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PATIENT INFORMATION

Last Name_____First_____M_____

Address_____

City_____State_____Zip_____

Phone (home)_____ (Cell)_____

Male/Female Date of Birth _____/_____/_____ SS#_____/____/_____ Marital Status_____

Place of Employment_____Occupation_____

Address _____

Emergency Contact:_____Relationship_____

Address if different from above _____

City_____State_____Zip_____

Phone (home)_____(Cell)_____

If Patient is a minor name and address of parent(s):

Father_____ Phone _____

Address_____City_____State_____

Mother_____Phone _____

Address_____City_____State_____

Family/Personal Physician_____

Insurance Information

Name of Insurance _____

Will you attempt to get reimbursement from your insurance company? Yes No

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MEDICAL/SUBSTANCE DEPENDENCY HISTORY

Use the opposite side of the page as necessary to complete your answers. **Please print legibly.**

Name: _____

Address: _____

Phone: (w) _____ (h) _____ (c) _____

DOB: _____ Age: _____SS no.: _____

Emergency contact: _____

Relationship to patient: _____ Phone: _____

Primary care physician: _____ Phone: _____

Date of last physical: _____ Have you ever had an EKG? **( )** N **( )** Y Date: _____

Current or past medical conditions (check all that apply) :

( ) Asthma/respiratory	**( )** Cardiovascular (heart attack, high cholesterol, angina)	
( ) Hypertension	**( )** Epilepsy or seizure disorder	**( )** GI disease
( ) Head trauma	**( )** HIV/AIDS	**( )** Diabetes
( ) Liver problems	**( )** Pancreatic problems	**( )** Thyroid disease
( ) STDs	**( )** Abnormal Pap smear	**( )** Nutritional deficiency

MD NOTES: _____

_____

_____

_____

_____

Is there a family history of anything NOT listed here? **( )** N **( )** Y (Please explain) _____

_____

Have you ever had **surgery** or been **hospitalized**? **( )** N **( )** Y (Please describe) _____

_____

MD NOTES: _____

_____

Childhood Illnesses

Measles **( )** N **( )** Y Mumps **( )** N **( )** Y Chicken Pox **( )** N **( )** Y

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? **( )** N **( )** Y (Please describe) _____

Have you ever taken or been prescribed **antidepressants**? **( )** N **( )** Y For what reason _____

Medication(s) and dates of use: _____ Why stopped: _____

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).
DO NOT include medications you may be currently misusing (that information is needed later): _____

_____

_____

Please list all current **herbal medicines**, **vitamin supplements**, etc, and how often you take them: _____

_____

MD NOTES: _____

_____

Please list any **allergies** you have (eg, penicillin, bees, or peanuts): _____

_____

MD NOTES: _____

Tobacco Use

Cigarettes: Now? **( )** N **( )** Y In the past? **( )** N **( )** Y

How many per day, on average? _____ For how many years? _____

Pipe: Now? **( )** N **( )** Y In the past? **( )** N **( )** Y

How often per day, on average? _____ For how many years? _____

Have you ever been **treated for substance misuse**? **( )** N **( )** Y (Please describe when, where and for how long)

_____

How long have you been **misusing substances?** _____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? **( )** N **( )** Y (Please list) _____

_____

_____

What was your longest period of abstinence? _____

_____

Have you experienced withdrawal symptoms in the past (check all that applies)

Blackouts	( )	Anxiety	( )	ETOH Seizures	( )
Tremors	( )	DTs	( )	Nausea/vomiting	( )
Diarrhea	( )	Body cramps	( )	Body Aches	( )
Sweats	( )	Other:_____			

Are you receiving, or have you ever received counseling support? **( )** N **( )** Y (Please describe when and for how long) _____

_____

Additional information you feel we should know to help in your recovery:

_____

_____

_____

_____

_____

_____

_____

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PATIENT ASSESSMENT: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name: _____

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married/in long-term relationship: _____Times married: _____Times divorced: _____

Children? **( )** N **( )** Y Current ages (Please list) _____

Residing with you? **( )** N **( )** Y If no, where? _____

Where are you currently living? _____

Do you have family nearby? **( )** N **( )** Y (Please describe) _____

Education (check most recent degree):

( ) Graduate School **( )** College **( )** Professional or Vocational School

( ) High School Grade _____

Are you currently employed? **( )** N **( )** Y Where (if no, where were you last employed)? _____

