Patient Agreement to Medication Assisted Treatment for Opioid Use Disorder

Patient Printed Name:	_____	Patient DOB:	_____
PCP Printed Name:	_____		

Please read this Agreement carefully, and ask your provider if you have any questions.

This Agreement between myself and ETSU Health is intended to provide important information about the use of Buprenorphine as part of my course of treatment for my diagnosis of Opioid Use Disorder.

I understand that ETSU Health will prescribe Buprenorphine only if the following terms are adhered to:

1. I will keep my medication in a safe and secure place away from children and others who should not have access to my medication (e.g., in a lock box). My plan is to store it (describe where and in what):

   _____

   _____

2. I will take the medication exactly as my ETSU Health doctor prescribes. If I want to change my medication dose, I will speak with the doctor first. Taking more medication than my doctor prescribes or taking my medication more often than my doctor prescribes is medication misuse. Taking the medication by snorting or by injection is also medication misuse. If misuse is found to be occurring, this may result in referral to a higher level of care or change in medication based on my doctor's evaluation.
3. I will fill my controlled substance prescriptions at one pharmacy. This pharmacy is authorized to release a record of my medications to this office upon request.

   The pharmacy that I have selected is: _____

   The pharmacy phone number is: _____

   I understand in certain situations I may need to fill my prescription at a different pharmacy for reasons not under my control (e.g. medication shortages). I understand ETSU Health monitors when and where I fill my prescriptions for controlled medications and any evidence of inappropriate behavior may violate the terms of this Agreement.

4. I will be on time to my appointments and be respectful to the office staff and other patients.
5. I understand an office appointment with my doctor is necessary to obtain refills for Buprenorphine. Requests for refills made after clinic hours or on weekends will not be honored. I understand that if I take my medications more often than prescribed then I will "run out" early. If this happens my medications will not be filled early. Accidental destruction, loss of medications or prescriptions will not be a reason to refill

medications or rewrite prescriptions early.

6. If I come to the office intoxicated, I understand that the doctor will not see me, and I will not receive more medication until the next office visit.
7. Violence, threatening language or behavior, or participation in any illegal activity at the office may result in treatment termination from our clinic.
8. I will keep my ETSU Health doctor informed of all my medications (including herbs, vitamins, and other over-the-counter medications) and medical problems. I understand I must immediately inform my ETSU Health Clinic of any new medications or treatments.
9. I understand it is against the law to provide false information to my provider to try to obtain controlled substances. I understand it is against the law to visit multiple doctors to try to obtain controlled substances.
10. If I am going to have a medical procedure that will require a sedative or opioid medication, I will let my ETSU Health doctor know in advance so that my condition will be adequately treated.
11. I understand that it is illegal to give away or sell my medication – this is diversion. If I do this, I may be referred to a higher level of care or require a change in medication based on my doctor's evaluation.
12. I will submit urine, saliva and/or blood on request for testing at any time, without prior notice. These tests will be used to detect the use of non-prescribed drugs and medications and confirm appropriate use of prescribed ones. If I do not provide a sample at the time it is requested, it will count as a positive drug test. I will pay any portion of the costs that result from urine and blood testing that is not covered by my insurance.
13. I understand that I may be called at random times to bring my medication bottle into the office for a pill/film count. Missing medication doses could result in referral to a higher level of care at this clinic or potentially at another treatment provider based on my individual needs.
14. I understand that people have died by mixing Buprenorphine with other drugs like alcohol and benzodiazepines (drugs like Valium®, Klonopin® and Xanax®).
15. I understand that treatment of opioid use disorder involves more than just taking my medication. I agree to comply with my ETSU Health doctor's recommendations for additional counseling and/or for help with other problems.
16. I understand that there is no fixed time for being on Buprenorphine.
17. I understand that I may experience opioid withdrawal symptoms when I stop Buprenorphine.
18. I have been educated about the other two FDA-approved medications for opioid dependence treatment: Methadone and Naltrexone.
19. **For Women of Childbearing Age with Reproductive Capacity (under Tennessee law ages 15-44):** I have been educated about the effects of poor diet, illicit opioid use, use of dirty needles/sharing injection equipment, physical and mental trauma, and lack of pre-natal medical, substance use and mental health care during pregnancy and how these things can adversely affect my health and my current or future fetus/newborn's health. I understand that neonatal abstinence syndrome can occur when taking illicit opioids and that neonatal abstinence syndrome (NAS) is less severe, but can still occur, when pregnant women take Methadone or Buprenorphine as prescribed/dispensed in substance use disorder treatment. Cigarette smoking can make the severity of NAS worse and cause pre-term birth and small babies. Alcohol use can cause significant cognitive/brain damage in fetuses and newborns. I recognize that the long-term consequences of a child's development who was exposed to opioids is not fully understood and cannot be predicted, but it could be harmful to the child. I also understand that **birth defects** can occur to any baby whether or not the mother is on medications and there is always the possibility that my baby will develop a birth defect while I am taking an opioid or any other medication.
20. **Birth control counseling:** I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting Buprenorphine treatment and offered methods for preventing pregnancy. I have been informed of the birth control (or contraceptive) options available to me. I understand that birth control can reduce the chances that I become pregnant while being treated with an opioid medication such as Buprenorphine. I have been counseled on appropriate and effective forms of birth control. I have also

received information about how I can receive free or reduced cost birth control. ***If I plan to become pregnant or believe that I have become pregnant while taking controlled substances, I will immediately inform my ETSU Health Clinic.***

21. My doctor may discontinue or adjust my medications at any time, as needed.

I understand that I am responsible for meeting the terms of this Agreement and if I fail to do so my doctor may refuse to prescribe Buprenorphine as part of my treatment. In certain instances, I may be dismissed from ETSU Health if I fail to meet the terms of this Agreement. Grounds for dismissal from ETSU Health include, but are not limited to: evidence of recreational drug use; drug diversion (selling or giving drugs to other people); altering prescriptions; obtaining controlled substances from other providers without notifying my ETSU Health Clinic; abusive language toward staff; engagement in criminal activities, etc.

By signing below, I confirm that I have read and understand this Agreement, and that I had the opportunity to have this Agreement explained to me. I confirm that I have had the opportunity to ask questions and that all my questions have been answered. I understand treatment that includes controlled medications is not the only option to treat my condition or symptoms, and the benefits and risks of alternative treatments (including declining treatment) have been explained to me. By signing below, I confirm that I have enough information to make a decision to use Buprenorphine as prescribed as part of my course of treatment.

You should NOT sign this form if you do not believe you have enough information to make an informed decision about your use of Buprenorphine and how Buprenorphine fits into your opioid use disorder treatment plan.

Patient Signature:	_____	Date:	_____
Physician Signature:	_____	Date:	_____
Witness Signature:	_____	Date:	_____

If signed by someone other than the Patient, state your relationship to the Patient and a description of your authority to act on the Patient's behalf:

_____.