LOGO

**AGREEMENT FOR ADMISSION INTO THE MAT PROGRAM**
**(Medication Assistance Treatment)**

For admission and as a participant in the Medication Assistance Treatment (MAT) Program for opioid dependence, I _____ agree to honor this treatment agreement.

**Purpose and goals of treatment:**

1. I understand that the long-term goal of this treatment is to remain drug and alcohol free and to build a foundation of recovery that allows me to completely change my life.

2. I will abstain from the use of other addictive substances; including **alcohol, marijuana, and all other legal and illegal substances**. I understand that continuing to use other substances is potentially deadly and may result in the treatment team referring me to a higher level of care/treatment or discontinuing my treatment with Buprenorphine at this MAT program.

**Treatment Requirements:**

3. **I will attend clinic as required and scheduled.** I understand the MAT Clinic consists of Medical Management Appointments, Group Therapy Appointments, and Individual Therapy Appointments as required by law and by the MAT team. **Attendance is required to each appointment** unless I have notified the treatment team in advance of my need to miss an appointment and I am eligible for a makeup appointment. I recognize once I have established a solid recovery program, including a sponsor, a home group in AA or NA, and working the 12 steps) my clinic attendance *may be* reduced to every two weeks or once a month after an extended period of time of successful participation in the program with the understanding that this agreement will still apply.

4. I understand that it is required that I attend a **minimum of 4 AA or NA meetings per week**. I understand that my meeting lists **must be signed** by the chairperson at the meeting. Falsifying meeting lists is prohibited and may also lead to my discharge or suspension from the program. I also understand that the treatment team may require that I attend more than four meetings each week. Failing to follow through on my meeting attendance may result in termination of my treatment in the clinic.

**5.** I understand that I will be screened for Hepatitis B and C as well as other communicable diseases and other relevant laboratory tests as required by the treatment team. If I test positive for Hep C I will comply with Hep C follow up appointments and/or referrals.

**Attendance:**

6. According to the makeup policy, I understand that while in the weekly group I am allowed to cancel, leave early, or be late one time every 6 weeks; while in the bi-weekly group once every 3 months; and while in the monthly group once every 6 months. The makeup policy applies so long as absences do not become habitual. Failure to adhere may result in being discharged, going without medication, and/or doing daily/weekly check-ins.

7. I will keep and be on time for all my scheduled appointments.

8. If an emergency arises, I will call the call center to inform the Care Manager, at (304) 205-7535 and ask for Lois Vance. I must call to cancel at least two hours before my scheduled appointment. The above makeup policy applies.

9. I understand that a cancelled appointment may result in my not being able to get my medication/prescription until the next scheduled visit.

10. I understand that an unexcused missed appointment or "no showing" an appointment may result in my being terminated / suspended or referred out of the program.

11. Cancellations 2 weeks in a row may result in termination from treatment. If terminated from the program for <u>any reason</u>, I must wait 30 days to reapply for treatment or longer depending on the waiting list. **Readmission to the MAT program is always at the discretion of the MAT Team**.

**Payment:**

12. If there is a co-payment or charge I will pay my fee on the day of the service. (Co-payment amounts are determined by the patient's type of insurance coverage and patients will be provided information on anticipated charges (if any) at the time of enrollment.) Failure to pay for services, without prior payment arrangements, may result in suspension or termination from the program or referral to an indigent care program.

**Use of Medicine:**

13. I will take my Buprenorphine as my doctor has instructed (place under tongue until dissolved) and not to alter the dose or the way I take my medication. If I am required to come to the clinic, for any reason, for a daily prescription I understand that my dose for that day will be taken at the clinic and the dosing will be witnessed by a MAT team member.

14. **I will not sell, share, trade, or give away any of my Buprenorphine or any other prescription medication.** I understand that such mishandling of my medication is a serious violation of this agreement as well as illegal and **will result** in my treatment being terminated without any recourse for appeal.

15. I understand prescription brand Suboxone contains an opioid (Buprenorphine) that can be a target for people who abuse prescription medication or street drugs. I understand that the medication I receive is my responsibility and that I agree to keep it in a safe, secure place and protect it from theft. I understand that replacement prescriptions for lost or stolen medication will likely not provided. The lost or stolen medication policy also applies. Also, written prescriptions will have no refills.

