ORTHOPEDIC
& WELLNESS

PATIENT DEMOGRAPHIC INFORMATION
SUBOXONE

Appointment Date, Time:	
Referring Physician:	**Phone**:
	Fax:
Primary Care Physician:	**Phone**:
	Fax:
MRI: ☐ **Yes** ☐ **No** **Date/Location:**	

How did you hear about ORTHOPEDIC & WELLNESS (please select one): ☐ PCP, ☐ Social Media, ☐ Internet/Website, ☐ Family/Friend, ☐ Newspaper/Magazine, ☐ Other_____.

All Information Must Be Obtained

Last Name:	First Name:	Middle Initial:
Address:		
City:	State:	Zip code:
(H) Phone:	(w) Phone:	(C) Phone:
Email:		
Social Security Number:	Preferred Language:	
Date of Birth:	Sex: ☐ F ☐ M	
Employer:		
Emergency Contact:	Phone:	
Primary Insurance Name:		
Policy Holder:	S.S.N:	DOB:
Insurance ID #:	Insurance Group #:	
Insurance Phone #:		
Secondary Insurance Name:		
Policy Holder:	S.S.N.	DOB:
Insurance ID #:	Insurance Group #:	
Insurance Phone #:		
Workers Comp / PIP:	DOI:	Claim #:
Ins Carrier:	Claim Address:	
Adjuster Name:	Phone:	

ORTHOPEDIC
& WELLNESS

HIPAA NOTICE OF PRIVACY
NOTICE OF PRIVACY PRACTICES

Name: _____ **DOB:** _____ **Date:** _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ORTHOPEDIC & WELLNESS including pain management physicians and orthopedic physicians, are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

General Authorization of Release of Medical Records that you sign authorizes your Medical Care Provider to disclose the information in your medical records to the extent needed for the following purposes:

1. For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other Health Care Providers who are treating you or consulting in your care.
2. For the purpose of arranging payment for your care. This may include, for example, your insurer or other third-party who is responsible for paying all or part of the cost of your care.
3. For the purpose of Provider's "Health Care Operations." This would include such things as internal quality assessment activities, contacting other Health Care Providers regarding treatment alternatives, evaluating provider performance, training Providers of care, legal and medical review of care provided, business planning and management, customer service, resolution of internal grievance and the provision of legal and auditing services.
4. For the purpose of other Health Care Provider's "Health Care Operations", to the extent that they have a treatment relationship with you.

Specific Authorization for Release of Medical Records that you may sign authorizes the Provider to make a specific disclosure that is not covered under the section above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose your records.

1. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.
2. Provider may be required by law, in some cases, to make disclosures of your records that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by license agencies or the U.S. Department of Health and Human Services.
3. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
4. You have the following rights with respect to your medical records/information:

[continued]

- **a.** You have the right to request restrictions on the use and disclosure of your medical records/ information; however, Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
- **b.** You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
- **c.** You have the right to inspect and copy your medical records (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
- **d.** You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
- **e.** You have the right to receive an accounting (list) of disclosures of your medical records/information made by Provider (Except for those disclosures that are made to you or with your specific authorization that fall within the scope of Provider's "Health Care Operations," or disclosures made for payment or treatment purposes).
- **f.** You have the right to receive a paper copy of this notice.

In the event that **ORTHOPEDIC & WELLNESS** is sold or merged with another organization, your health information/records will become the property of the new owner.

Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate. If a patient believes that his or her privacy rights have been violated, the patient may complain to the Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to the Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

If you, as a patient or guardian, believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Compliance Contact at 240.629.3998, or submit your complaint to: **ORTHOPEDIC & WELLNESS** 1050 Key Pkwy, Ste 202, Frederick, MD 21702.

If you are not satisfied with the manner in which our office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Avenue, SW, Room 509F HHH Building, Washington, DC 20201. Or call 410.402.8000. www.medicare.gov/Ombudsman

Acknowledgement of Receipt of Notice

☐ I wish to restrict my Private Healthcare information: I have filed a Request of Restriction Form.

