OPIOID ABUSE NEW PATIENT MEDICAL HISTORY FORM

FIRST NAME:	LAST NAME	DATE:
BIRTH GENDER:		DOB:

How does your opioid abuse affect your life and health?

_____

_____

OPIOID HISTORY:

When did you first notice that opioid is a problem? □ Childhood □Teens □ Adulthood

What is your opioid of choice? _____

How long can you go without taking opioids? _____ hours _____ Days _____Weeks _____

What is your average opioid intake a day?_____

TRAUMA HISTORY (Life events associated with opioid abuse. Check all that apply)

□ Marriage	□Injury	□Pregnancy	□Illness
□Travel	□Drugs	□Work	□Quitting smoking
□Divorce	□Abuse	□Job Change	□Other: _____

Previous Opioid Control Treatment Programs you have tried: (check all that apply)

□AA	□Smart Recovery	□Inpatient Rehab
□NA	□Sinclair Method	□Other: _____
□IOP	□Church	

What are your greatest challenges with controlling your opioid use?

_____

_____

_____.

Have you ever taken medication to control opioid use? (Check all that apply)

□ Kratom	□Gabapentin	□Suboxone/Buprenorphine
□Xanax	Naltrexone	□Anti-depressant Medication (which one) _____
□Zofran	□Tramadol	□Other:
□Methadone		_____

What worked? _____

What didn't work?_____

Why or why not? _____

New Patient Demographic Information

- ☐ Driver's License or State Issued Photo ID.
- ☐ Photocopy of the front and back of your insurance card.

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)	Birth Date	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address / Apt #	City, State ZIP			
Email Address	Primary Phone ☐ Home ☐ Cell	Okay to leave message? ☐ Yes ☐ No		
Employer (or parent/guardian employer if patient is a minor)	Work Phone			
Primary Care Provider (where you go for your routine medical care) ☐ None				
Preferred Name/Pronoun Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer			

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last)	Social Security # ☐	Date of Birth

Preferred Pharmacy I understand I am only allowed to use ONE pharmacy by Paragon ☐ Yes ☐ No

Pharmacy Name	Pharmacy Location

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Address		Phone

PATIENT SIGNATURE: X_____ DATE:_____

Patient Agreements and Authorizations

CONSENT FOR TREATMENT

I Hereby consent to the treatment provider by providers at Paragon Health Partners and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.

CONSENT FOR MEDICATION HISTORY.

I authorize Paragon Health Partner and its employees or designee to access my medication history via PMP portal and from participating pharmacies that Paragon Health Partners request medication history.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or the purposes of conducting the healthcare operations of Paragon Health Partners. I authorize Paragon Health Partners to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Paragon Health Partners may release objective clinical information related to my diagnosis and treatment, which may be requested, by my insurance or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GURANTEE/COLLECTION FEE

I authorize payment to be made directly to Paragon Health Partners, Paragon Pain & Rehabilitation, LLP for insurance benefits payable to me. I understand that I am financially responsible for Paragon Health Partners, Paragon Pain & Rehabilitation, LLP for any non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue it may be referred to collection agency.

PRIVACY POLICY

I acknowledge having received Paragon Health Partners, Paragon Pain & Rehabilitation's "Notice of Privacy Practices". My rights including the right to see a copy of my medical record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent Paragon Health Partners has already made disclosures with my prior consent.

DISCLAIMER: By typing your name above, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Patient Name

PARAGON Health Partners

Date

FINANCIAL AGREEMENT & OFFICE BILLING / INSURANCE POLICIES

1. I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance. I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account.

2. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.

3. I understand that if my insurance(s) require a referral from my primary care physician, Norberto Vargas, M.D or JP Benavides, D.O. at Paragon Pain & Rehabilitation, LLP. must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).

4. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s), including that an insurance company representative may review the clinical record.

