Pre-Treatment Agreement & Patient/Provider Attestation of Readiness

Medication & Treatment Regimen: _____

Please review the following statements and initial beside the response as acknowledgement that you understand:

___ I know drinking alcohol or misusing opioids or other drugs can hurt my liver.

___ I will tell my provider if I have any serious medical conditions (such as heart disease, high blood pressure, diabetes, high cholesterol, rheumatoid arthritis, or drug addiction), or psychiatric conditions (depression, history of suicide attempts, bipolar disorder, or psychosis).

___ I am willing to check in with the clinic during treatment and follow up 12 weeks after end of treatment to test for cure. If I am unable to attend follow up appointment, I will let my provider know ahead of time and I will reschedule my appointment.

___ I understand that my provider can stop my treatment if the provider feels that stopping it is in the best interest of my health and well-being.

___ I understand that my hepatitis C may not respond to treatment.

___ If I have any problems with the medications or side effects that bother me, I will let my provider or nurse know right away.

___ I will do my best to take my medications as prescribed by my provider. If I am unable to do so, I will contact my provider.

___ I will protect myself and others from hepatitis C by not sharing needles, toothbrushes, razors or nail clippers, and covering cuts to prevent blood exposure.

___ If female, I understand that I cannot be pregnant or breastfeeding during treatment. I understand that my treatment will be stopped if I become pregnant. ___Not applicable, I am surgically sterile or post-menopausal.

If using **ribavirin**: ___ Not applicable, ribavirin will not be used.

___ I will use 2 acceptable methods of birth control during treatment and for 6 months after I stop treatment.

___ If female, I understand that I cannot be pregnant or breastfeeding during treatment & for 6 months after treatment. I understand that my treatment will be stopped if I become pregnant. ___ Not applicable, I am surgically sterile or post-menopausal.

___ If male, I understand that I should not father a child during treatment and for 6 months after treatment. ___ Not applicable, I am surgically sterile.

My signature below means that I have read and understand or the meaning of the information has been explained to me. I agree to complete treatment.

_____

Patient's Name (PLEASE PRINT) **Patient's Signature** **Date**

_____

Provider's Name (PLEASE PRINT) **Provider's Signature** **Date**