Patient Name: _____ Patient Signature: _____ Date: _____

ORTHOPEDIC
& WELLNESS

PATIENT BILL OF RIGHTS

As a patient being treated in our office you have a right to:

- To have consideration of your privacy concerning your own medical care.
- To know the name of all physicians and/or staff directly assisting in your care.
- To have medical records pertaining to your medical care treated as confidential (except as required by law or third party contracted agreement).
- To know what rules and regulations in our practice apply to your conduct as a patient.
- To expect emergency procedures to be implemented without delay; if there is a need to transfer you to another facility the responsible person and facility will be notified of your condition prior to your arrival.
- To have good quality care and high professional standards that are continually maintained and reviewed.
- To have full information in layman's terms concerning diagnosis, treatment, prognosis and possible complications.
- To give an informed consent to the physician prior to the procedure.
- To be advised of participation in a medical care research program or donor program (You will be asked to give your informed consent prior to participation in such a program and you may refuse to continue in a program that you may have previously given informed consent to participate in).
- To refuse drugs or procedures and have a physician explain the medical consequences of your refusal.
- To be given medical and nursing services without discrimination based upon age, race, color, religion, national origin, handicap, disability or source of payment.
- To have access to an interpreter whenever possible.
- To have access to all information contained in your medical record unless access is prohibited by law.
- To expect good management techniques to be implemented that consider effective use of your time and avoid unnecessary discomfort.
- To be able to examine and receive a detailed evaluation of your bill.
- To be informed at your request of your provider's credentials.
- To exercise your rights without discrimination or reprisal.
- To voice grievances.
- To designate power of attorney to exercise rights on your behalf.
- To receive care in a safe setting.
- To be free from abuse/harassment.

We recognize that you have a choice for healthcare services, and we are grateful that you have chosen us as your provider.

For more information or to report a problem, please contact Corporate Management at 240.629.3998, or State of Maryland DHMH, Office Healthcare Quality (www.dhmh.maryland.gov/ohcq) Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228, OR call 1.800.492.6005 or http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Patient Name: _____ Patient Signature: _____ Date: _____

ORTHOPEDIC
& WELLNESS

PATIENT RESPONSIBILITY STATEMENT

The patient has the responsibility to:

- Provide the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- Participate in health care decisions and for the following the treatment plan outlined by the practitioner responsible for his/her care.
  - This includes following instructions of the physicians, nurses, and other health care personnel carrying out the plan of care and enforcing rules and regulations.
- For assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible, and in the case of financial difficulty, making all reasonable efforts to meet any agreed upon financial payment plan.
- Responsibility for his/her actions if he/she refuses treatment or is non-compliant in following a plan of treatment recommended by his/her physician.
- To know the rules and regulations of ORTHOPEDIC & WELLNESS affecting his care and conduct, and for following those ORTHOPEDIC & WELLNESS rules and regulations.
- For being considerate of the rights of other ORTHOPEDIC & WELLNESS patients and ORTHOPEDIC & WELLNESS personnel, and for assisting in the control of noise and the non-smoking policy of the ORTHOPEDIC & WELLNESS.
- For being respectful of the property of other persons and of ORTHOPEDIC & WELLNESS.
- To make known to his/her physician, attending nurse, or other health care personnel, any concerns or complaints he/she may have.
- To make sure he/she understands all information regarding the implications of his symptoms, his/her surgery or procedure (if applicable) and any risks related to having or declining such surgery or procedure, the expected outcomes of the plan of care outlined by this physician, and his responsibilities in regards to that plan of care.
- To be made aware of advanced directives, living wills and the limitations if any to comply with such request.
- To refuse any drug regimen he /she does not feel is necessary and assume the risks involved with such refusal.
- To change providers at any time or gather a second opinion from another provider.
- To provide urine sample for purposes of drug screening and adhere to the opioid agreement.
- To provide transport and a responsible caregiver after any procedure if directed to do so by the provider or physician.

We recognize that your have a choice for healthcare services, and we are grateful that you have chosen us as your provider.

For more information or to report a problem, please contact Corporate Management 240.629.3998, or State of Maryland DHMH, Office Healthcare Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228, OR call 1.800.492.6005

Patient Name: _____ Patient Signature: _____ Date: _____

ORTHOPEDIC
& WELLNESS

OFFICE POLICIES

CONSENT AND INSURANCE AUTHORIZATION FOR TREATMENT AND BILLING

Patient Name: _____ **DOB:** _____ **Date:** _____

BILLING NOTICE

I hereby authorize the Physicians at ORTHOPEDIC & WELLNESS to provide medical treatment, release information pertaining to treatment deemed necessary by my insurance companies, attorney or referring Physician, and to receive direct payments for professional treatment otherwise payable to me for service rendered. My insurance carrier or I may revoke this authorization at any time in writing. **Initial:** _____

