Park Avenue Medical
85 Barnes Road
Suite 202
Wallingford, CT, 06492
P: 203-309-0070 Fax: 1-203-309-0071

Patient Treatment & Suboxone Contract:

Name: _____ DOB: _____

1. ____ I agree to keep and be on time to all my scheduled appointments. If I am late to my appointment, I understand that I may not be seen, and I will not receive my prescription until I am able to be seen.

2. ____ I agreed to adhere to the payment policy outlined by this office including all copays and No-Show fees.

3.____ I agree to conduct myself in a courteous manner in the office.

4.____ 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 will result in my treatment being terminated without any recourse for appeal.

5.____ I agree not to deal, Steal or conduct any illegal or disruptive activities in the doctor's office.

6.____ I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the doctor's office or pharmacy where my Buprenorphine, and, or Suboxone is filled, that the behavior will be reported to by the doctor's office and could result in my treatment be terminated without any recourse for appeal.

7.____ I agree that my medication/prescription can only be given to me at my regular office visit. A missed visit will result in me not being able to get my medications/prescription until the next scheduled visit. No scripts will be sent electronically without an office 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 of why it was lost. The medication has to be in a locked place. In case someone gets exposed to the medication, they need to go to the ER immediately.

9.____ I agree not to obtain any pain medication from any doctors, pharmacy or other source without telling my treating physician.

10.____ I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium, Klonopin, Xanax, and/or Ativan), can be dangerous and might lead to death. I also recognize that several deaths have occurred when mixing Buprenorphine and benzodiazepine (especially if taking outside the care also a physician, using routes of administration other than sublingual or doses higher than the recommended therapeutic doses).

11.____ I agreed to take my medication as my doctor has instructed and not to alter the way I take my medications without first consulting a doctor. If I run out of my medication early, I understand that I will not be given more until my scheduled appointment.

12.____ I understand that medication alone is not sufficient to treat my condition, and I agreed to participate in counseling as discussed and agreed upon with my doctor unspecified in my treatment plan.

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13.____ I agree to abstain from alcohol, opioids, cocaine and other addictive substances (except nicotine). If my urine or oral toxicology report shows any of these substances then I understand that I will be seen weekly until the substances are no longer detected and that I may also be decreased in the amount of medication I am given.

14.____ I agreed to provide random urine/oral samples and have my doctor test my blood alcohol level.

15.____ I understand that violation of the above may be grounds for termination of treatment

16.____ I will be responsible for making sure that I do not run out of my medications on weekends and Holidays, because abrupt discontinuation of these medications can cause severe withdrawal Syndrome and/or death. In case I start having symptoms of withdrawal I need to go to the Emergency Department.

17.____ The doctor may terminate this agreement at any time if he/she has cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.

18.____ I understand that I may terminate this agreement at any time. If the agreement is terminated, I will not be a patient of Park Avenue Medical, LLC and its providers and would strongly consider treatment for chemical dependency if clinically indicated.

19. ____ I fully read this agreement and understand it clearly and all my questions were answered by the doctor.

20. ____ 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 (Suboxone) ____

b. Starting Buprenorphine (Suboxone) _____

c. Side effect and drug interactions with Buprenorphine (Suboxone) _____

21. ____ I consent to the above terms and to begin treatment with Buprenorphine (Suboxone)

22. ____ You must inform your treating physician about any pregnancy.

23. ____ I understand that Dr. Anace Said, Ursula Hoxie APRN, and Juanita Dee APRN are not my primary care physicians and that I must continue to follow up with my PCP regularly.

24. You need to come with someone to the office for your first few appointments.

25. ____ I understand that I may be called to bring my medication into the office for a count randomly and I agree that I will do so within 24 hours of being notified.

26. ____ I understand that my urine and/or oral specimen will be sent to a Toxicology Lab and it may be out of network with my insurance company. I understand that I may receive a bill from the laboratory, and I may be responsible to pay the cost of testing or contact the lab to reduce my cost.

Patient's Signature: _____ Patient's Name: _____ Date: _____

Physician's Signature: _____ Physician's Name: **Anace Said MD, Ursula Hoxie APRN, Juanita Dee APRN Date: _____**

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