheduled to the next available appointment and will not be able to get medication renewal until I am seen. I understand that if I miss more than three appointments with no notice, I will be subject to dismissal from the practice.
20. I understand that I will be asked to bring in my medication in their original containers to the office while I am on Substance Abuse Treatment.
21. Refills will not be given over the phone, after office hours, during the weekend, or on holidays.
22. The risks and potential benefits of these treatments have been explained to me, including, but not limited to psychological addiction, physician dependence, withdrawal and overdose.

23. I understand that failure to adhere to these policies and/or failure to comply with the physician's treatment plan may result in cessation of therapy with controlled substance of therapy by this prescribing physician.
24. I, the undersigned patient, attest that the foregoing was discussed with me and that I have read, fully understand, and agree to all the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this agreement.
25. I acknowledge I have read and been given a copy the Patient Intake packet to review and take home with me. I agree to all the terms and conditions stipulated there and will be held accountable for all directions on that packet.

Patient Name / Authorized Representative (Please Print)	Date of Birth
Patient Name / Authorized Representative Signature	Date
Physician's Signature	Date