Confession of Judgment: I hereby acknowledge and agree that I am responsible for any portion of this claim that for any reason is not covered by my insurance. In the event that my account is past due more than sixty (60) days, I understand that ORTHOPEDIC & WELLNESS will exercise its rights and remedies under the law to enforce such payment, including, but not limited to, institution of legal proceedings against me to recover the above amount. I irrevocably authorize any attorney to appear in any court of competent jurisdiction and confess a judgment without process in favor of the creditor for such amount as may then appear unpaid hereon, and consent to immediate execution upon such judgment. I understand and agree that I will be responsible for all costs incurred by ORTHOPEDIC & WELLNESS to enforce such payment, including attorneys' fees.

Initial: _____

For Worker's Compensation Cases: It is your responsibility to make sure that your accident insurance company has authorized your procedure. If your insurance company does not pay for the visit, you will be held accountable for the entire charge. **Initial:** _____

Waiver: If I am a member of a HMO insurance and the Physicians at ORTHOPEDIC & WELLNESS, are not participating members or I choose to be treated without a referral or authorization, I acknowledge that I am fully responsible for any and all charges incurred as a result of my decision to be treated by ORTHOPEDIC & WELLNESS. I understand and agree that I am financially responsible to ORTHOPEDIC & WELLNESS for co-pays, deductibles and non-covered items as outlined in my insurance policy contract. I hereby certify that the information above is correct. **Initial:** _____

For Health Insurance Cases: It is your responsibility to adhere to all of the regulations and requirements of your health plan, in or out of network. If your health insurance plan requires you to obtain a written referral and/or authorization number from your Primary Care Physician for your office visit or procedure, you must supply us with the referral/auth number. If you do not, you will be responsible for the entire charge for that date of service. This is a rule of the Health Plan that you selected. **Initial:** _____

Statements that you are expected to receive: Be advised that ORTHOPEDIC & WELLNESS and our associated ambulatory surgery centers function under different Tax ID numbers and therefore insurance participation may vary. Depending on the location of your choice, surgeries, procedures, and injections may take place under APSC, ASSC, FMH (Frederick Memorial Hospital), Adventist Hospitals and you should expect a separate statement from that facility. **Initial:** _____

OWNERSHIP NOTICE

ORTHOPEDIC & WELLNESS is a health care facilities owned by Dr. Ojedapo Ojeyemi, Dr. Matthew Roh and Khalid Kahloon, J.D. Pursuant to federal and state regulations, the above individuals hereby notify you that they maintain ownership and financial interest in ORTHOPEDIC & WELLNESS. You have the option to seek treatment at a health care service provider of your own choice. **Initial:** _____

ORTHOPEDIC & WELLNESS

ACKNOWLEDGEMENT OF OWNERSHIP

I acknowledge that I am aware of the ownership and financial interests held by Dr. Ojedapo Ojeyemi, Dr. Matthew Roh and Khalid Kahloon, J.D. in ORTHOPEDIC & WELLNESS, and further, I am aware that I may request that my treatments be performed elsewhere. It is my choice to be treated at ORTHOPEDIC & WELLNESS. **Initial:** _____

CRISP NOTICE

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1.877.952.7477 or completing and submitting on Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. **Initial:** _____

MISSED/LATE ARRIVAL APPOINTMENT POLICY

All patients are required to give a **24 hour notice if unable to keep a scheduled appointment**. A **$35.00 fee** will be collected for any non-compliance with our policy. Repeated late cancellations and/or missed appointments will result in the discontinuation of your treatment with ORTHOPEDIC & WELLNESS. At ORTHOPEDIC & WELLNESS, we value your time and in turn, we strive to maintain a time-conscious schedule. Our Physicians and Staff work together to keep the schedule on time. We ask that our patients help us by arriving at least 30 minutes early for each appointment in order to be ready to be seen at their scheduled appointment time. Our Physicians are rotationally "on call" which can sometimes impinge the promptness of an appointment; we apologize for any inconvenience but ask for your support and understanding. If a patient arrives after their scheduled appointment time, ORTHOPEDIC & WELLNESS has the right to ask that patient to reschedule their appointment if there is no available time for the patient to be seen.

