

# Patient Treatment Contract

This agreement is between Dr. Erin Kershisnik and/or Dr. Samantha Ritchie ("Physician"), whose principal place of business is Vantage Physicians, 3703 Ensign Road Suite 10A, Olympia, WA 98506 and patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_("Patient").

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

Patient must initial each line:

\_\_\_\_\_\_ I agree to keep and be on time for all of my scheduled appointments.

\_\_\_\_\_\_ I agree to adhere to the payment policy outlined by this office.

\_\_\_\_\_\_ I agree to conduct myself in a courteous manner in the doctor’s office.

\_\_\_\_\_\_ 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.

\_\_\_\_\_\_ I agree to avoid any disruptive activities in the doctor’s office.

\_\_\_\_\_\_ I agree that my medication/prescription can 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 my next scheduled visit.

\_\_\_\_\_\_ I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place (away from a toilet/sink/or where it can be taken by others). I agree that lost/damaged/stolen medication may not be replaced regardless of why it was lost/damaged/stolen.

\_\_\_\_\_\_ I agree not to obtain medications from any doctors, dentists, pharmacies or other sources without telling my physician.

\_\_\_\_\_\_ 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.

\_\_\_\_\_\_ I understand that mixing buprenorphine 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 therapeutic doses).

\_\_\_\_\_\_ I understand that medication alone is not sufficient treatment for my condition and I agree to participate in counseling and support groups (NA, AA Celebrate Recovery, etc.) as discussed and agreed upon with my doctor and specified in my treatment plan.

\_\_\_\_\_\_ I agree to abstain from all illegal substances.

\_\_\_\_\_\_ I agree to provide random urine samples and submit to blood testing if required. I also agree to random “film/pill counts” if asked. I will bring my medication into the office to be counted when my doctor asks me to.

\_\_\_\_\_\_ I authorize my doctor to disclose any information needed to confirm the validity of my prescription and for submission and for payment of my prescription. My doctor may disclose needed information to the dispensing pharmacy to whom I present my prescription or to whom my prescription is called/sent/faxed, as well as to third party payors, for the purpose of assuring the pharmacy of the validity of the prescription, so it can be legally dispensed, and for payment purposes.

\_\_\_\_\_\_ I agree that violation of the above may be grounds for termination of treatment.

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| Patient Signature | Office Staff Witness |
| Print Name | Date |