THE
University of Vermont
MEDICAL CENTER

Addiction Treatment Program
Treatment Agreement

Patient Name: _____ **DOB:** _____

In order to ensure the quality of your care and to increase success in recovery, we ask you to agree to the following treatment expectations.

Please read carefully, initial beside each item and fill in the necessary blanks.

1. I understand that it is my sole responsibility to ensure that the UVM Medical Center Addiction Treatment Program (ATP) staff can reach me. I understand that program staff must be able to contact me by phone with voicemail set up. I will return voicemail messages within 24 hours. If I will be unreachable for *any* reason, I will notify my primary counselor within 24 hours: _____.
   My current phone number(s) are: _____ (home / cell / work)
   _____ (home / cell / work).
2. I agree to provide 1 week (7 days) notice to program staff if I am going to be out of town: _____.
3. I agree to sign all necessary release of information forms to ensure collaboration of care with all physicians and/or counselors involved in my treatment: _____.
4. I agree to use a single physician to prescribe my medication-assisted therapy: _____.
5. I agree to develop a treatment plan with my primary therapist and that the plan is shared with my physician(s) and any other providers that are pertinent to my recovery. The purpose of this is to ensure that all parties are collaborating to provide the best treatment possible: _____.
6. I agree to attend treatment sessions, both group and/or individual, as determined by my treatment plan: _____.
7. I understand that as ATP is a short-term, acute treatment program, we will not prescribe additional controlled substances: _____.
8. I understand that ATP only offers combination buprenorphine-naloxone, and we will not prescribe buprenorphine mono-product (Subutex): _____.
9. I understand that if I arrive more than 15 minutes late for an appointment without calling beforehand, I will need to reschedule the appointment for a later date: _____.
10. I understand that if I miss or cancel an appointment without 24-hour notice, I am not guaranteed a prescription until I attend a scheduled appointment with an ATP staff member: _____.
11. I agree to follow all treatment recommendations for counseling and/or psychiatric services: _____.
12. I agree to take medication as directed by my prescribing physician. If a change is made to my medication, I will notify program staff and any other providers involved with my care: _____.
13. I agree to inform all of my professional providers about any of the following:
    a. Use of medication in any way other than prescribed: _____.
    b. Use of other opioids, alcohol, illicit benzodiazepines or other illicit drugs: _____.
14. I understand that observed urine drug screens will be conducted randomly, and the results will be shared with the appropriate professionals. I agree to provide a urine sample *the day my color is announced* through the color line or upon request by the ATP staff: _____.
15. I understand that if I miss one urine drug screen, I will be restarted at the beginning of the level I am currently on in treatment: _____.
16. I understand that if I miss a second urine drug screen my prescription will be written for daily dosing and will be contingent upon going for UDS on the day(s) your color is called: _____.
17. I agree to regular film/strip counts and will bring both my used film wrappers and all remaining medication from my current prescription to every appointment. For example, if my current prescription is for 1 week, I agree to come to the office with a combination of wrappers and unused medication equaling 7 days of dosing: _____.

