Fountains of Health

Fountains of Health

7 Taggart Drive, Suite E
Nashua, NH 03060 Tel: 603-943-8923

PATIENT AGREEMENT FOR SUBOXONE TREATMENT:

I,_____ , understand and voluntarily agree that (initial each statement after reviewing):

I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team____

I will participate in all other types of treatment that I am asked to participate in____

I will keep the medicine safe, secure and out of the reach of children____

If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all____

I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team____

I will not call between appointments, or at night or on the weekends looking for refills___

I understand that prescriptions will be filled only during scheduled office visits with the treatment team____

I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately____

I will treat the staff at the office respectfully at all times

I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped____

I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped____

I will sign a release form to let the doctor speak to all other doctors or providers that I see. I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine____

I will use only one pharmacy to get all on my medicines:

Pharmacy name_____

Telephone Number_____

I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Amphetamine) without telling a member of the treatment team before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends____

I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped____

I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs___

I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore____

I understand that I may lose my right to treatment in this office if I break any part of this agreement____

PROVIDING OFFICE STATEMENTS

We here at **FOUNTAINS OF HEALTH** are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment. We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects____

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well. We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals____

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively. We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for____

Patient signature _____

Patient name printed _____

Date_____

Provider signature_____

Provider name printed Date _____

*Adapted from the American Academy of Pain Medicine