Initial: _____

INSURANCE, BILLING AND PRIVACY NOTICE ACKNOWLEDGEMENT

I have received and read the above information in this packet, which includes the company's referral policy, the billing information, and the Notice of Privacy Practices. I have read and acknowledge the policies of ORTHOPEDIC & WELLNESS, as stated above. I understand failure to comply with these policies may result in the discontinuation of my treatment with the said facilities.

Patient Signature:_____ Date: _____

Guardian/Power of Attorney: _____ Date: _____

ADVANCE DIRECTIVES NOTICE

At your request, we can make available an Advance Medical Directives formulary for you to read, fill out, and sign at your discretion. Maryland law recognizes as valid "living wills" and advance medical directives allowing you to decide under certain circumstances, in advance, that in the event of an unexpected medical crisis such as cardiac or respiratory arrest, no attempt should be made to resuscitate you, and all life sustaining procedures should be withheld from you. Also, in the event that you are incapacitated and unable to make such a decision on your own behalf, medical decisions, including the decision to withhold or withdraw life support, may, under the same circumstances, be made for you by a "health care agent" previously designated by you, or by a "surrogate" decision maker, such as your adult child, parent or spouse. Because of the nature of our facilities, and recognizing that surgical services provided in these facilities are elective, we are unable to honor "do not resuscitate" orders or similar advance medical directives. In the event of a sudden life-threatening medical situation, we will immediately begin the administration of life-sustaining procedures, and transfer you to the nearest hospital as soon as possible.

•••Please read all options and write your initials on the ONE that applies to you***

- I am aware of Advance Directives. I have one but I do not have it with me **Initial:** _____
- I am aware of Advance Directives. I have one and it is on my file. **Initial:** _____
- I am aware of Advance Directives. I do not have one and do not require one. **Initial:** _____
- I am aware of Advance Directives. I do not have one and I want more information. **Initial:** _____

Patient Name: _____ Patient Signature: _____ Date: _____

Guardian/Power of Attorney: _____ Date: _____

t 240.629.3944 **f** 240.629.3945
t 240.629.3952 **f** 240.629.3953

1050 Key Parkway, Suite 103, Frederick, MD 21702
12070 Old Line Center, Ste 210, Waldorf, MD 20602

ORTHOPEDIC
& WELLNESS

AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications and other information pertinent to our patient's care. In this event with your signed authorization, we would discuss such information to a person you designate. Please complete the section below:

I, hereby, authorize ORTHOPEDIC & WELLNESS to discuss any information required in the course of my examination or treatment (when I cannot be reached by phone) to the following designated person(s):

Name of Designee (1): _____

Relationship to Patient: _____

Name of Designee (2): _____

Relationship to Patient: _____

☐ No Designee

When a designee is not on file, family members, spouses or friends are not permitted to make or change a patient's appointment time.

I agree to all of the above.

Patient Name (PRINT)	Patient or Legal Guardian Signature	Date

This form shall expire one year from date of signature.

ORTHOPEDIC
& WELLNESS

PATIENT SUBOXONE TREATMENT CONTRACT

Patient Name _____ DOB _____

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. 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 any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician. You will only use one pharmacy for refilling opioids. Should the need arise to change pharmacies, our office must be notified.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).
14. I agree to provide random urine samples and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment.

A copy of this document has been given to me.

Patient Name: _____ Patient Signature: _____ Date: _____

Physician Name: _____ Physician Signature: _____ Date: _____

PHARMACY AND PCP INFORMATION MUST BE COMPLETED.

NAME OF PHARMACY	NAME OF PRIMARY CARE PHYSICIAN
ADDRESS	ADDRESS
PHONE NUMBER	PHONE NUMBER

ORTHOPEDIC
& WELLNESS

UNDERSTANDING OPIOID DEPENDENCE

SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet

Opioid dependence is a disease in which there are biological or physical, psychological, and social changes. Some of the physical changes include the need for increasing amounts of opioid to produce the same effect, symptoms of withdrawal, feelings of craving, and changes in sleep patterns. Psychological components of opioid dependence include a reliance on heroin or other drugs to help you cope with everyday problems or inability to feel good or celebrate without using heroin or opioids. The social components of opioid dependence include less frequent contact with important people in your life, and an inability to participate in important events due to drug use. In extreme cases, there may even be criminal and legal implications.

