ADDICTION SERVICES – New Patient Paperwork

To be completed by Patient…PLEASE PRINT and take your time to fill out completely

Name:____ Sex: ( ) Male ( )Female

Address:____

Phone (Home)_____________________ (Cell)___________________ (Other)______________________

D.O.B.___________________________ Age__________________ SS#____________________________

Emergency Contact:____

Relationship to Patient:___________________________________ Phone #_________________________

Primary Care Physician:___________________________________ Phone #_________________________

MEDICAL/SOCIAL/BEHAVIORAL (PSYCHIATRIC) HISTORY

Current or Past Medical Conditions *(check all that apply)*

( ) Asthma/respiratory ( ) Cardiovascular (heart attack, high cholesterol)

( ) Hypertension ( ) Epilepsy or seizure disorder

( ) Head Trauma ( ) HIV/AIDS

( ) Pancreatic problems ( ) Thyroid Disease

( ) Abnormal Pap smear ( ) Blood disorder

( ) Kidney disease ( ) Stroke or Neurological problems

( ) Hepatitis A, B or C ( ) Pregnant

( ) GI Disease ( ) Diabetes

Other (Please describe)

____

____

For Females of childbearing age: LMP: __________ Birth control used: ________________________
No Birth control used ___________ Sexually active?____________ Not sexually active? _____________

Have you ever had surgery or been hospitalized, including Psychiatric? (Please describe)

____

____

____

____

____

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

____

____

Have you ever taken or been prescribed antidepressants or other psychiatric drugs? ( )Y ( ) N

If yes, what medication and for what reason:

____

____

If no longer on it, why discontinued?

____

____

Please list any allergies you have (medication, food, bees, etc.)

____

____

____

Please list all current prescription medications and how often you take them (Include all over the counter, herbal medicines, vitamin supplements, etc. and how often you take them as well.)

MEDICATION NAME	DOSE (STRENGTH)	HOW MANY PILLS AT A TIME AND HOW OFTEN TAKEN
(EXAMPLE) *Penicillin*	*250 mg*	*1 tablet three times a day*

SUBSTANCE USE/ABUSE HISTORY

Cigarettes: Now? Y N In the past? Y N

How many per day on average? ___________ For how many years? ___________

Pipe: Now? Y N In the past? Y N

How often per day on average? ___________ For how many years? ___________

Smokeless tobacco (snuff/dip): Now? Y N In the past? Y N

How much per day on average? ___________ For how many years? ___________

How long have you used/misused/abused drugs or other substances? ___________________________

Please briefly describe your substance abuse history:

____

____

____

____

____

____

____

____

Have you ever been treated for substance misuse? ( ) Y ( ) N

If Yes, Please describe when, where and for how Long.

____

____

____

____

____

____

____

____

SUBSTANCE ABUSE CHART ***(This is very important, please take your time)***

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

*****When was your last dose of opiates/narcotics and what drug was it – before coming in for your initial doctor visit today?** ***(PLEASE BE ABSOLUTELY SPECIFIC – AS THIS IS VITALLY IMPORTANT TO YOUR HEALTH & SAFETY)***

____

What was your longest period of abstinence? ____

What caused you to Relapse?:

____
____
____

Have you ever overdosed? ( ) Y ( ) N

If Yes, Please provide details (how many times, when, on what, was it accidental or intentional):

____
____
____
____

SOCIAL/LEGAL/FAMILY HISTORY

Relationship Status:

Circle One: Married Single Long-Term Relationship Divorced/Separated Widowed

Years Married/in Long-term relationship_______ # Times Married _______ # Times Divorced _______

Children? ( ) Y ( ) N Current ages? ____

Do the Children live with you? ( ) Y ( ) N

If no, where? ____

Where are you currently living? ____

Are you living with anyone who abuses drugs or alcohol ( ) Y ( ) N

If Yes, please describe:

____
____

Do you have family nearby? ( ) Y ( ) N (please describe):

____

Do you have a support network in place? ( ) N ( ) Y (please describe):

____
____

Education/Military (check most recent degree):

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

( ) High School Completed through what Grade?______

Are you currently employed? (   ) Y (   ) N

If Yes, Where? ____

If No, when and where were you last employed? ____

What type of work do/did you do? ____

How long have/did you work(ed)there? ____

Have you ever served in the military? (   ) Y (   ) N

If yes, please give details: ____

____

Type of Discharge, if not still serving: ____

Have you ever been arrested or convicted? (   ) Y (   ) N *If yes, please check the appropriate item & explain:*

(   ) DWI/DUI (   ) Drug-related (   ) Domestic Violence (   ) Other ______________________________

____

____

Are you currently on probation or parole? (   ) Y (   ) N

Have you ever been abused? (   ) Y (   ) N
(   ) Physically (   ) Sexually (including rape or attempted rape) (   ) Verbally (   ) Emotionally

