**SAMPLE FAMILY MEDICINE MAT PROGRAM CONSENT FORM**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby voluntarily consent to participate in the Buprenorphine-Naloxone Program. I am requesting Buprenorphine-Naloxone therapy as a treatment for Opioid Use Disorder. I understand it is my responsibility to tell the Program Physician/Nurse as much as I can about my health. It is my responsibility to seek medical attention immediately if any reaction occurs to Buprenorphine-naloxone or if any changes occur in my health status. I understand Marquette Family Medicine is committed to providing me with the resources I need to help me with my recovery from Opioid Use Disorder.

As a participant, I freely and voluntarily agree to adhere to the treatment protocol as follows:

Please initial each statement:

1. \_\_\_\_\_\_ I understand medication alone is not sufficient treatment for managing my disease. I understand that an outpatient counseling and/or other Substance Use Disorder treatment is important to my recovery and is recommended.
2. \_\_\_\_\_\_ I understand that my primary care provider must be through Marquette Family Medicine while receiving Buprenorphine-Naloxone at this clinic. If my primary care provider is unable to prescribe Buprenorphine-Naloxone to me, a qualified provider within Marquette Family Medicine will prescribe Buprenorphine-Naloxone to treat my Opioid Use Disorder.
3. \_\_\_\_\_\_ I will not receive Buprenorphine-naloxone or other medications with the potential for misuse from any provider outside Marquette Family Medicine.
4. \_\_\_\_\_\_ I agree to keep and be on time for my scheduled appointments at Marquette Family Medicine. I understand Family Medicine may not be able to reschedule me and I may experience a lapse in medication if I miss my appointment. If I cannot keep an appointment, I will call ahead to cancel and reschedule.
5. \_\_\_\_\_\_ I understand if I no-show for three appointments, I may face discharge from the Marquette Family Medicine Clinic and therefore the Buprenorphine-naloxone program.
6. \_\_\_\_\_\_ I understand if I miss or reschedule an appointment, I will not get a refill of my medication, and I may have withdrawal symptoms from being out of Buprenorphine-naloxone.
7. \_\_\_\_\_\_ I understand I must take Buprenorphine-naloxone as prescribed.
8. \_\_\_\_\_\_ I understand that if I lose my medication or if it is stolen, I will not get early refills.
9. \_\_\_\_\_\_ I understand that once I have a prescription, it is my responsibility to bring it to the pharmacy.
10. \_\_\_\_\_\_ I agree to participate in assessments measuring my level of motivation and level of risk relating to my substance use disorder.
11. \_\_\_\_\_\_ I agree to have a blood or urine specimen taken for any test deemed necessary by my provider prior to and/or during Buprenorphine-naloxone treatment.
12. \_\_\_\_\_\_ I understand that I will be asked to complete random urine drug screens during my scheduled MAT appointments and I will need to empty my pockets, and leave coats, bags, etc., outside the restroom when providing my sample. Inconclusive tests may require a new sample.
13. \_\_\_\_\_\_ I understand that I may need to provide a witnessed urine specimen for a urine drug screen if my provider thinks it is necessary.
14. \_\_\_\_\_\_ I understand that I must inform any medical provider treating me that I am receiving Buprenorphine-naloxone treatment.
15. \_\_\_\_\_\_ I understand I should disclose if I am pregnant or contemplating pregnancy.
16. \_\_\_\_\_\_ I agree to receive communications via phone and must have access to a working phone number to respond to Marquette Family Medicine inquiries and requests within 24 hours.
17. \_\_\_\_\_\_ I understand it is my responsibility to provide health insurance coverage information and notify Marquette Family Medicine if changes occur, so I do not have problems accessing my Buprenorphine-naloxone prescription.
18. \_\_\_\_\_\_ I understand that a urine drug screen containing alcohol or substances with the potential for misuse may result in more frequent office visits, fewer days of medication at one time, and/or a recommendation to counseling or other substance use disorder treatment.
19. \_\_\_\_\_\_ I understand that I may be required to receive prescriptions for Buprenorphine-naloxone that are less than 28 days, which may result in me having to pay extra co-pays due to insurance.
20. \_\_\_\_\_\_ I agree to comply with random pill counts and will present to Marquette Family Medicine office or my pharmacy (I will be told where to go) within 24 hours of being notified of a random pill count. If I am out of town, I will purchase something (gum, gas, coffee, etc.) in the town that I am in and provide the receipt for purchase at my next appointment.
21. \_\_\_\_\_\_ I understand that failure to comply with a random pill count suggests diversion or misuse of my medication and I may face termination from the program. A non-working number, full voicemail or no minutes on a phone will not be accepted as reasons to miss a pill count and will be considered failure to comply with the pill count.
22. \_\_\_\_\_\_ I will keep my provider at Marquette Family Medicine informed of any legal issues I have
23. \_\_\_\_\_\_ I will be courteous with all office staff at all times. I understand that violating any of these conditions may result in dismissal from the Buprenorphine-naloxone program

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned have defined and fully explained the above information to this individual.

Provider Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_