Intensive Health
a stepworks company

Treatment Agreement

Patient Name: _____

Date of Birth: _____ / _____ / _____

Please **initial each line below** to indicate that you agree with the statement. Violating the terms below could result in changes to your treatment plan or discharge from the practice.

1. _____ I will arrive on time to all of my scheduled appointments. (If I am not on time, I may not be seen.) I will cancel at least 24 hours before my appointment time if unable to attend. If I miss an appointment, I know I will not receive my medications until I am seen for an office visit.
2. _____ I will conduct myself courteously and respectfully to Stepworks team members and other patients.
3. _____ I will pay all fees including copays and deductibles at the time of my appointment.
4. _____ I will not arrive at the office intoxicated or under the influence of any drugs.
5. _____ I will not share, sell, or give away any medications I receive from this office.
6. _____ I know that using opiates while receiving MAT treatment could result in severe withdrawal symptoms and increase my risk of overdose. I also know that abruptly stopping MAT treatment could result in withdrawal.
7. _____ I know that lost or stolen medications will not be replaced or refilled early. I will keep my medications safe and secure.
8. _____ I will inform my Intensive Health providers of any medication changes made by other providers I may see.
9. _____ I will inform all of my other providers (and anyone who provides care to me) of my treatment with Intensive Health.
10. _____ I will actively participate in my treatment plan including counseling, group therapy, or treatment programs.
11. _____ I know my treatment will be monitored via KASPER reports, communications with other people involved in my care, and drug screens (random and scheduled).

Patient Signature: _____ Date: _____ / _____ / _____