THE TAUB GROUP
Treatment for Pain and Addiction

Contract for Use of Suboxone and other related Medications

When other treatments for addiction have not been effective, Suboxone and other medications may be considered. With proper monitoring, these medications can be safely used. All medications have possible side effects.

To Participate in the Program, You Must Agree With the Following Statements:

1. **I will not allow** other individuals to take my medication.
2. **I will obtain all medications/**prescriptions from The Taub Group.
3. I will inform The Taub Group if I see another physician in an emergency for any other medical reason.
4. I will actively participate in additional therapies as requested by The Taub Group.
5. **I am not involved in the sale, illegal possession, diversion, or transport of controlled substances**.
6. I will designate **one pharmacy** where all my prescriptions will be filled.
7. I understand that **lost or stolen prescriptions or medications will not be replaced**.
8. If I am a female of child-bearing age, I will inform my physician if I become pregnant.
9. I agree to random pill counts and lab testing and will present my medication **within 24 hours upon request**.
10. Any medications that I cannot take will be returned to the practice and wasted with a member of our clinical staff prior to any new prescriptions being given.
11. For **"No Show"** appointments medications will be refilled at the next available refill appointment.
12. I will keep all medications out of the reach of children.

I Understand That Medications May Be Discontinued or That I May Be Discharged If Any of the Following Occur:

1. My physician feels that the program has not produced improved level of function.
2. I give away or sell the medications.
3. I allow my medications to be stolen.
4. I lose/misplace the prescriptions or medications.
5. I do not follow instructions and take more medications than is prescribed.
6. I obtain medications from sources other than The Taub Group.
7. I use other illegal substances or alcohol (narcotics, marijuana, cocaine, ect.)
8. I do not comply with random pill counts within 24 hours.
9. If I do not give a sufficient urine specimen when requested.
10. I do not keep appointments or referral appointments.
11. If I commit prescription fraud.
12. If I destroy my medications without the consent of my physician.
13. If I abuse the after hours phone lines or verbally abuse the office staff.

Refills of medications will be by <u>APPOINTMENTS ONLY</u> during regular office hours. Refills will not be made on nights, weekends, or holidays.

I have read this document and understand it. All of my questions have been answered by the staff. I consent to the use of the medications my physician feels will be the most beneficial to me and I understand that my treatment will be carried out in accordance with the conditions stated above. I understand that if I do not follow the conditions of this contract, I can endanger my health as well as my life. I also understand that any infractions of the above conditions may result in my immediate discharge from the practice.

Patient Signature:_____ **Today's Date**:_____

Witness Signature:_____ **Today's Date**:_____

I have received a copy of this contract_____(initial)