Who was the abuser? ____

If yes, have you ever been in treatment for abuse? ____

____

Have you ever attended:

Alcoholics Anonymous (   ) Current (   ) PastNarcotics Anonymous (   ) Current (   ) Past
Cocaine Anonymous (   ) Current (   ) Past Opiate Anonymous (   ) Current (   ) Past
If you are not currently attending meetings, what factors led you to stop? ___________________________

____

What benefited you the most from attending meetings? ____

____

Have you ever been in counseling or therapy? (   ) Y (   ) N ____

____

What other forms of treatment for opiate addiction have you attempted? (i.e. Inpatient, Intensive Outpatient, detoxification; when and how long) ____

____

____

Have you ever had any suicidal ideations, plans, and/or attempts? (   ) Y (   ) N __________________________

____

TREATMENT GOALS & EXPECTATIONS

How did you hear about this treatment program and what are your reasons for entering this program? Please briefly describe your goals or expectations from your treatment in this clinic.

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Office Policies

Thank you for choosing AIM Behavioral Health as your healthcare provider. We are committed to providing you with the best possible care and we are pleased to discuss our office policies with you, at all times. Your clear understanding of our office policies is important to our relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

Financial Policy:

-- I have been given, understand and have agreed to fees that I am responsible for services provided.

-- Any payment for services that you are responsible is required to be paid in full prior to seeing the practitioner.

Office Conduct:

-- I agree to conduct myself in a respectful and courteous manner at all times on office and Pharmacy property. I agree to follow all written and verbal office rules provided to me. I agree to be mindful and read posted signs for my benefit. I understand that I may be dismissed for any misconduct at the office or pharmacy and that this behavior may be documented and shared as part of my record to any practice requesting this information for continuity of care.

______________________________	__________________________________	__________________
PRINTED Name of Patient	**Signature of Patient**	**Date**

Drug Screen Policy

For the health and safety of patients and to comply with regulations this policy will be adhered to on all patients undergoing buprenorphine maintenance treatment.

1. Preferred method of screening: urine. Oral swab is acceptable if unable to obtain urine sample due to medical reasons and at the discretion of clinical provider.
2. An instant screen which will also be sent to lab for confirmation is to be done and reviewed by the provider prior to initiation of treatment.
3. All sample collections will be monitored by screeners.
4. Sample will typically be collected at each provider visit and no less than 12 times per year.
5. Minimum of three specimens per year will be collected randomly along with a pill Count.
6. Any patient on probation will have weekly monitored urine drug screens.
7. specimens may be sent to lab for confirmation. inconsistent specimen must be sent to lab for confirmation.
8. Instant screens may be done on any patient that had a prior inconsistent confirmation screen.
9. Providers are to review the confirmation screen and utilize it in their clinical decision making at each visit.
10. Samples at a minimum are to be tested for buprenorphine, norbuprenorphine, opioids, benzodiazepines, amphetamines, Cocaine and cannabis.
11. Urine samples will be tested for temperature, specific gravity, creatinine and pH.
12. Any deviant or suspicious behavior by the patient during the Collection process is to be reported immediately to providers

________________________	________________________	_____________
PRINTED Name of Patient	**Signature of Patient**	**Date**

NOTICE OF PRIVACY PRACTICES

SHORT FORM SUMMARY

This is only a summary of our Notice of Privacy Practices. Please review the full Notice to learn how we use and disclose medical information about you and your rights Concerning these uses and disclosures. **How We Use and Disclose Your information**

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in Order to provide your medical Care, to bill for our services and to collect payment from you and/or your insurance company; and for the general operation of our business

Marketing, Fundraising, and Sale of PHI. We will obtain your prior Written authorization before Sending you Certain marketing Communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

--public health reporting and oversight activities

--judicial, administrative, or law enforcement proceedings

-- complying with workers' compensation laws

-- communicating with your family or caregivers

--sending appointment reminders **You**

Have the Right to:

Request certain restrictions on our use and disclosure of your PHI. Request communications from us by specific means or locations. Inspect and copy your medical record. Ask us to correct the information in your medical record. Receive an accounting of disclosures of your PHI by Our practice. Be notified in the case of a breach of unsecured PHI.

Contact Us

Please inquire with any staff member should you have any questions, comments, or complaints; or to exercise any of your rights at Ashland Integrative Medicine.I know that a copy of Ashland Integrative Medicine's Notice of Privacy Practices will be provided upon request.

I ______________________________certify that the historical information provided by me is correct to the best of my knowledge. I have read and understood the drug screen, office, financial policies and Notice of Privacy Practices.

