

52-4 District Court Drug Therapy Court

Participant Healthcare Contract

This document is intended to support communication and collaboration between healthcare providers, participants, and the 52-4 Treatment Court Program. A careful review of this agreement by both the healthcare provider and the participant ensures that all treatment and prescribed medications align with the participant’s recovery, sobriety, and program requirements.

Participant Information

Participant Name: _____

Date of Birth: _____

Treatment Court Program: _____

Case Manager / Probation Officer: _____

Date of Appointment: _____

Provider Acknowledgment

I, the undersigned healthcare/medical provider, understand that the above-named individual is an active participant in a court-supervised treatment program that requires abstinence from alcohol, illicit substances, and certain addictive or mood-altering prescription medications unless medically necessary and approved through the program.

I acknowledge that I have reviewed the participant’s status in the treatment court program and have considered this status in my clinical evaluation and treatment recommendations.

Discussion of Treatment and Recommended Medications

I certify that I have:

1. Discussed the diagnosis, proposed treatment, and/or prescribed medication with the participant, including potential risks, benefits, and side effects.
2. Reviewed non-addictive, non-controlled, and evidence-based alternatives to any potentially habit-forming or mood-altering medication, including non-pharmacologic options where appropriate.
3. Informed the participant that their participation in a treatment court program requires communication and documentation of prescribed medications that could impact recovery or sobriety.
4. Evaluated whether the recommended medication may pose a risk for relapse, dependency, or interference with treatment court goals, and discussed ways to minimize such risks.

Medication/Purpose	Alternative	FINAL RECOMMENDATION

Participant Acknowledgment

I, the undersigned participant, acknowledge that:

- I have informed my healthcare provider that I am a participant in a treatment court program.
- I have discussed with my provider the risks, benefits, and alternatives of the proposed treatment or medication.
- I understand that I must immediately report any new prescription, medication change, or medical treatment to my treatment court case manager or probation officer.
- I understand that my ongoing recovery and program compliance require full transparency about any medication use.

Participant Signature: _____ Date: _____

Provider Certification

I certify that I have provided the information above, discussed non-addictive alternatives, and made my recommendations consistent with sound medical judgment and the participant’s recovery goals.

Provider Name (Print): _____

Provider Signature: _____

License/Title: _____ Date: _____

Provider Office/Clinic: _____

Contact Information: _____

Section 6: Court Program Verification

(To be completed by Treatment Court Staff)

Reviewed by: _____ Date Received: _____

Follow-up Required: Yes No

Notes: _____

Confidentiality Notice:

This form may contain information protected under federal confidentiality laws (42 CFR Part 2) and the Health Insurance Portability and Accountability Act (HIPAA). It is intended solely for communication between the treatment court team and authorized healthcare providers, with participant consent.