What type of work do/did you do? _____ How long have/did you work(ed) there? _____

Have you ever been arrested or convicted? **( )** N **( )** Y (Check all that apply)

( ) DWI **( )** Drug-related **( )** Domestic violence **( )** Other _____

Have you ever been abused? **( )** N **( )** Y

( ) Physically **( )** Sexually (including rape or attempted rape) **( )** Verbally **( )** Emotionally

Have you ever attended:

AA: **( )** Current **( )** Past **NA:** **( )** Current **( )** Past **CA:** **( )** Current **( )** Past

ACOA: **( )** Current **( )** Past **OA:** **( )** Current **( )** Past

If you are not currently attending meetings, what factors led you to stop? _____

Have you ever been in counseling or therapy? **( )** N **( )** Y (Please describe) _____

NOTICE of PRIVACY PRACTICES

Confidentiality and Consent

As a patient getting treatment for a substance use disorder, your personal and medical information is protected under United States confidentiality law. This law states that your doctor is NOT allowed to tell anyone the reason you are being treated, without your permission. Doctors and treatment programs that provide addiction treatment are not even allowed to tell anyone whether or not you are a patient.

Patient Consent

With your approval, consent, your doctor may let others, such as your insurance company or your family, know about your treatment. No information will be released unless you sign a consent form, which will include the name of your doctor or treatment provider, the person/group to whom your information is going, the purpose of the disclosure, how much information may be communicated, when the consent form expires and the date. Even if you sign a consent form, you have the right to change your mind at any time. If you do change your mind, your doctor will not share any additional information with others.

Impact on Treatment

The confidentiality law is strict, but it will not keep you from getting excellent treatment. Exceptions were written into the law to make sure that patients still get excellent care. For instance, information can be shared among treatment staff in order to provide you with better treatment. Also the law takes into account unexpected things that might happen. For instance, if there is a medical emergency and if they need to know, the medical personnel treating you can be told that you are receiving maintenance treatment for a substance abuse disorder.

Remember, the confidentiality law was set up to protect your rights. Ask your doctor if you have more questions about confidentiality or consent.

Acknowledgement of Receipt

of

Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____ _____

Parent or Authorized Representative (if applicable) Date

_____

Patient Signature

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CONSENT TO DISCUSS CONFIDENTIAL INFORMATION

I, _____, DOB:_____/_____/_____, give permission for Douglas A. Brown, MD to discuss my treatment and/or progress with the following people:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____	_____
Patient Signature	Date
_____	_____
Witness	Date

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FINANCIAL DISCLOSURE FOR 3RD PARTIES

Patient: _____

I give permission for Addiction Recovery Center at Success in Mind to discuss financial matters, and/or accept payments on my behalf with the following:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

This consent is for financial matters only. No discussion of treatment is authorized unless a separate consent is signed.

_____	_____
Patient Signature	Date

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TELEPHONE CONSENT

I, _____give Douglas A. Brown, MD and/or staff of Addiction Recovery Center ,
Patient Name (Print) Physician Name (Print)

and members of his/her staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):

( ) Home _____

( ) Work _____

( ) Cell _____

Yes, this office may leave (check all that apply):

( ) Voice mail at my Home

( ) Voice mail on my Cell

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

_____	_____	_____
Patient Signature	Patient Name (Print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Name (Print)	Date

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BUPRENORPHINE TREATMENT AGREEMENT & CONSENT

Patient Name: _____ Date: _____/_____/_____

PROGRAM RESPONSIBILITIES

I understand that not all patients are accepted into this program. I understand Dr. Brown will determine my eligibility for acceptance based on 2 factors:

a. Will this program meet my particular recovery needs?
b. How likely am I to meet my responsibilities to this program?

I understand that there are alternatives to buprenorphine treatment for opioid addiction including:

a. Medical withdrawal and drug-free treatment
b. Naltrexone treatment
c. Methadone treatment

I understand that medication alone is not sufficient treatment for my disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my treatment.

I understand that receiving regular counseling is an important part of this program and that I am required to attend individual or group sessions at least 2 times per month.

I understand the Addiction Recovery Center reserves the right to contact the Virginia Prescription Monitoring Program to ensure your compliance with this treatment program.

I understand that I will be urine drug screened on every visit and that Dr. Brown reserves the right to perform additional testing if he deems necessary.

