FREEDOM
RECOVERY CENTER
COMMUNITY-BASED RESPONSIBLE MEDICAL TREATMENT FOR OPIOID DEPENDENCY

Patient Treatment Contract

Patient Name: ____ Date: _________________

As a participant in medication treatment for either opioid misuse and dependence or pain management purposes, I freely and voluntarily agree to accept the treatment contract as follows:

I agree to keep, and be on time to, all my scheduled appointments. **I understand that a $50 fee will be applied to my next visit following a missed appointment. I understand that if I miss 2 appointments, I will be discharged from the practice and must re-apply to become a new patient paying the $350 new patient fee if I wish to be treated.**

I agree to adhere to the payment policy outlined by this office. I understand that there is **No Refund of payment once I am engaged in services,** regardless of circumstances. All fees for appointments will be paid in advance or at the time of service.

I understand that I am responsible for acquiring my medication at the pharmacy and Freedom Clinic is not responsible for my ability to pay for my medication. It is my responsibility to find out if my medication is covered by my health insurance. **If Freedom Clinic is required to complete a prior authorization with my insurance company for coverage of my medication, there is a $25 fee that I am responsible for before it is completed. There will be no refund given to me if that prior authorization is denied by my insurance company.**

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

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 recourse or appeal.**

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

I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication/prescription is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse or appeal. I understand that illegal activities will be reported to the proper authorities immediately.

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.

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.

I agree not to obtain medications from any doctors, pharmacies or other sources without telling my treating physician. I understand that this will be monitored by my physician on a monthly basis.

I understand that mixing this medication with other medications, especially benzodiazepines (for example, Valium*, Klonopin*, or Xanax*) can be dangerous, even fatal. 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 read the Medication Guide and consult my doctor should I have any questions or experience any adverse events.

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.

I understand that medication alone is not sufficient treatment for my condition and I agree to participate in counseling and/or other supportive activities as discussed and agreed upon with my doctor or Freedom Clinic staff. **I understand that monthly drug counseling is mandatory. I will need to bring written proof of services provided elsewhere or counseling will be provided to me by trained Freedom Clinic staff, once a month, for a fee of $50.**
I agree to abstain from alcohol, opioids, marijuana, cocaine, methamphetamines, and other addictive substances (except nicotine). Marijuana is acceptable if I have a valid Medical Marijuana card.

I agree to provide monthly urine/drug screens and have my doctor test my blood alcohol level at a charge of $10.

I understand that if I am being treated for chronic pain, I will need to provide my doctor with medical documentation of the need for pain management. I understand that my doctor may order appropriate diagnostic tests if no proof is given before.

I understand that violations of the above may be grounds for termination of treatment.

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Physician Signature Date

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Patient Signature Date

*Valium is a registered trademark of Roche Products Inc.
*Klonopin is a registered trademark of Roche Laboratories Inc.
*Xanax is a registered trademark of Pharmacia & Upjohn Company
05/04/13