Holon Inclusive Health System
P.O. Box 242
Wildwood, MO 63040
Phone: 844-902-2554 Fax: 636-242-5095

Patient Contract and Informed Consent for Treatment with Buprenorphine Medication

This agreement between _____ (patient) and HIHS and any associates contracted with HIHS, on this _____ day of _____ 20_____, is for the purpose of establishing an agreement between the provider and patient on clear conditions that the patient agrees to in order to receive buprenorpine. The provider and patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a provider/patient relationship.

I agree to and accept the following conditions for my psychiatric treatment: (initial by each)

_____1. I understand that controlled substances carry multiple health risks. (Risks may include addiction and withdrawal from physiological dependence. Overdose and withdrawal of controlled medications may cause injury or death. I am aware there may be interactions with other medications, and unknown risks of long-term controlled substance use).

_____2. Buprenorphine is a medicine that is approved by the Food and Drug Administration (FDA) for the treatment of opioid dependence. It can be used for detoxification or for maintenance. The goal of treatment of opioid dependence is to learn to live without misusing drugs. I understand that if I am taking this medication for any condition other than those listed above than it is considered "off label" and that the FDA may not have safety or efficacy data available in that disease state and it puts me at a higher risk of adverse effects, side effects, or long term adverse outcomes up to and including death all of which may be unknown because it has not been studied. I understand and accept fully the responsibility of the potential for adverse outcomes with this medication.

_____3. Alternatives to Buprenorphine: Some hospitals have special drugs treatment units that can provide detoxification and counseling for drug abuse. Some outpatient drug abuse treatment services also provide individual and group therapy that may recommend treatment that does not include Buprenorphine or other opioid medications. Another form of opioid maintenance therapy is Methadone Maintenance. Also, some opioid treatment programs use Naltrexone, a medication that blocks the effects of opioids but has no opioid effect itself. Each of these options has their own associated risks and benefits, which I have talked about with my practitioner.

_____4. I understand that Buprenorphine is an opioid medication. Buprenorphine can result in physical dependence. If I stop taking Buprenorphine suddenly, I may have muscle aches, stomach cramps, diarrhea, nervousness, insomnia, or other symptoms. These symptoms may last several days.

_____5. I will refrain from activities I cannot perform safely while on controlled substances. (I realize that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my activity to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve).

Holon Inclusive Health System
P.O. Box 242
Wildwood, MO 63040
Phone: 844-902-2554 Fax: 636-242-5095

_____6. If a female of childbearing age, I certify that I am not pregnant and I will use appropriate contraceptive measures during the course of treatment with medications. (I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on the controlled substances, and withdrawal can be life threatening for a baby. Many medications could harm the fetus or cause birth defects).

_____7. Buprenorphine treatment for opioid dependence works the best when it is used with other forms of treatment including drug abuse counseling, 12-step recovery work, and/or recovery support groups. While I am taking Buprenorphine, I agree to go to counseling and to work on a program of recovery. I should keep using Buprenorphine treatment as long as I need to prevent relapse to opioid abuse/dependence. I understand that buprenorphine by itself is not enough treatment for my addiction, and I agree to participate in counseling/support groups as discussed and agreed upon with my healthcare provider. I understand that if my attendance at these groups is not confirmed then I will not be able to continue to receive buprenorphine.

_____8. I agree that my goal is to stop using addictive drugs, and that I will work to stop using all addictive and illegal drugs during my treatment with buprenorphine (Suboxone).

_____9. I understand that if I decrease my use of opioids (stop using heroin, pain pills) or substitute buprenorphine for these drugs, I have a higher risk of dying from an overdose if I relapse. I understand that if I relapse, I need to use small doses of opioids until I learn what my body can tolerate. I understand that my provider can prescribe life-saving treatments like Narcan, Naloxone, or other treatments at their discretion.

_____10. I understand that if I relapse when I have been taking buprenorphine, at first I may not get high from the other opioids because buprenorphine blocks their effect. I understand that if I keep using larger and larger mounts to try to get high, I could stop breathing and die.

_____11. I understand that buprenorphine (Suboxone) is extremely dangerous for infants and children. They can stop breathing and die after taking in tiny amounts of this medication. I agree to keep my supply of this medication locked securely away from others, especially infants and children.

_____12. At each office visit, my provider will prescribe enough Buprenorphine for me to last until my next office visit. The length of time between each visit will depend on my progress. My medication can be given to me only at my regular office visits unless prior agreement is made with my provider. Any missed office visits may result in my not being able to get medication until the next scheduled visit. I agree to keep all my scheduled appointments or change the appointment in advance, except in case of emergency.

Holon Inclusive Health System
P.O. Box 242
Wildwood, MO 63040
Phone: 844-902-2554 Fax: 636-242-5095

_____13. Timely requests for refills of medications are the patient's responsibility.

A. Refill requests for medication requiring a written prescription must be called to the office 72 business hours prior to pick up. Written prescriptions must be picked up at the office. Written prescriptions will not be mailed or delivered by any other manner.

