FOOTHILLS CONSULTING ASSOCIATES
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SUBOXONE/ CONTROLLED MEDICATION CONTRACT

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Patients Name_____Date:_____

As a patient of Foothills Consulting Associates, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep, and be on time to all my scheduled appointments; to adhere to the payment policy outlined by this office.
2. I agree to conduct myself in a courteous manner in the doctor's office.
3. 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 any recourse for appeal.
4. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
5. 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 filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
6. I agree that my medication/prescription can only be given to me at my regular office visit. A missed visit may result in my not being able to get my medication/prescription until the next visit.
7. 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 or stolen medication will not be replaced regardless of reason it was lost.
8. I agree not to obtain medications from any other doctors, pharmacies, or other sources without telling my treating physician.
9. I understand that mixing suboxone, alcohol, and/or other drugs with other medications, especially benzodiazepines (for example Valium, Klonopin, or Xanax) can be dangerous. 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 doses)
10. I agree to take the medication as my doctor has instructed and not to alter the way I take medication without first consulting my doctor.
11. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling with Foothills Consulting Associates counselor monthly. Failure to comply with counseling appointments may result in the doctor's appointment being cancelled or not receiving my medications until I have seen the counselor.
12. I agree to abstain from alcohol, opioids, marijuana, cocaine and other addictive substances.
13. I agree that my provider has the right to call me in for a random pill count, urine screen, and/or administer a breathalyzer test.
14. I understand that violations of the contract may be grounds for termination of treatment.

Patient Signature_____ Date_____