The hallmarks of opioid dependence are the continued use of drugs despite their negative affect, the need for increasing amounts of opioids to have the same effect and the development of withdrawal symptoms upon cessation.

There are a variety of factors than can contribute to the continued use of opioids. Among these are the use of heroin to escape from or cope with problems, the need to use increasing amounts of heroin to achieve the same effect, and the need for a "high."

TREATMENT

Treatment for opioid dependence is best considered a long-term process.
Recovery from opioid dependence is not an easy or painless process, as it involves changes in drug use and lifestyle, such as adopting new coping skills. Recovery can involve hard work, commitment, discipline, and a willingness to examine the effects of opioid dependence on your life. At first, it isn't unusual to feel impatient, angry, or frustrated. The changes you need to make will depend on how opioid dependence has specifically affected your life. The following are some of the common areas of change to think about when developing your specific recovery plan:

1. **Physical** – good nutrition, exercise, sleep and relaxation.
2. **Emotional** – learning to cope with feelings, problems, stresses and negative thinking without relying on opioids.
3. **Social** – developing relationships with sober people, learning to resist pressures from others to use or misuse substances, and developing healthy social and leisure interests to occupy your time and give you a sense of satisfaction and pleasure.
4. **Family** – examining the impact opioid dependence has had on your family, encouraging them to get involved in your treatment, mending relationships with family members, and working hard to have mutually satisfying relationships with family members.
5. **Spiritual** – learning to listen to your inner voice for support and strength, and using that voice to guide you in developing a renewed sense of purpose and meaning.
6. **SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet**
   During the treatment process, SUBOXONE will help you avoid many or all of the physical symptoms of opioid withdrawal. These typically include craving, restlessness, poor sleep, irritability, yawning, muscle cramps, runny nose, tearing, goose-flesh, nausea, vomiting and diarrhea. Your doctor may prescribe other medications for you as necessary to help relieve these symptoms. You should be careful not to respond to these withdrawal symptoms by losing patience with the treatment process and thinking that the symptoms can only be corrected by using drugs. To help you deal with the symptoms of withdrawal, you should try to set small goals and work towards them.

ORTHOPEDIC
& WELLNESS

FREQUENTLY ASKED QUESTIONS—PATIENTS

SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet

1. Why do I have to feel sick to start the medication for it to work best?

   When you take your first dose of SUBOXONE, if you already have high levels of another opioid in your system, the SUBOXONE will compete with those opioid molecules and replace them at the receptor sites. Because SUBOXONE has milder opioid effects than full agonist opioids, you may go into a rapid opioid withdrawal and feel sick, a condition which is called "precipitated withdrawal."

   By already being in mild to moderate withdrawal when you take your first dose of SUBOXONE, the medication will make you feel noticeably better, not worse.

2. How does SUBOXONE work?

   SUBOXONE binds to the same receptors as other opioid drugs. It mimics the effects of other opioids by alleviating cravings and withdrawal symptoms. This allows you to address the psychosocial reasons behind your opioid use.

3. When will I start to feel better?

   Most patients feel a measurable improvement by 30 minutes, with the full effects clearly noticeable after about 1 hour.

4. How long will SUBOXONE last?

   After the first hour, many people say they feel pretty good for most of the day. Responses to SUBOXONE will vary based on factors such as tolerance and metabolism, so each patient's dosing is individualized. Your doctor may increase your dose of SUBOXONE during the first week to help keep you from feeling sick.

5. Can I go to work right after my first dose?

   SUBOXONE can cause drowsiness and slow reaction times. These responses are more likely over the first few weeks of treatment, when your dose is being adjusted. During this time, your ability to drive, operate machinery, and play sports may be affected. Some people do go to work right after their first SUBOXONE dose; however, many people prefer to take the first and possibly the second day off until they feel better.

   If you are concerned about missing work, talk with your physician about possible ways to minimize the possibility of your taking time off (eg, scheduling your Induction on a Friday).

6. Is it important to take my medication at the same time each day?

   In order to make sure that you do not get sick, it is important to take your medication at the same time every day.

