WESTBROOK
Health Services
Community Focused. People Driven.

2121 7th St., Parkersburg, WV 26101
(304) 485-1721
Crisis Line: (304) 485-1725 or 1-800-579-5844

PATIENT INFORMED BUPRENORPHINE TREATMENT CONSENT CONTRACT

Patient Name: _____

Client ID#: _____

As a patient in Medication Assisted Treatment for opioid dependence, I freely and voluntarily agree to accept this treatment contract as follows: (Please initial beside each statement below)

____ I agree to keep and be on time to all of my scheduled appointments and to check in at the front desk. I agree to contact staff at least 24 hours in advance if I am unable to make a scheduled appointment.

____ I understand my rights and responsibilities as a consumer, and I have received a written copy of Westbrook Health Service's consumer rights and confidentiality/privacy practices.

____ I understand that if I have a grievance/complaint regarding my treatment in Westbrook Health Service's medication-assisted treatment program, I have the right to file a grievance and complete applicable appeal procedures if I deem the actions taken to resolve the grievance/complaint unsatisfactory. I have received a written copy of Westbrook's Grievance Policy and a Form.

____ I have been informed of and given a copy of Westbrook Health Service's MAT Program Orientation Information Sheet. This includes hours of operation, method of accessing after-hour services in emergencies, financial obligations, restrictions and incentives for the MAT program, a description of how my individualized plan of care/treatment strategy and coordination of care agreement will be developed, as well as an explanation of the toxicology

and random drug screening policy, and the purpose and process of the initial and subsequent physical and psychological assessments.

____ I understand that I may request a therapist and/or elect to receive supportive counseling and/or group counseling. I agree to the counseling session requirements set forth by Westbrook Health Services and agree to attend the counseling sessions at the frequency described, which is two hours per month or as required by my physician.

____ I agree to conduct myself in a courteous manner while at Westbrook Health Services, including but not limited to: not using alcohol, illicit or licit drugs on or prior to entry to the premises, not conducting illegal or disruptive activities, not smoking on the premises and not bringing weapons on the premises.

____ I have received written information regarding the signs and symptoms of an opioid overdose and when, where, and how to seek emergency assistance.

____ I have received written information regarding Suboxone, managing prescribed medication for opiates in the presence of pain, pregnancy and opioid pain medication, information about MAT, how WV DHHR defines MAT, HIV and Hepatitis, and the disease of addiction.

____ I have received written information on alternatives to medication assisted treatment and agree that Medication Assisted Treatment in addition to therapeutic services is the right choice for me. Additionally, I have received an introduction to the goals of medication-assisted treatment and the nature of substance use disorder.

____ I received written information on SMART recovery meetings, Narcotic Anonymous meetings, the CHESS Health Recovery App, and the MAT group schedule.

____ I agree not to obtain any type of therapeutic services through any other sources other than Westbrook Health Services to remain in compliance with program guidelines; unless specific circumstances arise, in which the physician/extender and the treatment team provide approval.

____ I agree to abstain from the use of mood-altering substances. I understand that continuing to use other substances may result in the prescribing physician/extender to refer me to a higher level of care/treatment or discontinuation of treatment in the medication assisted treatment program.

____ I agree to provide an observed sample of my urine for testing at any time for urine drug screen and to return to the center upon notification for a Medication Count, for treatment compliance review.

____ I agree to have a working voicemail that can receive messages.

____ I agree to alert my case manager of the need to be out of town or on vacation prior to leaving town.

____ I agree to present within 24 hours of notification to complete a medication count with all wrappers and remaining doses.

____ I understand that failing to comply with these mandates will result in a failed screen and/or medication count.

____ I understand that a successful medication count will consist of the correct number of wrappers and remaining doses from the current prescription.

The phone number that I can be reached at with a working voicemail is:

_____

The alternate phone number that I can have immediate access to messages left is:

_____

***If an alternate phone number involves a third party, please complete an ROI now.**

____ Women of childbearing age group: If I become pregnant or plan to conceive, I agree to inform my physician/extender. I agree to provide documentation of prescribed contraceptives from my OB/GYN provider. If I am not using oral contraceptives or have no documentation of a prescribed contraceptive, a urine pregnancy test may be required. This serves as consent for pregnancy tests throughout the course of my care.

____ I agree not to obtain medications from any doctors or other sources without telling my treating physician/extender and to inform Westbrook Health Services of any medications that have been prescribed to me by a physician, dentist, optometrist/ophthalmologist, or any other provider not associated with Westbrook Health Services.

____ I understand that an inter and intra-state Board of Pharmacy, a document that indicates prescriptions filled at any pharmacy, will be reviewed prior to admission into the program and

will be reviewed periodically throughout the course of care. These records will be maintained in my file and utilized as a tool in my care to help indicate compliance or need for more intensive service.

____ I have received a copy of the Medication Guide and have been advised that if I have medication questions, I may ask the physician/extender or call the nurse line at 304-485-1721 ext. 163.

____ I have been informed of the nature of the treatment and the risks of possible side effects of my medication has been explained to me. I have read and understand the above contract and my questions have been addressed.

____ I have been informed and have been given written information on treatment withdrawal procedures.

____ I understand that violating any of the above may be grounds for termination from the Medication Assisted Treatment Program.

_____ _____

Patient Signature Date

_____ _____

Clinician Signature Date

_____ _____

Provider Signature Date