AIM Behavioral Health
Ashland Integrative Medicine
10730 Midland Trail Rd. Ashland, KY, 41102
Phone: 606.618.0282. Fax: 606.618.9280

ADDICTION SERVICES - NEW PATIENT PAPERWORK

Name:	D.O.B:
Preferred Name/Nickname:	Preferred Language:
Insurance:	SS#:
Address:	City:
State: Zip:	Sex: ( ) Male ( ) Female ( )Intersex
Cell Phone:	Home Phone:
Email:	
Emergency Contact:	Relation:
Emergency Contact Phone (must be different than patient):	#
Primary Care Physician (PCP):	Last Visit w/ PCP:
PCP Phone:	Next Scheduled Appointment:
City of PCP:	State of PCP:
If no PCP, would you like to be referred: ( )Yes ( ) No	PCP Preferred:

EMPLOYMENT:

Are you currently employed? ( ) Yes ( ) No

If yes, where?_____

Employer City:_____ Employer State:_____

Please list days and times you are available for your appointment. Please note that each time you are in the office for your scheduled appointment, you will need to be available for up to two (2) hours:

Days	Times
❑ Monday	
❑ Tuesday	
❑ Wednesday	
❑ Thursday	

The office will be closed on all major holidays.

Do you have reliable transportation to and from your appointments? ( )Yes ( )No

MEDICAL/SOCIAL/BEHAVIORAL(PSYCHIATRIC) HISTORY:

Current or Past conditions (check all that apply)

( ) Asthma/Respiratory
( ) Hypertension
( )Head Trauma
( )Pancreatic Issues
( )Abnormal Pap Smear
( )Kidney disease
( ) Hepatitis A, B, or C
( ) GI disease
( )Cardiovascular (heart attack, high cholesterol)
( )Epilepsy or seizure disorder
( )HIV/AIDS
( )Thyroid disease
( )Blood disorder
( )Stroke or Neurological issues
( )Pregnant
( )Diabetes
( )Anxiety
( )Depression
( )ADHD
( )PTSD
( )Bipolar Disorder
( )Other

Other medical/social/behavioral (psychiatric) issues (please describe):_____

_____

_____

_____

FEMALES OF CHILDBEARING AGE:

LMP:_____ Birth Control:_____ Sexually active ( )Yes ( )No

Are you/could you be pregnant? ( )Yes ( )No

MEDICATION LIST

Please list all Current Medications (including over the counter):

❑ No Current Medications

Medication	Dose	Prescriber

MEDICAL HISTORY

Please list all Current Medical Conditions or Allergies:

Diagnosis/Medical Condition/Allergy	When Diagnosed/What is allergy to?

Please list any surgeries (include when occurred) or medical history that is pertinent for your treatment at AIMBH: _____

_____

_____

***Please use back of sheet for additional prescriptions or medical issues if needed.*

SUBSTANCE USE/ABUSE HISTORY

Cigarettes: Now: ( )Yes ( )No In the past: ( )Yes ( )No

How many per day on average:_____ For how many years:_____

Pipe: Now: ( )Yes ( )No In the past: ( )Yes ( )No
How many per day on average:_____ For how many years:_____

Smokeless tobacco: Now: ( )Yes ( )No In the past: ( )Yes ( )No
How many 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? ( )Yes ( )No

If yes, please describe when, where, and for how long:_____
_____

What was your longest period of abstinence?_____

What caused you to relapse?_____
_____

Have you ever overdosed? ( )Yes ( )No

If yes, please provide details (how many times, when, on what, was it intentional or accidental)?
_____
_____

Have you ever been arrested or convicted for any of the following:
( )DWI / DUI ( ) Drug offense ( ) Domestic Violence

Are you currently on probation or parole? ( ) Yes ( ) No

If yes, details (how long, reason, etc):_____

Have you ever experienced any of the following:

( )Physical Abuse ( )Verbal Abuse

( )Sexual Abuse/Assault ( )Emotional Abuse

If you selected yes to any of the above, have you ever been in treatment for the abuse?

( )No ( )Yes, When?_____

What other forms of treatment have you attempted?

( )Inpatient Services ( )Outpatient Clinic ( )Methadone ( )Detox

If any prior treatment, when and for how long?_____

_____

Have you ever had any suicidal ideations, plans and/or attempts: ( )Yes ( )No

If yes, please provide details (how many times, when was last attempt, what did you do, etc.)?

