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Suboxone (Buprenorphine): Informed Consent and Treatment Plan  
Agreement

1. I understand that the frequency of visits mutually agreed upon between myself and Dr. Nagaraja, are mandatory. I understand that I must call at least 48 hours prior to any appointment if I need to cancel. I understand that if I miss an appointment without contacting Dr. Nagaraja, I may be discharged from the Buprenorphine treatment program.\_\_(initial here)
2. I understand that if I am not seen in the office according to the mutually agreed upon schedule between myself and Dr. Nagaraja, I will be unable to obtain my prescriptions and may be discharged from the Buprenorphine treatment program.\_\_\_\_(initial here)
3. I agree to take Buprenorphine (ie: Suboxone) as prescribed and at the dosage determined by Dr. Nagaraja. I agree not to obtain Buprenorphine from any other provider. I agree not to give or sell medications prescribed to me by Dr. Nagaraja to anyone else.\_\_\_\_(initial here)
4. I understand I will be required to seek out and attend individual and/or group therapy while in the Buprenorphine treatment program.\_\_\_\_(initial here)
5. I agree not to take any other medications concurrently with Buprenorphine, without prior permission from Dr. Nagaraja. I understand that overdose deaths have occurred when patients have taken medications such as benzodiazepines (ie: Valium, Xanax, Klonopin) with opiates.\_\_\_\_(initial here)
6. I understand that combining illegal substances with prescribed medications increases my risk of breathing difficulties, heart problems and sudden death. If I do take illegal substances while on Buprenorphine, I may be discharged from Dr. Nagaraja's practice.\_\_\_\_(initial here)
7. I will submit a urine specimen for drug screening (including, but not limited to narcotics, marijuana, cocaine, amphetamines, pcp, alcohol, benzodiazepines) upon Dr. Nagaraja's request, as often as directed. Dr. Nagaraja may ask that he or a staff member observe me providing the appropriate specimen. If my drug screen is positive for illegal or inappropriate substances, I may be discharged from the Buprenorphine program.\_\_\_\_(initial here)
8. It has been explained to me and I understand that Buprenorphine itself is a very mild opiate drug and can produce physical dependency.\_\_\_\_(initial here)
9. The goal of treatment of opiate dependency is to learn to live without abusing drugs. Buprenorphine treatment could continue as long as necessary to prevent relapse. Dr. Nagaraja may determine it is necessary to decrease the dose of Buprenorphine until the medication is no longer needed.\_\_\_\_(initial here)
10. If I have been on Methadone maintenance, I agree that Dr. Nagaraja can coordinate my medication changes with my Methadone provider. This may involve exchange of medical records and discussions with the Methadone clinic, physician or staff. After switching from Methadone to Buprenorphine, I will not take Methadone.\_\_\_\_(initial here)

11. I understand that Dr. Nagaraja's general Informed Consent and Additional Policies will complement any terms of this agreement. One agreement does not supersede the others

12. I understand that I may be required at any time, and with short notice to bring in my medications for Dr. Nagaraja to inspect, count and/or destroy. If I do not show or have the appropriate number of pills, I may be discharged from the Buprenorphine treatment program. I may never dispose of Buprenorphine without Dr. Nagaraja or his staff as a witness. All films must be taken as prescribed or turned into Dr. Nagaraja for disposal. \_\_\_\_\_(initial here)

13. I will allow Dr. Nagaraja to communicate with other providers regarding my medical care, consistent with HIPAA guidelines. I acknowledge receipt of Dr. Nagaraja's Privacy Practices notice. In addition, I will allow the following people to communicate with Dr. Nagaraja about my medical condition and plan of care \_\_\_\_\_(initial here)

14. I will not sell, share or trade my medications with anyone. Doing so will cause me to be discharged from the Buprenorphine treatment program \_\_\_\_\_(initial here)

15. I will safeguard my written prescriptions, Buprenorphine films and any pain medications from loss, damage and theft. Dr. Nagaraja may replace missing medications only at his sole discretion and depending on the circumstances. \_\_\_\_\_(initial here)

16. I will never alter a prescription in ANY way. I understand this is a felony, punishable by incarceration. \_\_\_\_\_(initial here)

17. I authorize Dr. Nagaraja and my pharmacy to cooperate fully with any city, local, state, or federal law enforcement agency, including Virginia's board of Pharmacy and the US Drug Enforcement Agency (DEA), in the investigation of any possible misuse, prescription forgery, sale or any other diversion of my medications. \_\_\_\_\_(initial here)

18. I will allow Dr. Nagaraja to receive information from any pharmacy I have used, either currently or in the past. \_\_\_\_\_(initial here)

19. I will have all my medications filled only at the pharmacy I have listed below. I will inform Dr. Nagaraja of any pharmacy changes. \_\_\_\_\_(initial here)

20. I understand that rude or disrespectful treatment of Dr. Nagaraja and/or any of his staff members is not tolerated and will result in my discharge from the Buprenorphine treatment program. \_\_\_\_\_(initial here)

21. [For women of childbearing potential]: I agree to inform Dr. Nagaraja as soon as possible, if I become pregnant, have plans to become pregnant, or think I may be pregnant. \_\_\_\_\_(initial here)

I have read and understand the above details about the Buprenorphine treatment program, and I wish to proceed with treatment.

Name \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Town \_\_\_\_\_ Phone \_\_\_\_\_  
Primary Care Provider \_\_\_\_\_ Town \_\_\_\_\_ Phone \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_

**This agreement will remain in place for as long as patient is treated by Dr. Nagaraja**