B. The office staff is very busy attending to the needs of all our patients. When your prescription is ready you will be notified by phone or email if you have provided an email address. Once your prescription is called into the office, repeat calls to check on the status prior to the 72 hour lead time requirement will be considered abusive and will be noted in your chart. The provider may at this point determine that it is necessary to discharge you as a patient of the practice.

B. Refills will not be made over the phone, at night or on weekends. This policy will be strictly adhered to.

C. Refill's ***will not be made*** if I "run out early" or "lose a prescription" or "spill or misplace my medication" or if someone else has taken some of your prescription. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If I am concerned about withdrawal from my medication, it is my responsibility to seek emergency care at an urgent care, ER, detox facility, or another emergency care facility until I am able to get an appointment with my provider.

D. Refills will not be made consistently as an "emergency". I will call at least my pharmacy at least 4-5 days prior to needing my prescription(s) that do not require a written prescription. If I frequently call the office for "emergency" refills, this may be considered as possibly abusive staff behavior and may lead to termination from the practice.

E. If medications are stolen, and a police report regarding the theft is completed, a "***one time***" exception may be made at the discretion of my provider once a copy of the police report is supplied to the office and it is added to my medical record. Medication ***WILL NOT*** be called in early until the police report is on the chart. Police report numbers will not be sufficient alone. Frequent calls for "stolen medication" may be considered as unsafe medication handling and lead to the provider tapering me off of my medication or termination from the practice to seek alternative care at a higher level of care provider. Lost medication or prescriptions will not be replaced without following our treatment protocol for buprenorphine. Patients with lost scripts requiring "early fills" will require starting with our 3x a week meeting and drug screening protocol.

F. Abusive behavior to staff, patients, families, colleagues, or visitors, including rudeness, discourtesy, disruptive behavior, demanding behaviors, or negative comments about provider's or staff may be grounds for termination from the practice.

Holon Inclusive Health System
P.O. Box 242
Wildwood, MO 63040
Phone: 844-902-2554 Fax: 636-242-5095

____14. I agree to abstain from drugs and alcohol while I am taking Buprenorphine. I agree not to take other medications with Buprenorphine without prior permission from my provider. I understand that mixing Buprenorphine with alcohol or other medications, especially benzodiazepines (for example, Valium, Klonopin, or Xanax) can be very dangerous. Several deaths have occurred from people mixing Buprenorphine and benzodiazepines. The use of other opioids such as heroin or Oxycontin while on Suboxone may result in overdose and death. There is also a risk of overdose death from mixing buprenorphine (Suboxone) with large amounts of alcohol or other types of sedatives, such as barbiturates. I take full responsibility for the risk of combining these medications and if I combine them realize that I am putting myself at risk where even medications like Narcan / Naloxone may be ineffective in reversing an overdose.

____15. I agree to not arrive for my appointment under the influence of drugs. If I do, my practitioner will not see me, and I will not be given any medication until my next scheduled appointment.

____16. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being treated with controlled substances. I will not alter my medication in any way (for example: crushing or chewing tablets) or use any other route of delivery (for example: injection or insufflation) other than as prescribed. I will not share, sell, trade my medication or exchange medication for money, goods, or services. Violation of this will result in the cessation of the prescribing of any controlled substances, a necessary taper, or trigger a treatment plan for substance abuse, or in severe circumstances may lead to termination from the practice for a higher level of care provider.

____17. I will not alter written prescriptions given to me. I will never alter a prescription in ANY way. I understand this is a felony, punishable by incarceration. or federal law enforcement agency, including Virginia's board of Pharmacy and the US Drug Enforcement Agency (DEA), in the investigation of any possible misuse, prescription forgery, sale or any other diversion of my medications. An altered prescription will be grounds for discharge from the practice. (Changing dates, quantity, or strengths of medication, forging the physician's signature, or altering a prescription in any way is against the law).

____18. I agree not to deal or buy drugs at HIHS, or in its parking lots or property.

____19. I will discontinue all previously used controlled substance medications, unless told to continue them by my practitioner. I will keep this office informed of all medications and controlled substances I may receive from other physicians including prescriptions for pain, tranquilizers, and sleeping medications. I will not attempt to get controlled substances from any other health care provider including the ER without telling them that I am already taking controlled medications prescribed by this office. If I obtain controlled medications from another individual or am found using non-

prescribed illicit (illegal) drugs, I may be reported to all my providers, medical facilities, and appropriate authorities.