_____

_____

_____

_____

TREATMENT GOALS & EXPECTATIONS

Please briefly describe your goals and expectations for your treatment in this clinic:

_____

_____

_____

_____

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

	NO	Yes/Now Or Yes/Past	Route	How much	How Often	Date/Time Of Last Use	Quantity Last Used
(Example) Substance name	✓						
(Example) Substance name		*Yes/Now*	*Smoke*	*1 gram/ 1 line/ 2 tabs*	*daily*	*This morning*	*1 tab*
Alcohol							
Stimulants (Pills)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
LSD/ Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Inhalants							
Tranquilizers/ Sleeping Pills							
Ecstacy							
Other:							

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

_____

_____

AUDIT-C Questionnaire

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

	0P	1P	2P	3P	4P
1. How often do you have a drink containing alcohol?	NEVER	MONTHLY OR LESS	2-4 TIMES PER MONTH	2-3 TIMES PER WEEK	4 OR MORE TIMES PER WEEK
2. **How many standard drinks containing alcohol do you have on a typical day?**	1 OR 2	3 OR 4	5 OR 6	7 TO 98	10 OR MORE
3. **How often do you have six or more drinks on one occasion?**	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY

****

Person completing form, if different from the patient:_____ _____

Printed Name Signature

AIM BEHAVIORAL HEALTH OFFICE POLICIES

Thank you for choosing AIM Behavioral Health (AIMBH) as your provider. We are committed to providing you with the best possible care and we are pleased to discuss the office policies with you anytime you need. Your clear understanding of our office policies is important to our therapeutic relationship. Please ask if you have any questions regarding AIMBH policies.

BLOODWORK

As part of our treatment program, new patients will have blood drawn on their initial appointment with annual or semiannual follow up bloodwork as needed. This is a requirement of the program. If our phlebotomist is unable to draw your blood, you will be given an order to take to the hospital to have it drawn before your next appointment. Once your results are received, your provider will go over the results with you at your next appointment.

STI TESTING

Sexually Transmitted Infection Testing is performed through a urine sample collected at initial appointment. This screening tests for chlamydia, gonorrhea, trichomoniasis, and syphilis. Because each infection has a specific window period, you may be recommended to get tested/re-tested annually or as needed. Once results are received your provider will go over the results with you at your next appointment.

FINANCIAL POLICY

I understand and agree that I am responsible for my co-payment and any fees for my treatment that is not covered by my insurance. I understand that any payment for treatment is required to be paid in full prior to seeing the provider.

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 agree to be aware of my patient rights and patient responsibilities. 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.

Patient Initials:_____

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT BILL OF RIGHTS: Each patient has the right to:

- Choose your medication assisted treatment (MAT) provider. (AIM BH is a MAT provider).
- Access treatment and be treated in a manner sensitive to individual needs regardless of race, color, religion, national origin, age, sex, sexual orientation, gender identity, marital status, familial status, disability, veteran status, or any other legally protected group status outside of meeting program criteria.
- Receive considerate and respectful care & receive treatment in a manner that promotes dignity and self-respect; for example, adequate space to accommodate the need for privacy during visits and therapeutic interventions, e.g. urine collection.
- To be involved in creating your own treatment plan.
- Ask questions and get appropriate answers about services.
- Be well informed about your illness, possible treatments and their likely outcome, and to discuss this information with the providers.
- Participate fully in decisions about treatment or services, which includes informed consent to all services. In the event the patient is unable to give informed consent, a legally responsible party has the right to be advised regarding treatment recommendations.
- Know the names and roles of the people providing treatment services to you.
- You have the right to confidentiality in accordance with 42 CFR Part 2 and Health Insurance Portability and Accountability Act (HIPAA) of 1996.
- To be protected from invasion of privacy except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises.
- To consent to or refuse a treatment, as permitted by law, within the parameters of good behavioral health practice and program guidelines.
- To have all clinical and personal information treated in accordance with state and federal confidentiality regulations unless you have given permission to release information or reporting is required by law or medical necessity.
- Know about AIM BH policies and practices that relate to patient care, treatment and responsibilities.
- To be fully informed about charges/fees and payment methods for treatment services.
- To receive treatment and care in an environment that is free from abuse: including financial abuse, physical or emotional abuse, sexual abuse or harassment, racism or racial harassment.
- Be told of realistic care alternatives when treatment is no longer appropriate or you would benefit from supplementary assistance.
- To submit a grievance following the grievance procedure if not satisfied with care you are receiving.

