Atlanta Stress Center: Opioid Replacement Medication Patient Treatment Contract

Patient Name:_____ Date:_____

As a participant in medication treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to be on time to all my scheduled appointments.
2. I agree to adhere to payment policy outlined by this medical office.
3. I agree to conduct myself in a courteous and respectful manner in the doctor's office.
4. I agree not to sell, share, or give any of medication to another person. I understand that such mishandling of my medication is a serious violation and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if any illegal or disruptive activities are observed or suspected by employees at this office, or at the pharmacy where my medication is filled, that my treatment could be terminated without any recourse for appeal.
7. I agree that my medication prescriptions can only be given to me at my regular office appointments. A missed appointment may result in my not being able to get my medication prescription until the next scheduled visit.
8. I agree that the medication that I receive is my responsibility. I agree to keep it in a safe and secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medication from any other doctor, including opioid or benzodiazepine medications, while being treated by my doctor at the Atlanta Stress Center. This could be grounds for immediate termination of treatment without recourse for appeal.
10. I agree to use one and only one pharmacy to obtain my prescribed medication. I understand that using more than one pharmacy could be grounds for immediate termination of treatment.
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition and I agree to participate in counseling and/or groups as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine) throughout treatment.
14. I agree to provide urine drug samples to AnyLabTest now at least 4 days before my scheduled appointment so that my doctor will have the results before my appointment. I understand that failure to do so will be considered a relapse and increased treatment plan provisions will be required.
15. I understand that relapse use of any opioid or other addictive substances will require increased treatment as outlined in the treatment plan. Relapse is part of opioid addiction; a single relapse may cause termination of treatment, this depends on my willingness to increase treatment.

Patient signature:_____Date:_____