**TRICARE COUNSELING & CONSULTING, INC**
**731 TILGHMAN DR. DUNN, NC 28334**
**PHONE:910-249-4219 FAX: 866-279-1991**

# AGREEMENT FOR INDIVIDUALS REFERRED FROM A SUBOXONE PROGRAM & REQUIRE PSYCHOTHERAPY OR GROUP THERAPY

Our services restricts treatment to a limited number of pre-qualified clients. This program accepts only clients who are serious about overcoming opioid addiction. We do not offer medical care or Suboxone. We do coordinate care with your Suboxone provider who have referred you for required psychotherapy. If and when we are unable to provide services to you, we will inform the referring provider.

You agree to be compliant with your Suboxone provider agreement in addition to our agreement with you. We agree to provide the required weekly session for 12 weeks and then once a month thereafter if you are compliant with your Suboxone providers' treatment. We will provide your provider with weekly updates on your attendance.

If you are non-compliant with the required psychotherapy sessions, we reserve the right to discharge you and notify your provider of non-compliance.

**Client Responsibilities**

I Agree to attend weekly session for the initial twelve (12) weeks and monthly session after that for maintenance starting on _____ (date of initial session).

I agree to notify the office at least 48 hours in advance if I am unable to make an appointment and reschedule. I understand that If I cancel on the same day, it is considered a no-show. I understand that no-shows may lead to immediate discharge with notification to my Suboxone provider.

I agree to comply with the treatment plan that will be developed with me by the psychotherapist. I agree that I will be open and honest with my counselors and inform staff about cravings, potential for relapse to the extent that I am aware of such, and specifically about any relapse which has occurred before a drug test result shows it.

I have the phone number of this office and I understand the office hours. I understand that this office does not provide medical services other than psychotherapy.

Patient signature: _____ Date: _____

*Client:* _____ *DOB:* _____ *MR#:* _____

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*APPOINTMENT ATTENDANCE RECORD (to be completed by clinician)*

*Initial 12 sessions weekly*

***Client:*** _____ ***DOB:*** _____

| ***Date of session*** | ***Therapist*** | ***notes*** |
|---|---|---|
| ***Clinical Assessment & Treatment plan*** | | |
| *Session 1* | | |
| *Session 2* | | |
| *Session 3* | | |
| *Session 4* | | |
| *Session 5* | | |
| *Session 6* | | |
| *Session 7* | | |
| *Session 8* | | |
| *Session 9* | | |
| *Session 10* | | |
| *Session 11* | | |
| *Session 12* | | |

*Client:* _____ *DOB:* _____ *MR#:* _____

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## *Maintenance Monthly session*

***Client:*** _____ ***DOB:*** _____

| | | |
|---|---|---|
| *Session 13* | | |
| *Session 14* | | |
| *Session 14* | | |
| *Session 15* | | |
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*Client:* _____ *DOB:* _____ *MR#:* _____