Patient Initials:_____

INDIVIDUAL PATIENT CONFIDENTIALITY:

Patient confidentiality will be respected and upheld in accordance to 42. CFR Part 2 and Health Insurance Portability and Accountability Act (HIPAA) of 1996.

GROUP CONFIDENTIALITY:

Part of your treatment services at AIM BH may involve group counseling and/or peer support groups. While AIM staff may not disclose any client communications or information except as provided by law, group members' communications are not protected. As such, confidentiality within the group setting is often based on mutual trust and respect of each group member.

As a member of a group, you agree not to disclose to anyone outside the group any information that may help to identify another group member. This includes, but is not limited to, names, physical descriptions, biological information, and specifics to the content of interactions with other group members. Group expectations, rules, and guidelines should be reviewed prior to each group meeting.

LIMITS OF CONFIDENTIALITY:

Before any information about your health is disclosed by AIM BH in a manner not previously described, written consent must be obtained from the patient. You may revoke consent in writing.

However, in the following instances, federal law permits AIM BH to disclose information without your written consent:

1. To medical personnel in a medical emergency
2. To appropriate authorities to report suspected child abuse or neglect, dependent adult, or elder abuse, or instances where an individual is a danger to themselves or others
3. To report a crime committed on AIM BH premises or against AIM BH personnel
4. For audit or evaluations by managed care organizations or insurers
5. To AIM BH billing company (Promedclaim)
6. As allowed by court order
7. Pursuant to an agreement with a qualified service organization/business associate

If you feel your rights or confidentiality have been violated, you may file a complaint to the Medical Director.

GRIEVANCE AND COMPLAINT PROCEDURES (How to file a grievance/complaint):

- Every patient has the right to file a complaint or grievance if they are not satisfied with the services they are receiving.
- Information about the AIM BH grievance procedure can be found in the waiting area and obtained from AIM BH staff.
- Grievance forms are accessible in the waiting area of the office building, accessible from the front desk staff.
- To file a grievance, complete the form (all known information must be filled out in order to be processed)
- Within 4 business days, you will be contacted to resolve the grievance.
- The grievance may be resolved through telephone communication up to and including a face-to-face meeting with the Medical Director of AIM BH.

Patient Initials:_____

PATIENT RESPONSIBILITIES: It is AIM BH expectation that you will be responsible for:

- Providing honest and accurate information about your health including past treatment attempts and addiction history.
- Communicating with AIM BH employees. Employees are committed to best practice so it is patient responsibility for asking questions when you do not understand information or recommendations. If you believe you cannot follow through with your treatment, you are responsible for telling your provider.
- Being considerate of the needs of other patients, the employees, and the program.
- Treating yourself and others with dignity and respect by not loitering, not using abusive or threatening language, not arguing with staff or other patients, no physical threats/no fighting/no carrying concealed weapon or objects
- No misuse of your prescribed medication in any way (selling, buying, misusing, loaning, etc.)
- Providing unaltered urine samples for screens.
- Help develop your individualized treatment plan.
- Follow your individualized treatment plan, which includes attending your prescribed counseling sessions, urine drug screens, blood tests, case management, and any additional services.
- Be on time for your appointments.
- Limit rescheduling or cancelling appointments, but if you have an emergency and you have to reschedule an appointment, please notify AIM BH as soon as you are aware that you are not going to be able to make the appointment.
- If you are prescribed a controlled substance for any reason from another physician or hospital, inform AIM BH of this prescription.
- Keep your information (phone number, address, email, insurance information, etc.) updated and current at all times during your treatment at AIM BH.
- Inform anyone who provides you transportation to appointments that he/she must remain in the vehicle at all times to protect the confidentiality of patients.
- Not having children or pets in attendance when you arrive for appointments.
- Respect the property of AIM BH, including the parking lot, waiting area, restrooms, and any other materials or equipment used during your services.
- Protect your belongings. AIM BH is not responsible for any lost or stolen patient belongings.
- Maintaining financial responsibility for all payment of services. This includes following no-show and cancellation policies set forth by AIM BH as well as fees for other services as outlined in the informed consent and patient handbook.
- Recognizing the effect of lifestyles on your personal health and on the decisions you make in your daily life that can affect your life in the long term

Patient Initials:_____

FREEDOM OF CHOICE

I am aware of and understand that I have a choice of Medication Assisted Treatment (MAT) providers in the local area.