18. I agree that the medication I receive is *my* responsibility to keep safe and secure, and I understand ATP recommends I keep it in a lockbox: _____.
19. I agree that lost or stolen medication will not be replaced regardless of the reason: _____.
20. I agree to not eat any foods or bakery items that contain poppy seeds, including "everything" bagels, or use any mouth wash or cough syrup containing alcohol. I understand that this will not be accepted as an excuse for a positive drug screen: _____.
21. I understand that the following indicate non-adherence to the program:
    a. Failure to produce a urine drug screen upon request: _____.
    b. Failure to submit to film/pill counts upon request: _____.
    c. Presence of non-prescribed substance(s) in urine drug screen: _____.
    d. Falsification of a urine drug screen: _____.
    e. Aggressive behavior toward staff or other clients, including use of abusive or aggressive tone and language in person or on the phone: _____.
    f. Failure to attend medical and counseling appointments as scheduled: _____.
    g. Giving or selling medication to others: _____.
22. I understand that any non-adherence issues will be discussed with my physician and clinical team and may result in a change of treatment plan, a behavioral contract, or a possible discharge from the ATP. Typically, the first issue of non-adherence will result in weekly prescriptions. A second issue may result in daily prescriptions, more frequent UDSs and/or more intensive counseling requirements; and a third will result in a re-assessment to determine the appropriate level of care: _____.
23. I understand that the ATP reserves the right to immediately refer a patient to a higher level of care if the severity of non-adherence warrants such action: _____.
24. I understand that, like all health care providers, program staff are mandated reporters of suspected abuse, neglect or exploitation of vulnerable groups of people including children and elderly adults: _____.
25. I understand that I am prohibited from making any audio or video recordings of encounters with staff without the express consent from the staff member(s) being recorded.
26. I understand that the ATP maintains patient records which have confidentiality protections under federal law. I authorize the program to disclose information regarding my treatment and participation in the program, including but not limited to dates of service, recommendations for treatment, medications, diagnoses, laboratory tests, and medical and social history, to The UVM Medical Center and its staff and providers, for the purpose of treatment, coordination of care and administration. This authorization includes authorization for the ATP and The UVM Vermont Medical Center to re-disclose my substance use records to my primary care physician's practice, _____, for the purpose of treatment and coordination of my care. I understand that I have the right to revoke this authorization for the disclosure of my substance use records except and to the extent that action has been taken in reliance on it. This authorization will remain in effect until I revoke it by notifying the program staff in writing: _____.
27. I understand that my ATP records will be stored in The UVM Medical Center's electronic medical record and that information about my diagnosis of opioid use disorder and medications such as buprenorphine-naloxone (Suboxone) will be included in my electronic medical record and may be viewable by the UVM Medical Center, its staff and others involved in my medical care: _____.
28. I understand that I will be considered to have left the ATP against medical advice if I have not contacted ATP staff within 3 calendar days of a missed appointment or expired prescription: _____.
29. I understand that if I leave the program against medical advice and wish to re-engage, the ATP will require a new intake appointment, which may not be immediately available: _____.

Patient Signature: _____

Date/Time: _____

aspenti HEALTH

Consent to Receive Email and/or SMS Notifications form Color Line 2.0 Application

I hereby authorize BLA Partners, LLC d/b/a Aspenti Health ("Aspenti Health") to send notifications by email or short messaging service (SMS) of color assignments and due dates from the automated scheduling application Color Line 2.0 to the below designated email address or telephone number. I understand that Aspenti Health has no control as to whom may have access to the email accounts or telephone numbers I designate and that the notifications sent by may contain personal health information that is protected under the Health Insurance Portability & Accountability Act. With that knowledge, I am authorizing and consenting to the distribution of that information as designated below.

Authorized Notification Methods:

- ☐ Email
- ☐ SMS

Authorized Notifiable Contact Information:

Email Address: _____

Telephone #: _____

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying _____ in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) _____ agrees to maintain the confidentiality of my PHI; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Effective Dates: Unless otherwise revoked, this authorization shall be effective from: ___/___/_____ **(date)**

until: ___/___/_____ **(date)**

If no dates are designated above, this authorization will expire at the earlier of 180 days from the date of signing or revocation.

Patient Name: _____ **DOB:** _____

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name of Patient's Representative

Relationship to Patient (if applicable):

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

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MEDICAL CENTER

Buprenorphine-Naloxone Consent Form

Patient Name: _____ **DOB:** _____

Consent for Treatment with Buprenorphine-Naloxone (SUBOXONE®)