7. If I have more than one tablet, do I need to take them together at the same time?

   Yes and no—you do need to take your dose at one "sitting," but you do not necessarily need to fit all the tablets under your tongue simultaneously. Some people prefer to take their tablets this way because it's faster, but this may not be what works best for you. The most important thing is to be sure to take the full daily dose you were prescribed, so that your body maintains constant levels of SUBOXONE. SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet

8. Why does SUBOXONE need to be placed under the tongue?

There are two large veins under your tongue (you can see them with a mirror). Placing the medication under your tongue allows SUBOXONE to be absorbed quickly and safely through these veins as the tablet dissolves. If you chew or swallow your medication, it will not be correctly absorbed as it is extensively metabolized by the liver. Similarly, if the medication is not allowed to dissolve completely, you won't receive the full effect.

9. Why can't I talk while the medication is dissolving under my tongue?

When you talk, you move your tongue, which lets the undissolved SUBOXONE "leak" out from underneath, thereby preventing it from being absorbed by the two veins. Entertaining yourself by reading or watching television while your medication dissolves can help the time to pass more quickly.

10. Why does it sometimes only take 5 minutes for SUBOXONE to dissolve and other times it takes much longer?

Generally, it takes about 5-10 minutes for a tablet to dissolve. However, other factors (eg, the moisture of your mouth) can effect that time. Drinking something before taking your medication is a good way to help the tablet dissolve more quickly.

11. If I forget to take my SUBOXONE for a day will I feel sick?

SUBOXONE works best when taken every 24 hours; however, it may last longer than 24 hours, so you may not get sick. If you miss your dose, try to take it as soon as possible, unless it is almost time for your next dose. If it is almost time for your next dose, just skip the dose you forgot, and take next dose as prescribed. Do not take two doses at once unless directed to do so by your physician.

In the future, the best way to help yourself remember to take your medication is to start taking it at the same time that you perform a routine, daily activity, such as when you get dressed in the morning. This way, the daily activity will start to serve as a reminder to take your SUBOXONE.

12. What happens if I still feel sick after taking SUBOXONE for a while?

There are some reasons why you may still feel sick. You may not be taking the medication correctly or the dose may not be right for you. It is important to tell your doctor or nurse if you still feel sick.

13. What happens if I take drugs and then take SUBOXONE?

You will probably feel very sick and experience what is called a "precipitated withdrawal." SUBOXONE competes with other opioids and will displace those opioid molecules from the receptors. Because SUBOXONE has less opioid effects than full agonist opioids, you will go into withdrawal and feel sick.

14. What happens if I take SUBOXONE and then take drugs?

As long as SUBOXONE is in your body, it will significantly reduce the effects of any other opioids used, because SUBOXONE will dominate the receptor sites and block other opioids from producing any effect.

15. What are the side effects of this medication?

Some of the most common side effects that patients experience are nausea, headache, constipation, and body aches and pains. However, most side effects seen with SUBOXONE appear during the first week or two of treatment, and then generally subside. If you are experiencing any side effects, be sure to talk about it with your doctor or nurse, as s/he can often treat those symptoms effectively until they abate on their own.

ORTHOPEDIC & WELLNESS

Patient Name: _____ **DOB:** _____

REVIEW OF SYSTEMS only check the one(s) that apply

CONSTITUTIONAL	YES	NO	GASTROINTESTINAL	YES	NO	METABOLIC/ENDOCRINE	YES	NO
Change in Appetite			Abdominal Mass			Abnormal Habitus		
Chills/Rigors			Abdominal Pain			Abnormal Hair Distribution		
Fatigue			Constipation			Chronically Overweight		
Fever			Fecal Incontinence			Chronically Underweight		
Insomnia			Heartburn			Goiter		
Irritability			Hemorrhoids			Gynecomastia		
Lethargy			Melana			Heat intolerance		
Night Sweats			Nausea			Polyuria		
Weight Gain			Vomiting			**GENITOURINARY**	**YES**	**NO**
Weight Loss			Stomach Ulcer			Decreased Urine Stream		
CONSTITUTIONAL	**YES**	**NO**	**DERMATOLOGIC**	**YES**	**NO**	Decreased Urine Output		
Dizziness			Frequent Skin Infections			Frequent Urination		
Gait Disturbance			Rash			Hematuria		
Incontinence			Shingles			Nocturia		
Loss of Consciousness			**RESPIRATORY**	**YES**	**NO**	Polyuria		
Memory Impairment			Accelerated Respirations			Urinary Incontinence		
Near Syncope			Cough			**HEMATOLOGIC**	**YES**	**NO**
Seizures			Cyanosis			Easy Bleeding		
Tremors			Dyspnea			Easy Bruising		
Vertigo			Hemoptysis			Thromboembolic Events		
CARDIOVASCULAR	**YES**	**NO**	Wheezing			**MUSCULOSKELETAL**	**YES**	**NO**
Chest Pain			Frequent Upper Respiratory			Back Pain		
IMMUNOLOGICAL	**YES**	**NO**	Infection			Bone /Joint Symptoms		
Asthma			Known TB Exposure			Myalgias		
Contact Dermatitis			**PSYCHIATRIC**			Muscle Weakness		
Food Allergies			Difficulty Concentrating			Neck Stiffness		
			Psychiatric Emotional			Rheumatologic Manifestations		

