## **Bion Healthcare**

## Informed Consent For Concurrent Benzodiazepine and Opioid Therapy

(High-Risk Combination warning)	
I,	
acknowledge that my provider at <b>Bion Healthcare</b> has clearly explained the <b>serious risks</b> associated with taking <b>benzodiazepines</b> (such as Xanax®, Klonopin®, Valium®, Ativan® at the same time as <b>opioid medications</b> .	
Note: The muscle relaxant <b>Soma®</b> (carisoprodol) is also considered similar to benzodiazepines in its effects and risks. (We do not prescribe Soma® at Bion Healthcare)	
⚠ What I Understand and Agree To:	
I understand that combining benzodiazepines and opioids greatly increases the risk of accidental overdose and death.	
I know that this combination can also severely affect my ability to think clearly, stay alert and safely operate a vehicle or machinery.	
I will take both medications <b>exactly as prescribed</b> and will <b>never increase the dose</b> on my own.	
I agree to <b>completely avoid alcohol</b> while taking benzodiazepines and opioids.  This includes all occasions—no exceptions for holidays, birthdays, or special events.	
I understand that drinking alcohol while on these medications is dangerous and not tolerated under my treatment plan.	
I accept the high risks involved in taking these medications together and will follow my provider's instructions closely.	
If another doctor prescribes me a benzodiazepine, I will immediately let them know that I am also taking an opioid so they understand the <b>increased risk of serious side effects or death</b> .	
If I am being treated with <b>buprenorphine</b> (such as <b>Suboxone</b> ® or <b>Subutex</b> ®) and have a history of substance use, I am aware that benzodiazepines also carry a high risk of addiction and dependency.	

I understand that violating any of the terms outlined WILL RESULT IN IMMEDIATE DISCHARGE from Bion Healthcare, and no further prescriptions will be provided.
<b>△</b> Acknowledgment
I have read and understood this consent form. I have had the opportunity to ask questions and agree to follow these guidelines to protect my safety and well-being.
Patient's Printed Name:
Patient's Signature: Date: / /
Datc