- Buprenorphine-naloxone is an FDA-approved medication for treatment of people with heroin or other opioid addiction. It can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opioid addiction, including methadone, naltrexone and non-medication options (counseling, groups and 12-step meetings).
- Buprenorphine-naloxone is a combination of buprenorphine, a narcotic analgesic, and a short-acting opioid blocker (naloxone). Buprenorphine will maintain your physical dependence on opioids, and if you discontinue it suddenly, you will likely experience withdrawal symptoms.
- The Addiction Treatment Program only offers the combination product of buprenorphine-naloxone; our providers will not prescribe buprenorphine mono-product (Subutex®).
- After you become stabilized on buprenorphine-naloxone, it is expected that other opioids will have less of an effect. **Attempts to override buprenorphine-naloxone by taking more opioids could result in an overdose.** You should not take any other medications without discussing it with your physician first.
- Buprenorphine-naloxone is a narcotic medication and, like all narcotics, **may make you drowsy**. If you have this side effect, you should not drive, operate equipment, or perform any duty or task that requires complete mental or physical alertness.
- Combining buprenorphine-naloxone with other sedating medications is *dangerous*. The **combination of buprenorphine-naloxone with benzodiazepines (i.e. Valium, Librium, Ativan, Xanax, Klonopin, etc.) has resulted in overdose and death.**
- According the manufacturer of Suboxone®, Indivior Inc., **you should not drink alcohol while taking buprenorphine-naloxone, as this can lead to loss of consciousness or even death.**
- Buprenorphine-naloxone film or tablets must be held under the tongue until they dissolve completely. It is important not to talk or swallow until the film or tablet dissolves. This can take up to ten minutes. Buprenorphine-naloxone is absorbed over the next 30-120 minutes from the tissue under the tongue. Buprenorphine-naloxone is poorly absorbed from the stomach. If you swallow the tablet, you will not have the important benefits of the medication, and it may not relieve your withdrawal.
- You and your doctor will determine the appropriate dose, which will vary from one person to another. The effects of buprenorphine-naloxone plateau above a certain dose, so higher doses do not necessarily offer more benefit.

I have read and understand the above information about buprenorphine-naloxone treatment.

Patient Signature: _____

Date / Time: _____

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OPIATE CARE ALLIANCE of CHITTENDEN COUNTY

CONSENT TO DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND COORDINATION OF CARE

I, _____, date of birth _____, authorize the use and disclosure of my personal health information by and among each of the members of the Opiate Care Alliance of Chittenden County ("OCACC") including the staff of each member organization. The following organizations are members of the OCACC:

- Community Health Centers of Burlington, Inc.;
- Howard Center, Inc.;
- University of Vermont Medical Center, Inc.;
- Vermont Department of Health's Alcohol and Drug Abuse Programs.

THE MEANS OF THIS DISCLOSURE MAY BE WRITTEN, VERBAL, OR ELECTRONIC.

I understand that the purposes for the use and disclosure of my personal health information among the staff of the organizations that make up the OCACC are as follows: screening, assessment, placement, treatment planning, referral for treatment, monitoring progress, coordination of care, and aftercare.

The personal health information to be shared among the members of the OCACC will include the following:

(1) Name and other identifying information (including living situation and social history);
(2) Medical assessment, diagnosis, treatment, progress in treatment, and discharge summary;
(3) History and participation in services; and
(4) Mental health and/or drug and alcohol screening, urine drug screen results, assessment, diagnosis, treatment, progress, and discharge summary.

ADDITIONAL PROVISIONS CONCERNING YOUR CONSENT:

I understand that my decision to use the services offered by the OCACC is voluntary, and I may end services with members of the OCACC at any time.

I also may revoke this Consent at any time by notifying any member of the OCACC, but revoking this Consent will not affect any actions which were taken by the OCACC or its member organizations before I revoked the Consent. If not previously revoked, this Consent will terminate on the following date, event, or condition: _____. If none is indicated, this consent will remain in effect until one year after the last day of services provided to me by a member of the OCACC.

I understand that information used by and disclosed to members of the OCACC include medical, mental health, and/or substance abuse treatment information. I understand that regulations regarding federally assisted drug and alcohol treatment programs, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, prohibit the re-disclosure of this type of information without my written consent unless otherwise allowed by the regulations or required by law. I understand that the confidentiality of such records is also protected by State law.

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I understand that if I want members of the OCACC to disclose personal health information about me to someone other than members of the OCACC, I will need to sign a separate consent or authorization form. I understand that generally the members of OCACC may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied participation in the OCACC if I do not sign a consent form. I understand that I may be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or healthcare operations. I also understand I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand that I may request restrictions on the use or disclosure of information for the purposes described in this Consent and that any of the members of OCACC may or may not agree to the requested restrictions.

I have read all the above information, and I understand its contents and consent to the use and disclosure of the personal health information identified above to members of the OCACC.

_____ _____

Name of Patient (please print) Date

_____ _____

Signature of Patient or Parent/Guardian Date

Verbal revocation: _____ (date) at _____ (time)

Written revocation: I hereby revoke this authorization on _____ (date). Do not release any further information under this authorization.

Signature: _____

PCP Name: _____

Insurance Plan: _____