Vista Behavioral Health, LLC
152 Simsbury Road
Bldg 9, Fl 2
Avon, CT 06001
(860) 269-3101

As a patient at this office, and/or a participant in the buprenorphine protocol for treatment of opiate abuse and dependence, l freely and voluntarily agree to accept this treatment contract, as follows:

I agree to keep and be on time to all my scheduled appointments.

I understand that participation in treatment involves a fee that may be reimbursed by insurance.

I agree to pay my bill/co pay at the time of service and am responsible for any charges not covered by my insurance.

I agree to conduct myself in a courteous manner in the physician's office.

I agree not to sell, share or give any medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.

I agree not to deal, steal or conduct any other illegal or disruptive activities in the doctor's office.

I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visit 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 secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.

I agree to thoroughly dispose of pharmacy labels from discarded medication bottles and packaging.

I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines, such as Valium and other drugs of abuse, can be dangerous. I also understand that a number of deaths have been reported among persons mixing buprenorphine with benzodiazepines.

I agree to take my medication as the doctor/nurse practitioner has instructed and not to alter the way I take my medication without first consulting the doctor/nurse practitioner.

I understand that medication alone may not be sufficient treatment for my disease. I agree to participate in substance abuse and or behavioral health treatment programs, which may be recommended to assist me in my recovery.

I agree to abstain from alcohol, opiates, marijuana, cocaine and other addictive substances (excluding nicotine).

I agree to provide random urine or saliva for verification of abstinence at my expense if necessary.

Violation of the above are grounds for termination of treatment.

_____ _____

Name Date