TUSCARAWAS COUNTY
GENERAL HEALTH DISTRICT

Participant Agreement
Vivitrol Program

Client Name: _____ Date: _____

As a participant in the Vivitrol Program, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments and to check in and out at the front desk. I understand that I am to wait in the lobby until called by staff.
2. I agree to conduct myself in a courteous manner while in the facility or on the facility grounds.
3. I understand that payment is due PRIOR to receiving services. If I do not have payment, including my co-pay (as applicable) I will not be seen by the medical provider, counselor or case manager.
4. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating medical provider.
5. I understand that use of alcohol or other drugs with Vivitrol is dangerous and may be life-threatening. I agree to remain abstinent from alcohol and other drugs not prescribed specifically for me. I understand that use of other substances may result in the medical provider referring me to a higher level of care/treatment or discontinuing my treatment with the program.
6. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in the recovery program as discussed and agreed upon with my medical provider and/or counselor and specified in my treatment plan.
7. I have been informed of the nature of the treatment and it was explained to me the risks of possible side effects of the medication.

Public Health
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8. I agree to report immediately to Program staff any concerns or problems related to my medication or Program participation.
9. I agree to provide random urine samples counts. Failure to submit to this upon request may result in my discharge from the Program.
10. I agree to complete all requested laboratory testing.
11. I understand that violations of the above may be grounds for termination of treatment.

I have been informed of the nature of treatment including the risks of possible side effects of possible side effects of the medication. I have read and understand the above contract. My questions have been answered. I have received a copy of this contract.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date