NEW SMYRNA WELLNESS CENTER

BUPRENORPHINE (SUBOXONE) TREATMENT AGREEMENT

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

1. To keep all my scheduled appointments or change the appointment 24 hours in advance, except in cases of emergency. I understand that I must be seen at least every 30 days with a urine drug screen.
2. To report my history and symptoms honestly to my doctor and the office staff.
3. 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.
4. Not to obtain buprenorphine (Suboxone), other opioids, or benzodiazepines (for example, lorazepam, diazepam/Valium, clonazepam, alprazolam/Xanax, etc.) from any other healthcare providers, pharmacies, or other sources without telling my treating physician.
5. I understand that mixing buprenorphine with other medications, especially benzodiazepines (as in #4) can be dangerous. I understand that several deaths have occurred among persons mixing buprenorphine (Suboxone) and benzodiazepines. 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.
6. Not to sell, share, or give any of my medication to another person.
7. Not to deal or buy drugs at New Smyrna Wellness Center or in its parking lots or property.
8. I agree that it is my responsibility to keep my medication secured and stored safely, where it cannot be taken accidentally by children, pets, or stolen. If anyone else, including a child, takes my medication, I will call 911 or Poison Control at 1-800-222-1222 immediately.
9. Lost/ stolen medication will not be replaced regardless of why it was lost/ stolen.
10. I understand that such mishandling of my medication is a serious violation of this agreement AND A FELONY and would result in my treatment being terminated without any recourse for appeal.
11. I understand that buprenorphine (Suboxone) 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 (Suboxone).
12. I understand that I may be called to present to the clinic for random drug screens and medication counts *in addition* to my regularly scheduled appointment. Failure to report to the clinic within 24 hours may result in my termination from the outpatient program at New Smyrna Wellness Center.
13. 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).
14. 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.
15. 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.
16. I understand that Dr. Meredith and staff may collect and send out to a third party, billable to the patient, urine, oral swabs, blood, hair, nails, etc. for additional/confirmatory testing.
17. I understand that an evaluation/office visit is not a guarantee of buprenorphine therapy and no refunds will be given.
18. Failure to comply with the buprenorphine guidelines may result in a referral to more intensive management at the sole discretion of Dr. Meredith.

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

Name: _____ DOB: _____

Patient signature: _____ Date: _____

NEW SMYRNA WELLNESS CENTER

OPIOID DEPENDENCE INTAKE QUESTIONS

Patient Name: _____ Date: _____

Please answer these questions truthfully. These answers will be kept confidential and only be used for medical purposes.

Circle YES or NO for questions 1-16 and then answer questions 17-26 in the spaces provided.

1. Have you ever noticed that drugs/pills stopped working or having the same effect as before? YES NO
2. Have you ever taken more or found yourself increasing your dose/amount to achieve the same effect? YES NO
3. Have you ever gone through opioid withdrawal? YES NO
4. Have you ever taken the drugs to avoid withdrawal? YES NO
5. Have you taken more than you intended to take or were prescribed (i.e. "today I'm only going to take 4 pills" but you end up taking 6, 10, 12 or more)? YES NO
6. Have you found yourself using drugs or taking the prescription longer than you had originally intended? YES NO
7. Do you constantly think about cutting down on your use or controlling how much you take? YES NO
8. Do you ration your drugs/pills? YES NO
9. Do you watch the clock for the next time you can take your pills/drugs again? YES NO
10. Do you take your drugs/pills first thing in the morning? YES NO
11. Do you set a "limit" for "tomorrow", but often find yourself exceeding your "limit"? YES NO
12. Do you go through your pills/drugs faster than you mean to (i.e. is your weeks supply gone in 2 days? Or is your monthly prescription gone in a week? YES NO
13. Do you try to wean yourself off the drugs? YES NO
14. Do you ever make resolutions (i.e. "this is my last bottle of pills" or "this is my last stash")? YES NO
15. Have you ever lost friendships because of your using? YES NO
16. Have you ever lost relationships because of your using? YES NO
17. Have you ever been on buprenorphine (Suboxone/Subutex) before? _____
18. Have you ever been to rehab for drug dependency? _____
19. Have you ever been abused? Physically? Sexually? _____
20. Have you ever been to AA/NA? _____
21. What is your longest period of abstinence? _____
22. Do you have any family history of drug addiction or alcoholism? _____
23. What is your drug of choice? _____
24. How much are you currently using (on average)? _____
25. How many years have you been using opiates? _____
26. What is the primary way you take/took your opiate? _____