ALAN J ZEND DO PLLC
PRIMARY CARE PHYSICIAN
7500 212th STREET SW, SUITE 201
EDMONDS, WA 98026
TELEPHONE: 425-775-4437
Fax: 425-771-2554

Name: **Date:**

BUPRENORPHINE AND CONTROLLED SUBSTANCE TREATMENT AGREEMENT

I am requesting that Dr. Zend provide buprenorphine treatment for opioid _____ addiction. Other controlled substances may be used during the course of therapy. The doctor is at liberty to add any requirements or stipulations as he sees fit at any time. This does not have to be in writing. You are free to find a new doctor any time you wish. I freely and voluntarily agree to accept this treatment agreement, as follows:

(1) I agree to keep, and be on time to all of my scheduled appointments with the doctor and/or his assistant. A “no show” fee will be assessed.

(2) I agree to conduct myself in a courteous manner in the physician’s or clinic’s office.

(3) I agree to pay all office fees for this treatment at the time of my visits. Failure to do so is cause for immediate termination of services.

(4) I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me, and I will not be given any medication until my next scheduled appointment. Immediate termination may ensue. Urine drug screens and medication counts will be random (*in urina latet veritas*).

(5) I agree not to sell, share or give any of my medication(s) to another person. I understand that such mishandling of my medication is a serious violation of this agreement (and the law) and would result in my treatment being terminated without recourse for appeal.

(6) I understand that the use of buprenorphine/naloxone (Suboxone, etc.) by someone who is using opioids could cause them to experience severe

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withdrawals. Stopping buprenorphine in itself can cause prolonged opiate withdrawals.

(7) I agree not to deal, steal, or conduct any other illegal or disruptive activities in, or in the vicinity of, the doctor's office.

(8) I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.

(9) I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost or stolen medication(s) will not be replaced regardless of the reasons for such loss. It is to be kept out of the reach of children.

(10) I agree not to obtain medications from any physicians, pharmacists, or other sources without informing Dr. Zend. I understand that mixing buprenorphine with other medications, especially benzodiazepines, can result in death or disability. I also understand that a number of deaths have been reported in persons mixing buprenorphine with other drugs or alcohol.

(11) I agree to take my medication as the doctor, or his assistant has instructed, and not to alter the way I take my medication without first consulting the doctor.

(12) I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in a patient education and a relapse prevention program, to assist me in my treatment.

(13) I understand that my buprenorphine and/or other controlled substance treatment may be discontinued, and I may be discharged from the practice if I violate any of this agreement or further requirements requested by the doctor.

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(14) I understand that there are alternatives to buprenorphine treatment for opioid addiction including:

a. medical withdrawal and drug-free treatment
b. naltrexone treatment
c. methadone treatment

The doctor will discuss these with me and provide a referral if I request this.

The failure to plan on your part does not constitute an emergency on our part.

Patient's Signature Date

Witness Signature Date

Witness Name