I have reviewed the providers and services available , and have chosen **AIMBH/Ashland Integrative Medicine LLC.** as my provider for the following services:

- Medication Assisted Treatment
- Substance Use & Addictions Counseling
- Targeted Case Management

Patient's Initials:_____

INFORMED CONSENT

- I voluntarily consent to behavioral health/medication assisted treatment/ care with AIM BH.
- I understand that treatment and services may be provided by a medical doctor, APRN, certified or licensed counselor/social worker, certified peer support specialist, case management, or an individual supervised by any of the professionals listed. Services may include interviews, assessment, medication assisted treatment, individual and/or group counseling, peer support groups or individual, case management, urine drug screens, lab work.
- I understand that I can make decisions regarding my treatment and be involved with my treatment planning.
- I understand that I may ask providers about the side effects of care.

Risks & Benefits:
Medication assisted treatment has both benefits and risks. Risks may include experiencing uncomfortable feelings because the process often requires discussing difficult aspects of one's life, experiencing medication side effects like with all medications, overreliance on medication without holistic treatment to include counseling, physical health care, and other recommended treatment services; and the potential for misuse or abuse if the treatment program is not followed as prescribed.

However, treatment has been shown to have benefits. The ultimate goal of MAT is recovery, including the ability to live a self-directed life. This treatment approach has been demonstrated to be safe, to improve patient survival, improve social functioning, reduces criminal activity, reduces the risk of overdose, reduces the risks of infections disease transmission, increases patients' ability to gain and maintain employment, improves birth outcomes among women who have substance use disorders and are pregnant, and increases retention in treatment.

A small number of clients may not improve because of treatment or may terminate before it is clinically indicated. It is important to keep your providers and counselors advised of any difficulty you may encounter during your treatment.

Person Financially Responsible for Account: The undersigned hereby agree to be financially responsible for this account.

I have read and understand the information provided in this packet, have discussed it with AIMBH staff as needed, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

I also understand that AIM BH is not a Primary Care provider, nor do we provide primary care services. We can assist with a referral to a PCP if desired.

By your signature below, I am verifying that I have reviewed this document in its entirety, that I understand my rights and responsibilities as a patient at AIMBH, and that I freely choose and consent to treatment at AIM BH.

Patient's Signature:_____ Date:_____

AIM BH Staff Signature:_____ Date:_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent amendments in office policy. I understand that this consent shall remain in effect from this time forward.

Signature: _____ Date:_____

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RELEASE OF MEDICAL INFORMATION

Name:	**DOB:**
Address:	
Home Phone:	**Cell Phone:**

Please transfer my medical records as follows:

To:_____
_____
_____

From: Ashland Integrative Medicine BH
10730 Midland Trail Rd.
Ashland, KY. 41102

From: _____
_____
_____

To: Ashland Integrative Medicine BH
10730 Midland Trail Rd.
Ashland, KY. 41102

I WANT THE FOLLOWING RECORDS RELEASED:
(records sent will include all dates of service since start date of the program)

_____All Medical Records (last 6 months)
_____Urine Drug Screens (ONLY)
_____Appointment compliance
_____Coordinate Care/Referral
_____Other:_____

I understand that my medical records and all PHI are protected under state and federal confidentiality regulations in accordance with 42 CFR Part 2 and HIPAA. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

My signature below is my written consent for release of approved records. I understand that I am able to revoke this consent at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in one (1) year.

Patient Signature:_____ Date:_____
Witness:_____ Date:_____
Interpreter, if needed:_____ 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, 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 doctor and counseling appointments, conduct myself in a courteous manner at the doctor's office as well as the pharmacy. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office. I understand the medications will NOT be prescribed for missed appointments, lost or stolen medications.
2. I agree to abstain from alcohol, benzodiazepines (i.e. Xanax, Klonopin, Valium, Ativan), opioids, marijuana, cocaine, stimulants (i.e. Adderall, Ritalin, Adipex) and other addictive substances (excluding 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 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 violation of the above may be grounds for termination of treatment.

_____	_____	_____
PRINTED name of Patient	Signature of Patient	Date

OFFICE USE ONLY ******* OFFICE USE ONLY ******* OFFICE USE ONLY******* OFFICE USE ONLY******

The above named patient has been evaluated by me and treatment by Buprenorphine containing medication is recommended. I have discussed other treatment options with the patient. Patient agrees to fully comply in our comprehensive addiction treatment program. I have gone over the 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 her/his rehabilitation.

_____	_____	_____
PRINTED name of Provider	Signature of Provider	Date