I understand that Dr. Brown reserves the right to discharge me from the program if I have a positive drug screening (Benzodiazepines, Opiates, Cocaine, or Amphetamine/Methamphetamine, Marijuana) or if I violate any part of this agreement.

I understand that I must be in a state of mild to moderate withdrawal before being admitted into this program.

_____ _____/_____/_____

Patient's Signature Date

OFFICE RESPONSIBILITIES

I understand during Phase I of the program (first 6 months), new patients are seen weekly and transfer patients are seen every other week.

I understand during Phase II of treatment (after 6 months), Dr. Brown will determine the frequency of my office visits based on my treatment plan. I understand that MOST patients are seen once every 4 weeks, provided there is no relapse history; however this is entirely at the discretion of Dr. Brown.

I agree to keep, and be on time to, all my scheduled appointments.

I understand that I must get approval by Dr. Brown to miss or reschedule an appointment and that I MUST call 24 hours prior to my appointment.

If I fail to show up for a scheduled appointment, or fail to give 24 hours' notice, I will be charged a $50 late/no show fee which will be due immediately.

If I fail to show up for a scheduled appointment, I will be given one opportunity to reschedule for the next office day. I understand that if I fail to show up for this appointment, I may be discharged from the program. I further understand that I may have to repeat the Patient Intake process and will have to pay additional fees to be readmitted to the program (if space is available and not greater than 6 months).

I agree to conduct myself in a courteous manner while in the physician's office.

I agree to leave all backpacks and large purses in my car.

I agree not to arrive intoxicated or under the influence of drugs. If I do, the staff will not see me and I will not be given any medication until my next scheduled appointment.

I agree not to deal, steal, or conduct any other illegal or disruptive activities in or in the vicinity of the doctor's office.

_____ _____/_____/_____

Patient's Signature Date

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MEDICATION RESPONSIBILITIES

I understand that NO MEDICATION is kept on site including Suboxone, Subutex, or any other Narcotic.

I agree that my prescription can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.

I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reason.

I agree to take my prescribed medication as Dr. Brown has instructed and not to alter my medication schedule without first consulting the doctor.

I agree not to sell, share or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal or reimbursement.

I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treatment physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines, such as Valium, (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), Klonopin, and/or other drugs of abuse including alcohol can be dangerous. I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines.

I understand that I may be discharged immediately if I test positive for <u>any</u> Benzodiazepine.

I understand that the use of buprenorphine/naloxone (Suboxone) by someone who is addicted to opioids could cause them to experience severe withdrawal.

_____ _____/_____/_____

Patient's Signature Date

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FINANCIAL RESPONSIBILITIES

I agree to pay all fees for this treatment program prior to being seen by Dr. Brown. I understand I WILL NOT BE SEEN if my program fees are not up to date.

I understand there is a $50 late/no show fee if I fail to show up for a scheduled visit or fail to make my scheduled payments on time.

I understand that Addiction Recovery Center does not accept insurance; However, I can request a monthly statement for reimbursement from my insurance company. I understand this medication will cost approx. $5-$10 a day (which is covered by most major medical prescription drug plans) and the office visits are a separate charge.

I understand during Phase 1 of this program, I have program fee that can be paid in full or financed. I also understand during Phase II, I will pay $150/visit. The frequency of my visits will be determined by Dr. Brown; however, MOST patients are seen once every 4 weeks.

I further understand if I am discharged from the program for any reason, I am not released from my financial obligations.

I understand that Dr. Brown reserves the right to discharge me from the program if I violate any part of this agreement.

I am requesting that Dr. Brown and his staff provide buprenorphine treatment for my opioid addiction. I freely and voluntarily agree to accept this treatment agreement. By signing each page, I affirm I have thoroughly read and understand this agreement. I agree to adhere to these policies and responsibilities:

I hereby release and agree to hold harmless, the Addiction Recovery Center of VA @ Success in Mind and its program, and the officers, directors and employees from any liability of any kind which may arise in connection with the taking of Buprenorphine/Naloxone (Suboxone) or Buprenorphine (Subutex).

_____ _____/_____/_____

Patient's Signature Date

If Minor, Parent or Guardian Signature

_____ _____/_____/_____

Witness Signature Date

_____ _____/_____/_____

Physician's Signature Date