Ammar Alrefai, M.D.

Board Certified Psychiatrist
708 Will Halsey Way, Suite C
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INFORMED CONSENT FOR THE USE OF SUBOXONE (BUPRENORPHINE)

I, the undersigned, have been duly informed by Dr. Ammar Alrefai of the nature, risks, and possible complications and consequences, as well as available alternative methods of treatment to the Buprenorphine Treatment Program ("Treatment') that he has recommended for me. I understand this Treatment is for the relief of opioid dependence and I hereby voluntarily consent to this Treatment as follows:

1. I agree to adhere to the Treatment as suggested by Dr. Alrefai, including my regular attendance of scheduled appointments.

2. I understand that the goal of treatment of opiate dependency is to learn to live without abusing drugs. Buprenorphine treatment should likely continue as long as necessary to prevent relapse to opiate abuse/dependence and then be weaned off.

3. It has been explained to me that Buprenorphine itself is a mild opiate drug and can produce some physical dependency.

4. I agree that prescriptions will be given to me only during my appointment with Dr. Alrefai. I understand that if I miss an appointment without giving at least 24 hours-notice I may be discharged from Treatment.

5. I agree to take Buprenorphine as prescribed at the dosage determined by Dr. Alrefai; and not to allow anyone else to take medications prescribed for me. The dose, frequency, and administration of Buprenorphine has been explained to me.

6. I agree not to sell, share, trade, or give my medication to anyone. It is understood that if caught doing so, I will be discharged from Treatment without the chance to be readmitted and that this could be considered unlawful activity by appropriate authorities, and possibly punishable by incarceration.

7. I will safeguard my written prescription and medication from loss, damage or theft. I am aware that a lock box is recommended for those with children. Dr. Alrefai will not replace lost or stolen prescriptions or medication and he may choose to discharge me from Treatment. Damaged prescriptions may be replaced at Dr. Alrefai's discretion. I am responsible for the safekeeping of my prescription at all times.

8. I will never alter a prescription in ANY way. I understand this may be a felony, punishable by incarceration.

9. I am aware that if the pharmacy fulfilling my Buprenorphine prescription has any doubts regarding my conduct then they will inform Dr. Alrefai and inappropriate or suspicious conduct may lead to the immediate termination of my Treatment without any recourse for appeal.

10. I agree not to take any other medications with Buprenorphine without prior permission from Dr. Alrefai. I understand that overdose deaths have occurred when patients have taken more than the prescribed amount of other medications with Buprenorphine. I agree to share with Dr. Alrefai a list of any and all of my current medications.

11. I understand that a new prescription of Buprenorphine will not be issued to me in advance of my regularly scheduled appointment.

12. I understand that I may be required at any time with short notice to bring in my medication for Dr. Alrefai to inspect, count and/or destroy. If I do not show or have the appropriate number of pills, I may be discharged. I may never dispose of Buprenorphine myself without a staff member as a witness.

13. I agree to abstain from all illegal/inappropriate substances including but not limited to: alcohol, marijuana, opiates, cocaine, PCP, ecstasy, LSD, narcotics, amphetamines, or benzodiazepines. I give Dr. Alrefai the permission to do random drug tests in urine or blood. If my drug screen indicates the presence of illegal/inappropriate substances, or has no buprenorphine or buprenorphine metabolites, I will be discharged.

14. I understand that combining illegal substances, alcohol or other medications with prescribed medication increases my risk of breathing difficulties, heart disorders, and sudden death. If I combine such without express authority from Dr. Alrefai, I may be discharged from Treatment.

15. I understand the use of Buprenorphine by injection or snorting may cause serious illness or even death. I agree to use Buprenorphine as prescribed and not for any recreational purpose.

16. Not adhering to the above mentioned terms and condition causes termination of my Treatment without any other options.

17. I acknowledge that I have neither asked for nor received any guaranties or promises as to the results which will be obtained. I acknowledge that I will be taking medication at my own risk.

18. I understand that I am required to see a therapist at Valley Behavioral Services monthly prior or adjacent to my monthly medication appointment. I understand that any missed therapy appointments will cause the medication appointment to be canceled and I may be discharged from Treatment.

It is the patient's responsibility to verify and pay all copays IN FULL PRIOR to any appointment.

This form has been explained to me and I acknowledge that I have read and understand its' contents.

Patient Signature _____ Date: _____

Print Name _____

Valley Behavioral Services

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VALLEY BEHAVIORAL SERVICES URINE DRUG SCREEN TESTING POLICY FOR MEDICATION ASSISTED TREATMENT WITH BUPRENORPHINE

All monthly drug screens must be completed **PRIOR** to medication management appointment. Drug screens must be completed **within 7 days prior to appointment** to be valid. Payment for drug screens is due at the time of the appointment.

Failure to complete the drug screen prior to appointment will result in cancellation of appointment without a prescription.

The only valid excuse for not completing the drug screen is illness (I.E. COVID, Flu, etc) or other significant medical issue which may interfere with ability to comply with drug screen. A doctor's note or documentation of the illness is required, or the drug screen will be considered uncollected, and the appointment will be canceled without a prescription. No other reason for missing drug screens shall be considered viable.

It is the responsibility of the **patient** to ensure they meet all the requirements of this treatment. This also includes attending therapy appointments **monthly.**

Patient Name: _____

Patient Signature: _____

Date: _____