Tremont Medical Center, P.A.

CONTRACT FOR MEDICALLY ASSISTED TREATMENT WITH SUBOXONE

When abstinence and other treatments for addiction have been unsuccessful, medical treatment including Suboxone can be considered. Suboxone film is a prescription medicine that contains the active ingredients buprenorphine and naloxone. It is used to treat adults who are addicted to opioids (either prescription or illegal).

All medications have possible side effects. Please speak to your physician about any concerns you may have.

TO PARTICIPATE IN THE PROGRAM, YOU MUST AGREE WITH THE FOLLOWING STATEMENTS:

1. I WILL NOT allow other individuals to take my medication.
2. I WILL obtain all medications/prescriptions from Dr. Tope.
3. I WILL inform Dr. Tope if I see another physician in an emergency for any other medical reason.
4. I WILL actively participate in additional therapies as requested by Dr. Tope.
5. I AM NOT involved in the sale, illegal possession, diversion, or transport of controlled substances.
6. I WILL fill all of my prescriptions at one pharmacy where my prescriptions will be filled.
7. I UNDERSTAND that lost or stolen prescriptions WILL NOT be replaced.
8. IF I AM a female of childbearing age, a pregnancy test will be done at no charge. I WILL inform Dr. Tope if I become pregnant.
9. I AGREE to random pill counts and urine and alcohol lab testing. I WILL present my medication packets, both used and unused within 24 hours upon request.
10. I WILL return any medications that I cannot take to Tremont Medical Center and they will be logged and secured by a member of the clinical staff before any new prescription is given.
11. I UNDERSTAND that if I “NO SHOW” to a scheduled appointment, I will be required to schedule another appointment in order to obtain a refill. NO REFILL APPOINTMENTS WILL BE MADE ON MONDAYS.
12. I WILL secure my medications safely and I WILL employ childproofing measure to keep medications out of the reach of children.

I UNDERSTAND THAT MEDICATIONS MAY BE DISCONTINUED OR THAT I MAY BE DISCHARGED IF ANY OF THE FOLLOWING OCCUR:

1. Dr. Tope feels that the program has not produced an improved level of function.
2. I give away or sell the medications.
3. I allow my medications to be stolen.
4. I lose or misplace my prescription or medications.
5. I do not follow instructions or take more medications that are prescribed.

6. I obtain medications from sources other than Dr. Tope
7. I use other illegal substances or alcohol.
8. I do not comply with random pill counts within 24 hours.
9. I do not give a sufficient urine specimen when requested.
10. I do not keep appointments with Dr. Tope or referral appointments.
11. If I commit prescription fraud.
12. If I destroy my medications without the consent of my physican.
13. If I verbally abuse the office staff either in person or on the telephone.

REFILLS OF MEDICATIONS WILL BE BY APPOINTMENT ONLY DURING REGULAR OFFICE HOURS TUESDAY-FRIDAY. REFILLS WILL NOT BE MADE ON MONDAYS.

I have read this document and understand it. I spoke with a staff member prior to my appointment. I consent to the use of the medications that Dr. Tope feels will be the most beneficial to me. I understand that my treatment will be carried out in accordance with the conditions stated above. I understand that if I do not follow the conditions of this contract, I can endanger my life as well as my health. I understand that any infractions of the above conditions may result in therapeutic detoxification from the medications or immediate discharge from the practice.

Patient Signature _____ **Date** _____

Dr. Tope Signature _____

I have received a copy of this contract _____ (Initial)