ORTHOPEDIC & WELLNESS

Patient Name: _____ **DOB:** _____

Past Medical History

Do you have any of the following conditions?

	YES	NO		YES	NO		YES	NO
Anemia			COPD			Migraine Headaches		
Angina			Coronary Artery Disease			Multiple Sclerosis		
Arrhythmia			Diabetes			Parkinson's Disorder		
Asthma			Fibromyalgia			Peripheral Nerve Disorder		
Atrial Fibrillation			Hepatitis C			Renal Disease		
Blood Clots			HIV/AIDS			Rheumatoid Arthritis		
Brain Tumor			Hyperlipidemia			Seizure Disorder		
Cerebrovascular Accident			Hypertension			Spinal Cord Tumor		
Cirrhosis			Kidney Failure			Thyroid Disease		
Colon Cancer			Liver Disease			Tremor		
Congestive Heart Failure			Lung Cancer			Stomach Ulcers		

Past Surgical History

SURGERY	YEAR

Family History

Diagnosis	Mother	Father	Other	Diagnosis	Mother	Father	Other
ADD/ADHD				Hearing Deficiency			
Alcoholism				Hyperlipidemia			
Allergies				Hypertension			
Alzheimer's Disease				Irritable Bowel Syndrome			
Asthma				Learning Disability			
Blood Disease				Mental Illness			
CAD				Migraines			
CAD – Premature				Obesity			
Cancer				Osteoporosis			
CVA (Stroke)				PVD			
Depression				Renal Disease			
Developmental Delay				Seizure Disorder			
Diabetes				Other: _____			
Eczema				Other: _____			

ORTHOPEDIC & WELLNESS

Patient Name: _____ **DOB:** _____

Social History

EMPLOYER NAME	
Phone	
Occupation	
Employment Status (Check One)	☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ DISABLED
Last Day Of Work	

Marital Status (Check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
Hand Dominance (Check one): ☐ Right ☐ Left ☐ Ambidextrous
Activity Level (Check one): ☐ Sedentary ☐ Moderate ☐ Vigorous

Have you ever filed any legal claims related to your pain problem? ☐ No ☐ Yes (please explain): _____

Have you ever had psychiatric, psychological, or social work evaluations or treatment for any problem, including your current pain? ☐ No ☐ Yes (please explain): _____

Are you suffering from or do you have a history of alcoholism? ☐ No ☐ Yes

Do you or did you ever smoke cigarettes or use tobacco? ☐ No ☐ Yes

Have you had any change in sleep patterns? ☐ No ☐ Yes (please explain): _____

Current Medications

List all your medications, dosages, how often you take them every day, and name of prescribing Physician.

	NAME	DOSAGE	DIRECTION	PRESCRIBING PHYSICIAN
1				
2				
3				
4				
5				
6				
7				
8				

Are you taking any blood thinners? ☐ No ☐ Yes

Drug Allergies

	MEDICATION NAME	REACTION
1		
2		
3		

ORTHOPEDIC & WELLNESS

Patient Name: _____ **DOB:** _____

Do you have any symptom such as red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

- ☐ Dye
- ☐ Iodine
- ☐ Shellfish
- ☐ Foods: _____
- ☐ Latex
- ☐ Rubber (band-aids, tape, spandex, balloons)
- ☐ Strawberries, Kiwis, Chestnuts.
- ☐ No Known Allergies

Please list any previously taken pain medications that you stopped taking and the reason for stopping:

_____

_____

_____

Have you ever been arrested or convicted? ☐No ☐Yes

☐ DWI : ☐ Drug-related : ☐Domestic violence : ☐ Other

Have you ever been abused? ☐No ☐Yes

☐ 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? ☐No ☐Yes (Please describe)_____

_____

_____