5. I authorize direct payment by my insurance company(s) to Paragon Pain & Rehabilitation, LLP.

6. I accept ultimate responsibility for payment for the services that I or my dependent(s) receive, whether or not my insurance(s) cover these services. This includes, but is not limited to fees for: clinical services or treatment, failed appointments and/or appointments not cancelled with 24 hours notice, report/letter writing, time spent in court or talking with attorneys on my behalf or the behalf of my dependent(s), telephone conversations longer than 5 minutes, site visits, reading records, longer sessions, travel time, etc.

7. I am aware of Paragon Health Partners office policy requiring 48 hours notice to cancel an appointment. I understand that I may notify the office staff or the answering service of my intention to cancel an appointment. I further acknowledge that I will be charged $50.00 for any New Evaluation, procedures, testing, injections appointments and $10.00 for Follow Up Appointment which I or my dependent(s) fail to keep without providing 48 hours notice.

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies.

_____

Patient Name (Printed)

_____

Responsible Party (Printed) (If patient is a minor or dependent adult)

_____ _____

Signature of Responsible Party Date

Paragon Health Partners
2895 Lewis Lane Paris, TX 75460
Phone: 972-203-3600 Fax: 972-203-3601
www.paragonphp.com

PARAGON
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Cancellation/Late Policy Form

Payment Policy

All Co-payments and any past due balances are due at the time of visit. If you receive a bill and would like to make payment. Our website has a online payment option. Simply go to website at www.paragonphp.com and in the upper right click online payment and follow steps.

Cancellation Policy

As our practice continues to grow, we have updated our cancellation policy to better serve our patients. Your appointment time is reserved especially for you. Please call 972-203-3600 at least 48 hours before your scheduled appointment if you will be unable to keep your appointment. This allows our practice to offer that appointment to another patient who needs medical care. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" calendar for the day. **If you do not cancel your appointment at least 48 hours in advance, you will be charged a no-show or late cancellation fee. This fee is not covered by insurance. Payment will be required before another appointment is scheduled**

We understand that life gets busy. However, a pattern of missed appointments without proper notice does not show mutual consideration. Patients who fail to provide advanced cancellation for three appointments in the span of one year may be subject to dismissal from the practice.

Late Arrival Policy

We know that delays can happen when you are trying to get to your appointment. However, we must try to keep the other patients and doctors on time. If you arrive 15 minutes past your scheduled time, we may have to reschedule your appointment.

Fee Amounts:

$50.00 Fee- New Evaluation, Procedure, Injection, EMG/NCV

$10.00 Fee- Follow Up Appointment.

I have read and acknowledged your payment, cancellation, and late policies.

Patient Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Paragon Pain Rehabilitation LLP ("Paragon") is committed to maintaining the privacy of your health information. We understand that health information about you is personal. We are required by law to maintain and protect health information about you. We are required by federal law to provide you with this Notice of Privacy Practices ("Notice") that describes how health information that we maintain about you may be used or disclosed. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

This Notice describes how medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures of Your Health Information
We are permitted to use and disclose your health information under a variety of circumstances. Some of the reasons that we may use or disclose your information include:

- For Treatment: We may use and disclose health information about you to provide you with medical treatment or services. For example, your doctor might use your name, age, possible diagnosis, and other information required to obtain laboratory testing.
- For Payment: We can use and disclose your health information to bill and get payment from you, your health insurers or other entities. For example, we may need to give your health plan information about your visit so that they will pay us or reimburse you.
- For Health Care Operations: We may use and disclose your health information for our operations. For example, we may need to use your information when in the course of quality assurance or utilization review activities. We may also combine medical information about our patients to decide what services we should offer or to see where we can make improvements..
- Use or Disclosure Required By Law. We may use or disclose your health information to the extent such use or disclosure is required by law.
- Health Agency Oversight Activities. We may disclose your health information to governmental, licensing, auditing and accrediting agencies for health oversight activities.
- Law Enforcement. We may disclose your health information for law enforcement purposes.
- To Avert a Serious Threat to Health or Safety. We may use or disclose your health information when necessary to prevent a serious threat to health or safety of a person.
- Public Health Risks: We may disclose health information about you for public health activities.
- Workers' Compensation. We may disclose your health information to covered entities that are government programs providing public benefits and for workers' compensation.
- To Respond to Lawsuits and Legal Actions: We may disclose your health information in response to a court or administrative order, or in response to a subpoena.
- Business Associates: We may disclose your health information with third-party vendors that provide services on our behalf, which are referred to as "Business Associates."
- Individuals Involved in Your Care or Payment for Your Care: We may use or disclose health care information to a family member or friend involved in your care or payment for your care.
- Marketing and Sale of Health Information: We must obtain your written authorization prior to most uses of your health information for any marketing purposes or disclosures that constitute a sale of your health information.
- Appointment Reminders and Communications. We may use and disclose your health information and the contact information you provide us with to contact you with appointment reminders or other health-related communications, including via email, text message or telephone or mail. While email or text messages may not be encrypted or secure and could be intercepted in transit, we will assume you understand these risks if you provide us with your mobile telephone number or email address and that you consent to us communicating with you in this manner.

