Western Sierra Medical Clinic
Better Health Together

Medication Assisted Treatment (MAT)

Program Agreement

www.wsmcmed.org

Patient Full Name: _____ DOB: _____ DATE: _____
Patient ID: _____ Program Admit Date: _____

This agreement outlines the expectations and responsibilities of participants in the Medication Assisted Treatment (MAT) program at Western Sierra Medical Clinic. Our evidence-based approach focuses on harm reduction, long-term recovery, and patient-centered care for individuals with substance use disorder (SUD). Please review each item carefully, initial to acknowledge your understanding and agreement, and sign at the end of this document.

	Initials	*Requirement*
1.		I understand that this program uses FDA-approved medications for the treatment of opioid use disorder (e.g., buprenorphine) and adheres to federal and state guidelines for prescribing controlled substances.
2.		I must take medication as prescribed. I cannot change the way I take my medication or adjust the dose unless approved by the provider. I understand that buprenorphine is a controlled medication. I know that taking buprenorphine regularly can lead to physical dependence and that if I abruptly stop taking it, I could experience symptoms of opioid withdrawal.
3.		I agree to see my buprenorphine provider on a regular basis. The frequency of visits will be at the discretion of my buprenorphine provider based on my treatment needs and will be explained to me.
4.		I am open to the idea of seeing a Substance Use Disorder Counselor, BH, psych, joining recovery groups, or attending AA or NA based on my recovery needs.
5.		I will attend scheduled appointments to the best of my ability. I understand that missing or rescheduling appointments may result in delays or additional steps to refill my medication.
6.		I agree to random urine and/or saliva screens as needed. I understand I will be tested for all substances, including alcohol. I understand that this is at the discretion of the provider and to ensure my safety.
7.		I agree to not sell, share, or give my medication to any other person. I understand that California law prohibits the sale or distribution of controlled substances.
8.		I agree to take full responsibility for the safekeeping of my buprenorphine and all other controlled medications. I understand a lock box is the safest for storing controlled medications. Lost or stolen medications will not be refilled before the date they are due to be renewed, unless I can provide a police report documenting the loss.
9.		I agree to notify my buprenorphine provider and SUD Counselor immediately in case of relapse with any substance. This will provide an opportunity for my treatment plan to be evaluated & adjusted as indicated for my safety.
10.		In the event of continual relapses, I agree to be open to further discussion of residential treatment with my provider as part of my recovery plan.
11.		I agree to inform my MAT Program treatment team of all medications I am taking, both prescribed and/or over the counter. I understand this is to ensure my safety and decrease the potential for harm. I understand that it can be dangerous to mix buprenorphine with alcohol or other sedatives (such as Valium, Ativan, Xanax, Klonopin, Librium), benzodiazepines – doing so could result in accidental overdose, over-sedation, organ failure, coma, or death. I agree to abstain from ALCOHOL and SEDATIVES while I am being treated with buprenorphine.
12.		I agree to obtain my medications from a single pharmacy. The pharmacy I would like to designate is _____ at (phone) _____.

13.		I understand that the following events may serve as grounds for my discharge from the MAT Program: A. An attempt to alter a urine and/or saliva specimen obtained for a drug screen B. Distribution of my MAT Program medications to any other individual C. Any dangerous, threatening, or inappropriate behavior that is disruptive to me, the clinic staff or other patients

Western Sierra Medical Clinic Medication Assisted Treatment Program staff are here to support you on your journey to recovery.

Resources for Medication lock boxes and safe medication disposal:

- Medication lock boxes, resources: Families | Locks Save Lives, Do Your Part For Safety: Free Safe Storage Devices Available Through Region Ten - Region Ten, Join Our Cause
- Safe disposal of medication:
- Nevada County medication disposal Prescription Drug Take-Back | Nevada County, CA
- Placer County medication disposal *New year-round medication disposal options NR-424 | Placer County, CA*

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

Signature of person giving consent or legal representation Date

Print Name: _____

Relationship to Patient: □ Self □Parent □Guardian □Authorized Representative

SUD Counselor Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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