OBAT AGREEMENT

_____As a patient in the OBAT program, I freely and voluntarily agree to accept this treatment contract, as follows.

_____I agree to keep all my scheduled appointments with my provider and nurse, and to conduct myself in a courteous manner in the clinic. It is my responsibility to call the clinic if I will be late/early or need to reschedule my appointment.

_____I agree not to arrive at the clinic intoxicated or under the influence of substances. If I do, my treatment plan may be adjusted accordingly. If a team member observes signs of intoxication or sedation, I may be evaluated by a provider and this could result in the delay of induction or the administration of medications.

_____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 may result in referral to a higher level of care or discharge.

_____I agree not to conduct any illegal, threatening, or disruptive activities in the clinic. This is grounds for discharge.

_____I agree not to tamper with urine screens and if I do so, this may be grounds to referral to a more intensive treatment program. I agree to provide a fresh urine specimen, of at least 30ml and within an acceptable temperature range. I understand that if the sample is less than the required amount or is not an acceptable temperature, the sample will not be accepted.

_____I agree that my prescriptions can be given to me only at my regularly scheduled times. Missed appointments with my Primary Care Provider, Recovery Nurse Care Manager, and Therapist may result in my not being able to get medication until the next scheduled visit.

_____I agree that the medication I receive is my responsibility and that I will keep it in a safe and secure place. I agree that lost medication may not be replaced regardless of the reasons for such a loss. My medication should never be kept in public places, and should be out of the reach and sight of children at all times. My medication should be kept in a labeled container that displays a prescription label.

_____I agree that if I obtain medication from any doctors, pharmacies, or other sources that I will inform my physician and/or OBAT nurse immediately.

_____I agree to take my medication as the provider has instructed and not to alter the way I take my medication without first consulting my provider or nurse.

_____I agree to random call back visits that include toxicology screens and medication counts. I understand that I need to have a working telephone contact. When called for random call backs, I need to respond within 24 hours by telephone.

Patient name_____ **DOB** _____

Initials_____

_____I agree not to consume poppy seeds while in this treatment program. Poppy seed consumption will not be accepted as a valid reason for a positive opioid screen.

_____I understand that if I misuse other substances or medications, this issue will be addressed through changes in my treatment plan to assist me. Positive urine screens for any non-prescribed medications and/or illegal drugs will result in weekly urine testing until 3 consecutive urine drug-free results are documented. If I continue to struggle with ongoing substance use this could be grounds for transfer to other more intense treatment options.

_____Positive urine screens for opioids will be evaluated by the treatment team. Ongoing positives or missed urines will prompt a team meeting to discuss a potential change in treatment plan including a referral to more intense treatment.

_____OBAT providers will access the Prescription Drug Monitoring Program to review medication profiles on all patients. If patients are found to be accessing prescriptions from other providers, this finding will be reviewed by the OBAT team. If it is determined that the medications obtained by any other providers are in violation of the treatment agreement, the OBAT Team will evaluate the situation, address it with me, and adjust my treatment plan.

_____I understand that the Office Based Addiction Treatment Program does not have a chain of custody over the urines, the purpose of these tests are for my treatment in OBAT only. If patients have legal or program requirements that require observed urine toxicology testing, this should be done independent of your treatment in OBAT.

_____If I am female and of child bearing age it is recommended that I utilize contraceptives while on treatment. If I become pregnant while on buprenorphine/naloxone I will alert my health provider immediately. This will result in a transfer to a provider who can safely treat me.

_____I understand that using a new medicine can cause me to react in a number of ways. I understand that it is recommended that I do not drive when I first start taking medication until I know how that medication affects me.

_____I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in the recovery services, as provided, to assist me in my treatment.

_____I understand that my medical records will be kept in an electronic medical record. These notes will be visible to any healthcare professional involved in my care at this institution. The healthcare providers will only access my medical record if they are involved in my care.

_____I have discussed all appropriate medication options with my provider and have had the opportunity to discuss alternatives to medication as well.

_____If at any time I am discharged from this program I may be reconsidered at a future time.

Patient Printed Name_____ **DOB**_____

Signature_____ **Today's Date**_____

Witness Printed Name_____ Date_____

Signature_____