The Fresh Start Program
Waterstone Counseling Center

Dr. Thomas Abbenante, MD • Dr. Richard Goulding, MD
Dr. Marc F. Bono, Psy.D

PATIENT TREATMENT CONTRACT

Patient's Name: _____
Date: _____

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

1. Your insurance **must** be verified in advance of your appointment. The CCR will work with you on this. However ultimately, it is your responsibility to make payment in the event that there are any changes or cancellations of services to your insurance policy that do not allow us to collect from your insurance. **I agree to pay any amount due to continue treatment.**

2. I agree to adhere to the payment policy outlined by this office; payment at the time of visit with cash, check, or debit/credit card is accepted. **Your copayment(s) is(are) due at the time of your appointment.**

3. I agree to keep, and be on time to, all of my scheduled appointments both with the physician and the therapist. **Patients that are late to their appointments (more than 15 minutes) may not be able to attend their scheduled therapy session or medication management and may be subject to discharge with a thirty-day notice if they show up late to more than six appointments in a calendar year.**

4. I understand that I can be immediately discharged from the program for diverting or selling Suboxone 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 or opportunity to appeal.

5. I understand that I can be immediately discharged from the program for providing false urine samples.

6. I understand that I can be immediately discharged from the program for any kind of violent or inappropriate behavior at the clinic or the pharmacy. I understand that if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication 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 opportunity to appeal.

7. I agree that the medication/prescription can only be given to me at my regular office visits. A missed visit will result in my not being able to get my medication/prescription until the next scheduled visit.

8. 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 why it was lost.

9. I agree not to obtain medications from doctors, pharmacies, or other sources without telling my treating physician.

10. I understand that mixing this medicine 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 when taken independently outside the

care of a physician, using alternative routes of administration or in higher than recommended therapeutic doses).

11. I agree to read the Medication Guidelines and consult my doctor should I have any questions of experience any adverse events.

12. 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.

13. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).

14. While CCR does not require that you use our therapy services specifically, we do require that you attend weekly therapy sessions addressing your opiate addiction diagnosis with a therapist of your choice/preference. Each visit needs to be 60 minutes in length, be it in a group or individual format. Proof/submission of your attendance at an outside therapist's office will be required on a monthly basis.

15. I agree to provide urine samples and have my doctor test my blood alcohol level.

16. I understand that missed appointments, without giving a minimum of 24 hours' notice, will result in being charged for the full appointment. If you normally use your insurance, the no-show charge will be your sole responsibility.

17. I agree to call the office at (203) 245-0412 with any questions, concerns, or clarifications.

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

_____ _____

Patient's signature — Date
(after reviewing contract with physician)

_____ _____

Patient's signature — Date
(after reviewing contract with therapist)

Please read the guidelines and policies document regarding missed appointments, late appointments, and re-scheduling appointments within the same day or in advance! ☺

* 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.

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