Sedative/Hypnotic (Benzodiazepine) Treatment and Safety AGREEMENT

Patient Name: _____ Patient D.O.B.: _____

Date of Contract Review: _____

As a participant in buprenorphine treatment for opioid dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1.) I agree to take benzodiazepines as prescribed, and to inform my treatment team if I wish to change my dose ***before changing*** *the way I take it*.

2.) I agree not to sell, share, or give any of my medication to another person. I understand that if I distribute my medications, **I may not be provided with future prescriptions**. I also understand that the distribution of my medication may be a reportable offense.

3.) I understand that mixing benzodiazepines with other medications, especially other benzodiazepines (for example, Valium®, Klonopin®, or Xanax®, Ambien, Sonata, Lunesta), **alcohol or opioids (including Suboxone® can be dangerous)**. I also recognize that **several deaths and serious injuries have occurred among persons mixing benzodiazepines with other sedating medications**.

4.) A benzodiazepine prescription can **only** be given to me during the benzodiazepine support group (also referred to as Beyond Benzodiazepines). A missed visit may result in not being able to get medication until the next scheduled visit. A prescription **will not** be called in for me, simply because I have missed my scheduled visit. Benzodiazepine refills **will not** be made through the walk-in clinic.

5.) I understand that I must be on time for a group visit in order to be seen. **I understand that if I am more than 30 minutes late, I may not be seen and may not receive a prescription.** I agree to notify the clinic **24 hours in advance** if I am unable to attend my scheduled visit. I acknowledge that if rescheduled, it is possible that I may not receive a new visit during the same week, and I may be asked to come more frequently or have shorter prescriptions at the discretion of the treatment team.

6.) **Lost or stolen medication will not be replaced** regardless of why it was lost. **There are no prescriptions or refills after hours, on weekends, holidays, or outside of regularly scheduled visits**.

7.) I agree not to obtain any other controlled medications (including buprenorphine, opiates, other benzodiazepines, or barbiturates) **from any doctors, pharmacies, or other sources without telling my treating physician.** I agree to tell my doctor about any/all medications/supplements I am taking.

8.) I understand that my team reviews a weekly prescription monitoring report showing what controlled substances I've been given. If additional controlled substances appear on my weekly report, **I agree to sign a release of information** for the **prescriber and pharmacy**. I am aware

that my Center For Healing team reserves the right to contact the prescriber.

9.) I agree to provide regular, valid, urine samples at each visit. I agree to provide other drug testing samples such as blood, saliva, or hair if requested by my treatment team. I understand that falsification of urine samples or reports of falsification may result in changes in my treatment plan. I understand that I may be asked to provide a urine sample while being observed by a member of the medical staff.

10.) I understand that I may have a "medication call back" at any time. The office will call me and ask me to come in **the same day** and to bring my medication to be counted. **I agree to participate in medication call backs**.

11.) I agree to conduct myself in a courteous manner while at the Center For Healing, and I will not conduct any **illegal or disruptive** activities on Cooper's premises. I will be respectful to all staff and patients at all times. I understand that if I violate this agreement, I will be asked to leave the clinic.

12.) I agree not to take actions which compromise the privacy of other patients. **This includes taking photographs, recording audio, capturing video** or engaging in any other activities that violate patient privacy. I understand that patient health information is protected by both the Health Insurance Portability and Privacy Act (HIPAA) and 42 CFR Part 2. I understand that if I behave in ways that violate the rights of other patients, I will be asked to leave the clinic.

13.) I agree that the medication I receive is **my responsibility** and I agree to keep it in a safe, secure place, preferably a safe or lockbox. Benzodiazepines are dangerous if ingested by children. If this occurs**, I will call poison control immediately.**

14.) I understand that medication alone is not sufficient treatment for my condition and I agree to **participate in adjunctive treatment services** as agreed upon and specified in my treatment plan.

15.) I understand that benzodiazepines treatment may not be given if my physician believes it is unsafe or ineffective. I may be referred to an alternative treatment type if a higher level of care becomes necessary.

16.) I am always welcome to come to my visits unless I threaten, harm, or pose a danger to staff or patients.

I have read, understand, and accept all of the terms of this agreement. I have been offered a copy of this agreement.

Patient Signature _____Date_____

Physician Signature _____Date_____