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Suboxone® Treatment Agreement

Name: _____

Date of Birth: _____

1. I understand that Suboxone® is a combination of buprenorphine and naloxone. Naloxone will counter act any opioid I'm taking, causing precipitated withdrawal. I understand I must take Suboxone® as ordered and follow instructions outlined.

2. I understand that Suboxone® is an opioid drug that, if taken in large quantities, can produce a "high." I know that if I abruptly stop taking it, I could experience opioid withdrawal symptoms.

3. My provider has discussed with me various options for treatment of my addiction, including non-pharmacological options. I understand the risks and benefits of Suboxone®, including potential side effects. I understand that I must follow certain safety precautions for the treatment and comply with the treatment the schedule as discussed by my provider.

4. I will take Suboxone® as directed. I will never inject Suboxone® as that could lead to sudden and severe opiate withdrawal.

5. I will not drive a motor vehicle or use power tools or other dangerous machinery while taking Suboxone® until my doctor has cleared me to do so.

6. I understand that mixing Suboxone® with alcohol or other sedatives, such as benzodiazepines, could result in accidental overdose that may lead to organ failure, coma, or death. I agree to abstain from **alcohol** and **sedatives** while I am taking Suboxone® unless otherwise prescribed by my Suboxone® provider.

7. I understand that Suboxone® is designed to treat opioid dependence, not addiction to other classes of drugs. Therefore, I will work with my provider to design an individualized treatment program to assist me in discontinuing the use of any other drugs.

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8. My medication must be protected from theft or unauthorized use. I agree to take full responsibility for the safekeeping of my Suboxone®. If my medications are stolen, I will file a report with the police and notify my provider and treatment team. If another person ingests my Suboxone®, I will immediately call 911 or Poison Control at 1-800-222-1222. Lost or stolen Suboxone® will not be refilled unless I can give the clinic a copy of the police report. I understand my physician reserves the right to refuse refills.

9. I agree not to sell, share, or give any of my medication to another person.

10. If I alter or forge a prescription, I understand that my provider has the right to terminate my care immediately and will inform the pharmacy and legal authorities of this felony act.

11. I agree to participate in a regular program of professional counseling as recommended by my provider and treatment team.

12. 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.

13. I agree to see my Suboxone® provider on a regular basis. The frequency of visits will be up to my provider and will be explained to me.

14. I understand that my provider will monitor my medication compliance through regular urine drug screens at my cost.

15. I agree to pay all office fees for this treatment at the time of my visits. Failure to do so is cause for termination of services.

I have read and understood all the requirements as stated and consent to treatment with Suboxone® for opioid use disorder.

Signature: _____ Date: _____