PATIENT MEDICATION TREATMENT AGREEMENT CONTRACT

Patient Name: _____ DOB: _____

As a patient who desires medication treatment from Dr. Doucette and Doucette Consultants LLC, including prescription treatment with the use of controlled substances, I freely and voluntarily agree to accept this treatment contract as follows:

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

2. I agree to adhere to the payment policy outlined by this office.

3. 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 would result in my treatment being terminated without any recourse for appeal.

4. I understand that if dealing or stealing or if any illegal or conducting threatening (verbal or physical) activities towards my doctor and/or my treatment staff, could result in my treatment being terminated without any recourse for appeal.

5. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.

6. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.

7. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.

8. I understand that mixing this medicine with other medications, especially benzodiazepines (for example, Valium®* , Klonopin ®† , or Xanax ®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses). I agree to not concurrently use, or mix, these medications, as they can result in respiratory depression and/or death.

9. I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events.

10. 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.

11. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.

12. I agree to abstain from illegal substance use.

13. I agree to provide random urine samples and have my doctor test my blood alcohol level, if requested or recommended by my doctor. I understand this information will remain confidential and be monitored in accordance to medical safety as deemed appropriate by my doctor.

14. I understand that violations of the above may be grounds for termination of treatment with Dr. Doucette and Doucette Consultants LLC.

_____ _____

Patient Signature **Date**