____20. Periodic testing for drugs or alcohol is used to detect relapse and to document progress in treatment. The frequency of testing depends on my progress. I agree to submit a urine drug screen through Holon Inclusive Health office at my provider's request for purposes of accountability and safe recovery. I agree that I will submit to a blood and/or urine test (may be witnessed), breath testing, or pill count at any time if requested, to determine my compliance with this agreement and my regimen of medication

____21. I understand that I may be required at any time, and with short notice to bring in my medications for my provider to inspect, count and/or destroy. If I do not show or have the appropriate number of pills, I may be discharged from the Buprenorphine treatment program. . I will bring in container(s) or all medications prescribed each time I am seen even if there is no medication remaining in their original bottles from the pharmacy. I may never dispose of Buprenorphine without my provider or staff as a witness. All films must be taken as prescribed or turned into my provider for disposal.

____22. I understand that Buprenorphine may sometimes affect the liver. My practitioner may recommend that I have a blood test to check for liver disease before starting Buprenorphine. I agree to other medical tests my practitioner believes that I need during my treatment.

____23. I agree to take Buprenorphine according to my practitioner's directions and in the amounts prescribed by my practitioner, and I will not allow anyone else to take any medication prescribed for me. If I let someone else take my medication, I understand that I will be terminated from Buprenorphine treatment.

____24. I understand that once I reach maximum medical improvement, as detailed in my plan of care, or my practitioner believes it is appropriate for my continued treatment to be referred to a specialist in pain management, substance use, or other specialized services, I agree to accept the referral to the specialist or discontinue treatment with our clinic.

____25. I agree that continue refill of medications may be contingent upon compliance with other treatment modalities recommended by my practitioner. I will keep all scheduled follow up appointments as outlined in my treatment plan. This may consist of regular physician and individual/group therapy meetings.

____26. I understand that my medication regimen may be continued for a definitive time period as determined by my practitioner. I will not discontinue or increase my dose of any medication I take

regularly without consulting my practitioner. My case will be reviewed periodically. If there is not significant evidence that I am improving or that progress is being made to improve my functioning or quality of life, the regimen might be tapered or possibly discontinued.

____27. I understand that the main treatment goal using controlled medications or controlled medications is to improve my ability to function and/or to work. I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine.

____28. Taking Buprenorphine may affect the management of my pain. This is important if I have an injury or need a surgical/medical procedure that requires pain medication. I need to tell my practitioners that I am taking Buprenorphine and ask them to talk with my Buprenorphine-prescribing practitioner about my care

____29. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my controlled substance medications both past and present and I authorize the practitioners and their staff, my pharmacy, insurers, and all others who participate in the planning and delivery of my health care, to cooperate fully with any city, state, or federal agency in the investigation of any possible misuse, sale, or other diversion of my controlled substance medication. I also authorize them to communicate regarding the treatment in regard to my medications.

____30. I authorize my provider to provide a copy of this agreement to my pharmacy, other healthcare providers, emergency department personnel, and all others who participate in the planning and delivery of my health care.

____31. I understand that when I fill a prescription for buprenorphine, the pharmacist will know that I am being treated for opioid dependence.

____32. If in the sole discretion of my provider, it is necessary for them to obtain my medical history to treat me. I give my permission to allow sharing of my medical history with my other providers and pharmacies regarding any and all information that they feel is needed in my treatment including medication use with other health care agencies.

____33. My provider and I agree that this agreement is important to my provider's ability to treat my psychiatric or other conditions effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my practitioner and termination of the provider/patient relationship.

Holon Inclusive Health System
P.O. Box 242
Wildwood, MO 63040
Phone: 844-902-2554 Fax: 636-242-5095

____34. I understand violation of any of the above agreements may be grounds for termination from Buprenorphine treatment. If I stop taking Buprenorphine as a result of non-compliance with this Agreement, I may experience symptoms of opioid withdrawal.

_____35. I understand that Holon Inclusive's general Informed Consent and Additional Policies will complement any terms of this agreement. One agreement does not supersede the others._

This form has been fully explained to me and I have read it or have had it read to me. I know my condition and the benefits, risks, and alternatives of taking Buprenorphine. I have had the opportunity to ask questions about my condition, taking Buprenorphine, and its alternatives, and I believe that I have enough information to give this informed consent. I want to start taking Buprenorphine according to all the directions above. I know that I have the right to take back my consent at any time by telling my practitioner.

I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction by my physician. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the controlled substance management program. I also agree to testing and detoxification if indicated.

Your provider understands that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Lack of strict adherence to any provision of this agreement by your practitioner in no way invalidates any other provisions of this agreement. If at any time you are concerned about your medication or side-effects of your medication, you may call the office at [844-902-2554].

I agree to use the Pharmacy listed below, for all my pain medications. If I change my pharmacy for any reason, I agree to notify this office at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacy's address and telephone number.

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Phone: _____

This agreement is entered into on this date of _____, 20_____.

Patient Signature _____ Witness Signature_____

Provider Signature _____