Other Uses of Your Health Information
Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. Your written, signed authorization is required before Paragon may use or disclose health information containing psychotherapy notes, if Paragon intends to use your health information for marketing purposes, or for the sale of your health information. You may revoke this permission for any of those purposes requiring authorization, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy: You have the right to inspect and obtain a copy of your health information maintained in a designated record set. We may charge a reasonable, cost-based fee. We may require you to submit your request in writing.
- Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, as those functions are described above. We will provide you one accounting of disclosures each year free of charge but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months. We may require you to submit your request in writing.
- Right to Amend: If you feel the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our organization. We may require that you submit a request in writing and provide a reason to support the requested amendment.
- Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. We may require you to submit such a request in writing. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny such request. However, we must agree to the request for a restriction if the request involves a disclosure about your health information to a health plan (1) when the disclosure regards carrying out payment or health care operations (and is not otherwise required by law), and (2) the health information solely pertains to health care that you, or a person other than a health plan, has paid to Paragon in full.
- Right to Request Confidential Communications: You have the right to request that we communicate your health information with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- Right to be Notified of a Breach. You have the right to be notified if there is any impermissible use or disclosure of your health information that compromises the privacy or security of your health information.
- Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

Changes to this Notice.

We are required to abide by the current version of this Notice, and we reserve the right to change this Notice. The revised or changed Notice will be effective for health information we already have about you as well as any information we receive in the future. The new notice will be available upon request, in our office and on our website.

Complaints

If you believe that we may have violated your privacy rights, or you disagree with a decision about your health information, you may file a complaint with us by contacting the Privacy Officer at the address listed below or with the Secretary of the Department of Health and Human Services. You will not face retaliation for filing a complaint.

Privacy Officer

For further information, please contact our Privacy Officer, Karen McNerney at:

[PO Box 1200 Colleyville, TX 76034]

Effective Date: June 15, 2022

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Paragon's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Paragon may use and disclose your health information. I understand that the Notice is subject to change.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Personal Representative Relationship (e.g., Attorney-In-Fact, Guardian, Parent if a a minor)

Date Signed _____/_____/_____

PARAGON
Health Partners

PARAGON PAIN REHABILITATION, LLP

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's name: _____ Prior Name, if any: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____ DOB: _____

RECEIVING PARTY: I hereby authorize Paragon Pain Rehabilitation, LLP ("Paragon") to release my health information, including copies of my medical records, to the following person or entity:

_____
Name of Person or Entity Telephone No

.

_____
Street City State Zip

PURPOSE OF RELEASE:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal Copy ☐ Leaving Paragon*
☐ Other

TYPE OF INFORMATION TO BE RELEASED (Please indicate by checking applicable box):	**SPECIFIC INFORMATION TO BE RELEASED (Please confirm release by initialing below):**
☐ Complete medical record (Please specify dates of service): _____ ☐ Partial Medical record (Please specify which records): _____ ☐ Billing Records ☐ Other	_____ HIV/AIDS/STD test results/information _____ Genetic testing information _____ Alcohol/Drug Abuse _____ Behavioral/Mental Health Information

1. **EXPIRATION OF AUTHORIZATION:** I understand that this Authorization is valid for three (3) years from the date I sign this authorization and will expire at that time unless another expiration date/event is written here: _____.

