Name ______________________________ Birth Date ______________
Date ________________

HCH BUPRENORPHINE (SUBOXONE) TREATMENT AGREEMENT

As a participant in buprenorphine (Suboxone) treatment for opioid addiction, I agree to the following:

1. To keep all my scheduled appointments or change the appointment in advance, except in case of an emergency

2. I agree not to sell, share, or give any of my medication to another person.

3. I agree not to deal or buy drugs at Health Care for the Homeless, or in its courtyard or parking lots.

4. If I will be going to an outside pharmacy, such as Duran's or UNM, I agree not to deal or buy drugs at that facility or in its neighborhood.

5. I agree that my medication/prescription will 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 safe and secure. I agree that lost medication will not be replaced regardless of why it was lost.

7. I agree not to obtain buprenorphine (Suboxone), other opiates, or benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡) from any other healthcare providers, pharmacies, or other sources without telling my treating physician.

8. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I understand 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 doses).

9. I understand that buprenorphine (Suboxone) by itself is not sufficient treatment for my addiction, and I agree to participate in counseling and/or group therapy as discussed and agreed upon with my healthcare provider.

10. I agree to provide random urine samples and have my healthcare provider test my blood alcohol level.

11. 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)

12. I agree that violating this agreement may result in my no longer receiving treatment with buprenorphine (Suboxone).

13. I understand that if I decrease my use of opiates (stop using heroin, pain pills, or substitute buprenorphine) 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 opiates until I learn what my body can tolerate.

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14. I understand that if I relapse when I have been taking buprenorphine, I may not get high from the other opiates because buprenorphine blocks their effect. I understand that if I keep using higher and higher amounts to try to get high, I could stop breathing and di

15. I have read the following patient handouts, and had a chance to ask questions about it so that I understand it:

    a. What is buprenorphine (Subxone)
    b. Starting buprenorphine (Suboxone)
    c. Side effects and drug interactions with buprenorphine (Suboxone)

I consent to the above terms and to begin treatment with buprenorphine (Suboxone).

Patient Signature ______________________________ Date __________

Healthcare Provider Signature ______________________________ Date __________

______________________________ Date ______________________
Patient Signature