16. **Medication should be kept out of sight and reach of children.** Accidental or deliberate ingestion by a child may cause respiratory depression that can result in death. If a child is exposed to your medication, medical attention should be sought **immediately**, even if the child has no symptoms and appears to be OK.

17. I will tell my treating physician about ANY other medications I receive from any doctors, dentists, and/or pharmacies. I understand it is my responsibility to tell all treatment providers about my participation in the MAT program and taking ANY medication that is addictive without prior authorization from the treatment team may result in my termination or suspension from the program.

18. **I understand mixing Buprenorphine with other medication, especially benzodiazepines, (for example Valium, Klonopin, Xanax, Ativan) and other Central Nervous System depressants (including alcohol) can be dangerous and even lethal. I have been informed that deaths have occurred from mixing Buprenorphine and benzodiazepines.**

19. I understand that I will use one pharmacy for filling the medications prescribed as part of the addiction treatment program.

20. Filling any controlled substance, such as Tramadol and/or Ambien, without first obtaining approval from the treatment team, may result in my immediate discharge or suspension from the program. Board of Pharmacy records will be monitored regularly. A **LIST OF CONTROLLED SUBSTANCES IS PROVIDED ON A SEPERATE FORM.**

**Conduct in clinic:**

21. I will conduct myself in a courteous manner and not engage in any illegal or disruptive activities on the clinic or pharmacy property. If I do not adhere I put myself at risk of being discharged.

22. I will provide my only own urine for random drug screens as requested. Random urine drug screens will be observed. **I understand that I have 30 minutes from my scheduled arrival time to provide a urine sample.** I understand that tampering with, buying, selling, or otherwise procuring urine will result in my immediate termination from treatment as it is an admission of a dirty urine. I also understand I am subject to random breathalyzer screens and film / package or pill counts. **I have 24 hours to report once contacted for a random pill/film count and or any other requested assessment. The only exception to this rule is agreeing to arrive within 2 hours if called on a Monday morning.** Failure to comply may result in being discharged from clinic.

23. **I understand bringing any children to my appointments is prohibited.** It is my responsibility to find arrangements for my children to be watched while in my appointments. If this becomes an issue that results in my missing my appointments, I understand it may result in my discharge from the program.

24. I understand **USAGE OF TOBACCO and/or NICOTINE PRODUCTS IS PROHIBITED** while on clinic property. Failure to comply may result in immediate termination or suspension from the program.

**Confidentiality:**

25. **I understand that those I see and what I hear in treatment is strictly confidential.** Violation of confidentiality will likely result in immediate discharge and may subject me to other penalties and sanctions as prescribed by laws and regulations governing the protection of individual confidential information.

26. Confidentiality extends to all forms of social media. Any posting on Facebook, Twitter or any other social media about any participation in the MAT program is strictly forbidden and any mention of any other patient or participant of the MAT program is a **blatant** violation of patient confidentiality and will result in immediate discharge may subject me to other penalties and sanctions as prescribed by laws and regulations governing the protection of individual confidential information.

27. I understand that my **health issues may be discussed in the group**, especially as it pertains to drug-related complications. For this manner of openness within the group, I **give** consent _____ I **do not** give consent f_____ for sharing of my information.
Initials Initials

I have read and understand the above agreement and my questions have been addressed. I received a copy of this agreement.

I have also received copies of the following forms:

- ❒ 1. Copy of consent
- ❒ 2. Hepatitis C information
- ❒ 3. Prohibited Drug list while in MAT
- ❒ 4. Benzodiazepine practice
- ❒ 5. Make-up policy
- ❒ 6. Urine drug screen policy
- ❒ 7. Lost or stolen medication policy
- ❒ 8. Voluntary and Involuntary withdrawal policies
- ❒ 9. Social Media policies
- ❒ 10. My relapse prevention plan
- ❒ 11. Patient Rights information

Patient Signature X_____Date ___/___/___

Witness Signature X_____Date ___/___/___