2. **SPECIAL INFORMATION**: This authorization may include disclosure of information relating to **DRUG**, **ALCOHOL** and **SUBSTANCE ABUSE**, **MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

3. **RIGHT TO REVOKE AUTHORIZATION**: I understand that I have the right to revoke this authorization at any time by giving written notification to Paragon at info@paragonphp.com. I understand that the revocation will not have any effect on actions taken by Paragon in reliance on this authorization before it receives my written notice of revocation. I also understand that the revocation will not apply to any health information that has already been released in response to this authorization. Once Paragon has released my health information to a recipient, the recipient may re-disclose my health information to third parties.

4. **RIGHT TO REFUSE TO SIGN AUTHORIZATION**: I understand that I may refuse to sign this authorization. I understand that my refusal will not affect my ability to receive treatment at Paragon and that Paragon may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

5. **RIGHT TO COPY OF AUTHORIZATION**: I understand that I have a right to a signed copy of this authorization.

By signing below, I understand the potential that medical records and information disclosed pursuant to this authorization in whatever form and/or means provided may be subject to re-disclosure by the recipient and will no longer be subject to protections under the federal privacy laws and regulations. I hereby release Paragon and its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of these medical records and the information included I have authorized above.

_____ _____

Signature of Patient (or Patient's representative) Date

_____ _____

Printed Name If Representative, Basis for Authority

If the patient is minor, the minor individual's signature is also required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____

Date: _____

OPIOID HISTORY CONT:

Alcohol triggers (check all that apply):

□Stress	□Insomnia	□Life changes	□ Seizure Disorder
□Boredom	□Seeking reward	□Work	□Eating out
□Anger	□Parties	□Divorce	□Other: _____

SLEEP HISTORY:

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Do you snore? □Yes □No Have you had a sleep study? □Yes □No

Do you need alcohol or opioid to sleep? □Yes □No

TRAUMA HISTORY:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No Please describe when, where, and by whom: _____

SUBTANCE ABUSE HISTORY: (Check if you have every tried the following)

☐ **Methamphetamine**	☐ **Marijuana**	☐ **Estasy**
☐ **Cocaine**	☐ **Pain Killers (Not Prescribed)**	☐ **Alcohol**
☐ **Herion**	☐ **Methodone**	☐ **Other _____**
☐ **LSD or Hallucinogens**	☐ **Tranquilizer/Sleeping Pills**	

SPIRITUAL HISTORY:

Do you belong to a particular religion or spiritual group? ☐ YES ☐ NO

If yes, What is the level of your involvement?

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you?

Is there anything else you would like for us to know?

SEXUAL HISTORY:

Are you sexually Active? _____ Conceptive Medication/Method? _____

Number of pregnancies: _____ Number of Children: _____

Age of first Pregnancy? _____ Age of last pregnancy? _____

PAST MEDICAL HISTORY (check all that apply):

□Heart attack
□High blood pressure
□High cholesterol
□High triglycerides
□Infertility
□Glaucoma
□Angina
□Stroke
□Diabetes
□Gout
□Arthritis
□Cancer (Type/s): _____
□Liver Disease
□Gallbladder stones
□Indigestion/reflux
□Pancreatitis
□PCOS
□Sleep apnea
□Thyroid
□Anxiety
□Depression
□Bipolar

Past Surgical History: (List Surgeries you have had)

FAMILY HISTORY:

	Mother	Father	Sibling	Child	Aunt/Uncle
Addiction					
Alcohol Abuse					
Depression					
Thyroid problems					
Suicidal Idea or Plan					
Bipolar Disorder					
Heart Disease					
Alcoholism					
Anxiety					
Hight Blood Pressure					
High Triglycerides					
High Cholesterol					
Stroke					
Liver Disease					
Cancer: List Types					