______________________________	______________________________	________________
PRINTED Name of Patient	**Signature of Patient**	**Date**

Medication-Assisted Treatment Program Contract

I ___________________________________have talked with my provider about treatment options for my Opioid use disorder. I have decided to take a Buprenorphine containing medication and participate actively in counseling as part of a comprehensive addiction treatment program to help treat my addiction to opioids.

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

1. I agree to keep and be on time to all my scheduled doctor and Counseling appointments, conduct myself in a Courteous manner at the doctor's office and the pharmacy. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office. I understand that medications will NOT be prescribed for missed appointments, lost or stolen medications.
2. I agree to abstain from alcohol, benzodiazepines (eg. Xanax, Klonopin, Valium, Ativan), opioids, marijuana, Cocaine, stimulants (is Adderall, Ritalin, Adipex) and other addictive substances (excepting nicotine). I understand that taking these products can be very dangerous and has been fatal."
3. I agree to keep my medication in a secure place & out of sight and reach of children and others. I agree not to sell, share, or give any of my medication to another person.
4. My doctor has explained how to properly take this medication. I agree to take my medication as instructed and not to alter the way I take my medication or take any other medications without first consulting my doctor.
5. 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.
6. I understand the office drug screen policy and agree to provide random urine drug screens and have my doctor test my blood alcohol level.
7. I understand that violations of the above may be grounds for termination of treatment.

______________________________ ________________________________ ________________

PRINTED Name of Patient **Signature of Patient** **Date**

The above named patient has been evaluated by me and treatment by Buprenorphine containing medication is recommended, deemed to be appropriate and medically necessary as part of this patient's treatment plan with counseling. I have discussed other treatment options with the patient. Patient agrees to fully comply in our comprehensive addiction treatment program. I have gone over above agreement with the patient who has verbalized understanding of the above policies. Patient agrees to comply with all counseling appointments as an important part of their treatment in our Medication assisted treatment program to help in their rehabilitation.

______________________________ ________________________________ ________________

PRINTED Name of Provider **Signature of Provider** **Date**

Cancellation/Late Fee Policy

AIM Behavioral Health is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. With that said - we understand that there are times when you must miss a scheduled appointment due to emergencies and/or obligations for work or family. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment schedule.

Therefore, if you need to cancel and/or reschedule your individual counseling appointment you are required to call no later than 48 hours prior to the scheduled appointment time. If you need to cancel/reschedule a Monday appointment - you must call prior to close of business on the Friday.

If an appointment is not cancelled at least 48 hours in advance of your scheduled appointment time you will be charged a fifty dollar ($50) NO SHOW fee; this will not be covered by your insurance company and <u>must be paid prior to your next appointment</u>. Multiple Non-Cancellation/No-Show events in any given 6-month period may result in termination from our practice.

PRINTED Patient Name:____ DOB:______________________

Patient Signature:____ Date:_______________________

Staff Witness:____ Date: _______________________

PRELIMINARY NEEDS ASSESSMENT

Patient Name: ______________________________________ **DOB:** ______________________

What is the name of your Insurance: ____

Telephone #: ______________________ **I have a working Voicemail on my Phone: Yes OR No**

SUPPORT SYSTEMS

Do you have the following Support Systems ACTIVE in place in your life today? (check all that apply)

Family ☐ Social ☐ Mental Health ☐ Medical Health ☐ Education ☐ Employment ☐ Spiritual ☐

Comments:____

BASIC NEEDS

Do you need help with getting any of the following Basic Needs for your life? (check all that apply)

Housing ☐ Housing Repairs ☐ Homeless Shelter ☐ Independent Living ☐ Food ☐ Clothing ☐
Phone Service ☐ Driver's License ☐ Vehicle Repairs ☐ Transportation ☐ Advocacy ☐
Recreation/Socialization ☐ Legal Services ☐ Expunging Criminal Record ☐ Financial Assistance ☐
Parenting Classes ☐ Child Care ☐

Comments:____

HEALTH NEEDS

Do you need help with getting any of the following Health Needs for your life? (check all that apply)

Primary Care ☐ Dental Care ☐ Psychiatry ☐ Other Specialty Care ☐ _______________________
Medication Assistance (Financial) ☐ Self Help/Support Groups ☐ Alcohol/Drug Abuse Treatment ☐
Residential/In-Patient Treatment Services ☐ Health Education/Prevention ☐ Tx of Hep-C/HIV ☐ _____

Comments:____

EMPLOYMENT/VOCATIONAL NEEDS

Do you need help with getting any of the following Employment Needs for your life? (check all that apply)

General Education Development (GED) ☐ Resource Classes/Tutoring ☐ College Degree ☐
Vocational Training ☐ Student Loan Payment/Deferment ☐ Employment ☐ Career Assessment ☐
Interview Skills ☐ Job Survival Skills Training ☐ Resume Building/Development ☐

Comments:____