

Patient Treatment Contract

Patient Name: _____ Date of Birth: _____

I acknowledge that the prescribing or continuation of controlled substances is subject to specific clinical requirements and practice policies. I agree to comply with the terms and procedures outlined in this agreement as a condition of the provider's determination to prescribe or continue prescribing controlled substances.

1. For new patients, 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 medical provider.
2. I will inform my medical provider of any current or past substance abuse, or any current or past substance abuse of any immediate family member.
3. I will be on time to my appointments. If I am more than 15 minutes late, I may be asked to reschedule my appointment.
4. I understand that any form of verbal abuse or disrespect—whether expressed by me, a family member, or anyone accompanying me—toward anyone in the office will not be tolerated and will result in dismissal from care. Please be kind.
5. I agree that I may be recommended for evaluation and subsequent treatment by a mental health provider at my own expense. I will provide Hope Integrative Medicine with any and all copies of mental health encounters. Any prescriptions for benzodiazepines or any of the sedative-hypnotics are to be initiated and maintained by a psychiatric provider. No benzodiazepines will be prescribed by HIM.
6. All controlled substances must come from my medical provider at Hope Integrative Medicine unless approved by Hope Integrative Medicine.

7. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform the office immediately so my record can be updated.
8. I will inform Hope Integrative Medicine of any new medication or medical conditions, or of any adverse effects I experience from any of the medications that I take.
9. I will inform any and all other of my healthcare providers that I am in a medication assisted 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.
10. I agree that my medical provider 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.
11. I will not 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.
12. 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.
13. 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.
14. 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 substances under false pretense is illegal. I will also not see multiple providers for the same prescriptions. This will result in immediate dismissal from the practice.
15. 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 medical provider.
16. I understand that this drug should not be stopped abruptly as withdrawal symptoms may develop.
17. I will cooperate with all requests for urine drug screens, as well as any random pill/film counts of medication. I will submit to urine drug screen within 48 hours of request unless otherwise directed by the office. A positive urine drug screen for mood-altering substances (excluding marijuana) or medications not prescribed to me will require weekly urine drug testing until a negative result is obtained. Failure to comply may result in immediate discharge from the practice.
18. I authorize and understand that urine screenings will be done at every visit. For virtual appointments, I understand that a urine drug screen must be completed prior to the appointment, and no medications will be prescribed until this requirement is met. If I am unable to provide a urine sample, I understand that an oral swab test will be administered. I understand that the presence of unauthorized substances, including legal but mood altering over the counter and/or illegal substances in the screening described previously may result in prompt discharge from the practice.

19. I understand that medications will not be replaced if they are lost, damaged, or stolen. If any of these situations arise, a copy of a filed police report will be required and the Medical Director will determine if additional medication may be prescribed.
20. I understand that prescriptions will not be provided early except in the event of an emergency, as determined by the medical provider. Any prescription issued under such circumstances will include instructions to the pharmacist specifying that it may not be filled until the appropriate date.
21. 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.
22. I authorize the practice to send me appointment reminders via text and email. I will keep my scheduled appointments in order to receive medication refills. 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 \$50.00 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 refills 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.
23. I understand that I may be asked to bring in my medication in their original containers to the office.
24. Refills will not be given over the phone, after office hours, during the weekend, or on holidays.
25. The risks and potential benefits of these treatments have been explained to me, including, but not limited to psychological addiction, physical dependence, withdrawal and overdose.
26. I understand that failure to adhere to these policies and/or failure to comply with the medical provider's treatment plan may result in termination from the practice.
27. 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.
28. I acknowledge I have read and been offered a copy of the treatment contract 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 Signature

Date

Medical Provider's Signature

Date