Patient Agreement for Buprenorphine (Suboxone) Maintenance Therapy

I understand that I have been prescribed a medication that will cause drug dependency and can be easily misused and overused. To help reduce my risk of harm from these medications I agree to the following rules.

1. I understand that buprenorphine can only be prescribed by a specially licensed physician (buprenorphine provider). I can only get buprenorphine refills during scheduled office visits with my buprenorphine provider and I will not be able to obtain buprenorphine refills during walk in visits, after regular clinic hours or on weekends.

2. 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, Jeffrey A. Kidd, M.D.

3. 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.

4. 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.

5. I understand that my buprenorphine provider will monitor my medication compliance by doing urine or blood drug screens at each visit. I agree to test for this purpose and I understand that it is a requirement of my participation in the buprenorphine clinic. I also understand that testing is not designed to punish me, but to provide a therapeutically appropriate response.

6. I understand my buprenorphine provider will monitor my medication compliance by counting my buprenorphine tablets. I agree to bring my buprenorphine medication to the clinic when asked.

7. I agree to take full responsibility for the safekeeping of my buprenorphine. Lost or stolen buprenorphine will not be replaced or refilled before the date it was due to be renewed.

8. I agree to notify the clinic immediately in case of relapse to drug abuse. Relapse to opiate drug abuse can be life threatening, and an appropriate treatment plan must be developed as soon as possible. I understand the physician should be informed about a relapse before any urine test shows it.

9. I agree to inform my buprenorphine doctor and all other care providers I am seeing of all medications I am taking. I understand this is important for my safety and to assure that another medication is not prescribed which may lead to harmful side effects.

10. I consent to allow the staff of Pain Management Center, Inc. to provide others with information regarding my medication usage as needed for my treatment or as otherwise permitted or required by law.

11. I agree to remain free of all other substances of abuse, testing for which will be undertaken at my expense at the discretion of my provider. Failure to comply with this will result in the discontinuation of my participation in the program and no more prescriptions for buprenorphine will be dispenses.

12. If I alter or forge a prescription, sell or in any way distribute prescribed narcotics or other controlled medications, including buprenorphine, to any other person, I understand that the Pain Management Center, Inc. Will terminate my care immediately and will inform the pharmacy and legal authorities of this felony act.

13. I understand by participating in the Suboxone program that I will solely be prescribe Buprenorphine (Suboxone).

14. I understand that if I miss three appointments and did not call the clinic in advance to cancel my appointment, I will be dismissed from the buprenorphine maintenance clinic and I will not be given any refills for my medication.

15. I understand that if I do not uphold this agreement I may be dismissed from Pain Management Center, Inc.

16. My provider has recommended that I obtain my buprenorphine from a single pharmacy.

17. I understand the treatment program for the office-based withdrawal from an opiate as described by Dr. Jeffrey A. Kidd. I have been given informational brochures about the program and adequate time to have my questions answered. As a result, I voluntarily consent to the program.

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Patient's Name

_____ _____

Patient's Signature **Date**