Office Based Addiction Treatment (OBAT) Program

As a patient in the Office Based Addiction Treatment (OBAT) program, I freely and voluntarily agree to accept this treatment agreement, as follows. I understand the OBAT program includes providers, nurses, care coordinators, medical assistants, and administrative support personnel.

**I agree to do my best to arrive on time to all my scheduled appointments. I will call the clinic if I will be late/early or need to reschedule my appointment.**

When I am in the clinic, I agree to conduct myself in a courteous and respectful manner.

**I agree not to sell, share or give any of my medication to others. I understand that any mishandling of my medication may result in a change of my treatment plan including referral to a higher level of care or discharge.**

I agree not to conduct any illegal, threatening, or disruptive activities in the clinic or on BMC campus. I will be discharged or referred to a higher level of care for behaviors that are unsafe or inappropriate.

**I agree that it is my responsibility to keep my medication safe and secure at all times. I understand that any lost medication will require an assessment and plan with my team. My medication should not be kept in public places (like a bathroom medicine cabinet, vehicles), and should be out of the reach and sight of children at all times. I will keep my medication in a container that displays a prescription label. If I carry sealed films on my person, I will do so with a pharmacy label.**

I agree to inform my provider and/or OBAT nurse immediately about prescriptions or over the counter medications from any prescribers, pharmacies, or other sources (such as the dentist, emergency department, or psychiatrist).

**Per Massachusetts law, BMC OBAT will routinely access the Prescription Drug Monitoring Program (PDMP) to review medication profiles. If I am found to be obtaining prescriptions from other providers, the OBAT team will address the circumstances with me, and if necessary, adjust my treatment plan.**

I understand that mixing buprenorphine with other substances, especially those that can cause sedation such as benzodiazepines, gabapentin, alcohol, etc. can be dangerous and can increase my risk of overdose and even death.

**I agree to take my medication as the provider has instructed and not to adjust the way I take it without first consulting my nurse or provider.**

I agree to random call back visits that include urine toxicology screens and medication counts. I understand that I need to have a working telephone. When called by the OBAT team, I will respond within 24 hours by telephone.

**I agree not to eat poppy seeds while in treatment. Poppy seed consumption may result in a positive opioid screen.**

I understand that if I misuse other substances or medications, the OBAT team will assist me by changing or intensifying my treatment plan. If I continue to struggle with ongoing substance use, I may be transferred to a more intensive setting to meet my treatment needs.

**I agree to urine toxicology screenings. I will not tamper with testing. I understand that it is best to be honest with my treatment team if I am struggling and understand the team is here to assist me in my treatment.**

Urine screens that are negative for buprenorphine will be evaluated by the OBAT team and toxicologist.

**I understand that the BMC OBAT does not maintain a chain of custody over urine toxicology screens. BMC OBAT collects urine toxicology tests as medically necessary. Testing that requires chain of custody must occur outside of the OBAT program.**

If I am female and of child bearing age and do not plan on becoming pregnant, it is strongly recommended that I utilize contraceptives. If I become pregnant while in treatment, I will alert my OBAT team immediately so they can assist me in connecting with an OB/GYN provider who understands addiction. I will not be discharged from the program.

**If I participate in a higher level of treatment or am discharged from OBAT, I may be readmitted at a future time.**

I agree to participate in patient education, counseling and relapse prevention programs to assist me in my treatment.

**I understand that my records, course of treatment and medical care is in an electronic medical record. These notes will be visible to any healthcare professional involved in my care at Boston Medical Center. The healthcare providers will only access your medical record if they are involved in your care.**

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Printed Name Signature

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Date

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Witness Signature

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Date