Prestige Virtual Care
8901 E Pima Center Parkwway
Ste #115
Scottsdale, Az 85258

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 mounts 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. If another person ingests my Suboxone, I will immediately call 911 or Poison Control at 1-800-222-1222. I agree to take full responsibility for the safekeeping of my Suboxone. Lost or stolen Suboxone will not be refilled before the date it was due to be renewed unless I can give the clinic a copy of the police report of the loss. I understand my physician reserves the right to refuse refills.
15. 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.
16. If I alter or forge a prescription, I understand that my MAT provider has the right to terminate my care immediately and will inform the pharmacy and legal authorities of this felony act.
17. I agree to participate in a regular program of professional counseling as recommended by my MAT health care team. If the program or counseling substance abuse counselor is located outside of the clinic, I will provide proof of attendance (which may be in the form of a note) at any programs or professional counseling that my MAT health care team recommends at each visit to my MAT care team.
18. I agree to receive support from peers as recommended by the MAT clinic staff and agree to invite significant persons in my life to participate in my treatment.

Prestige Virtual Care
8901 E Pima Center Parkwway
Ste #115
Scottsdale, Az 85258

19. I agree that a network of support and honest communication are important parts of my recovery. I will provide authorization to allow telephone, email, or face-to-face contact between the MAT clinic staff and physicians, therapists, probation or parole officers, the Department of Social Services, and parents to discuss my treatment and progress. I consent to allow the staff of the MAT clinic to provide others with information regarding my medication usage as needed for my treatment or as otherwise permitted or required by law.
20. I understand that buprenorphine can only be prescribed by a specially licensed physician (buprenorphine provider). I can only get buprenorphine refills as scheduled. I will not be able to obtain buprenorphine refills during walk-in visits, after regular clinic hours or on weekends.
21. I must take my medications as instructed by my buprenorphine provider. I cannot change the way I take my medications or adjust the dose until approved by my buprenorphine provider.
22. I agree to see my buprenorphine provider on a regular basis. The frequency of visits will be up to my buprenorphine provider and will be explained to me.
23. If I miss an appointment or if I need to reschedule an appointment for a later date, I understand that my medications will not be refilled until the time of my next scheduled appointment with a buprenorphine provider. I understand that if I miss or am late to three appointments and did not call the clinic in advance and provide at least 24hr notice I will be dismissed from the buprenorphine maintenance clinic and I will not be given any refills for my medication. I may also be given a lower dose, enough to avoid withdrawal.
24. I understand my Suboxone provider will monitor my compliance by counting my Suboxone tablets or films. I agree to bring my Suboxone medication to each Suboxone clinic visit.
25. I understand that I may be asked to bring in my Suboxone medication to be counted at any time and will come into the office within 24 hours of receiving such a request.
26. I understand that my Suboxone provider will monitor my medication compliance by doing urine or blood drug screens at each visit at my cost. I consent to testing for this purpose and I understand that it is a requirement of my participation in the buprenorphine clinic. Drug screens will be "supervised," and a staff person will be required to be present in the restroom with me in order to ensure that the test specimen is coming from my body.
27. I agree to notify the clinic immediately in case of relapse to opioid drug abuse. Relapse can be life threatening, and an appropriate treatment plan must be developed as soon as possible. I understand the physician should be informed about relapse before any urine test shows it.
28. My provider has recommended that I obtain my Suboxone from a single pharmacy. The pharmacy I would like to designate is:

    Pharmacy Name/location: ____

    Pharmacy Phone: ____

29. I agree to conduct myself in a courteous manner in the physician's or clinic's offices.
30. I agree to pay all office fees for this treatment at the time of my visits. Failure to do so will result in immediate termination of services.
31. I understand that if I do not uphold this agreement, I will be dismissed from the program.

Patient's name (Print): ____ Date of birth ____ / ____ /_____

Patient's signature:____Date:__________________________

Provider's name (Print):____

Provider's signature ____Date:__________________________