HEALTH SCREEN

Have you been tested for HIV? _____YES _____ No If yes, When _____

What was the results of HIV Test? _____

Have your been tested for Hepatitis C? _____YES _____NO

When were you last tested for Hepatitis C? _____

What were the results? _____

RELATIONSHIP HISTORY:

What is your current relationship status? _____

Describe your relationship _____

How many Children to you have? _____

Describe your relationship with your children _____

List everyone who lives with you _____

Do you have a history of DUI? _____

Have you ever been incarcerated? _____YES _____NO When? _____

EMPLOYMENT HISTORY:

Are you currently employed? _____YES _____NO

What is your occupations? _____

Describe your current arrangements? _____

Eductions History (Highest Degree or grade level Acheived) _____

SYSTEM REVIEW (check all that apply)

□Recent weigh loss more than 10 pounds
□Recent weight gain more than 10 pounds
□Acne
□snoring
□Difficulty breathing when flat
□Swelling ankles/extremities
□Constipation
□Dysphasia/difficulty swallowing
□Increased appetite
□Gas and bloating
□Nighttime Urination
□Back pain (lower)
□Dizziness
□Weakness/low energy
□Insomnia
□Mood Changes
□Cold intolerance
□Heat intolerance
□Skin rash
□Bloating
□Nausea/vomiting
□Food intolerance
□Heartburn
□Slow urine flow
□Back pain (upper)
□Muscle aches/pain

□Skin rash
□Shortness of breath
□Fainting/Blacking out
□Abdominal pain
□Diarrhea
□Indigestion
□Decreased appetite
□Urinary Frequency/urgency
□Blood in stools
□Joint Pain
□Headaches
□Anxiety
□Memory loss
□Nervousness
□Excessive sweating
□Blood Clots
□Cough
□Chest Pain
□Palpitations
□Seizures
□Depression
□Inability to concentrate
□Loss of interest
□Hair changes
□Fatigue/tiredness
□Suicidal Ideas or Planning

COMMENTS:

PARAGON
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PAIN • OBESITY • ADDICTION

Buprenorphine Treatment Agreement

1. I understand that Suboxone is a combination of buprenorphine and naloxone. Naloxone will counter act any opioid I'm taking, causing precipitated withdrawal. I understand I must take Suboxone as ordered and follow instructions outlined.

2. I understand that buprenorphine is a narcotic drug that, if taken in large quantities, can produce a 'high'. I know that if I abruptly stop taking it, I could experience opioid withdrawal symptoms.

3. My health care team has discussed with me various options for treatment of my addiction, including non-pharmacological options. They have explained, and I understand, the risks and benefits of Suboxone, including potential side effects. I understand that in order to be a satisfactory candidate for Suboxone, I must follow certain safety precautions for the treatment and comply with the treatment the schedule prepared for me by my attending physician and/or my substance abuse counselor. Additionally, my health care team has discussed this agreement with me and explained what is expected of me in the program. I have been given information about the program and have had adequate time to have my questions answered. As a result, I voluntarily consent to the program.

4. I will take Suboxone by placing it under my tongue to dissolve and be absorbed. I will never inject Suboxone or take it intravenously (IV), because IV use could lead to sudden and severe opiate withdrawal.

5. I will not drive a motor vehicle or use power tools or other dangerous machinery while taking Suboxone until my doctor has cleared me to do so.

6. I will inform my MAT provider and care team of all my other doctor and dentist appointments and any medications (prescription or non-prescription) that I am taking. I will also report any change in my medical history.

7. I understand that mixing Suboxone with alcohol or other sedatives (such as Valium, Ativan, Xanax, Klonopin, Librium), benzodiazepines can be dangerous. The result could be accidental overdose, over-sedation, organ failure, coma, or death. I agree to abstain from **alcohol** and **sedatives** while I am taking Suboxone. I understand this is important for my safety and to assure that another medication is not prescribed which may lead to harmful side effects.

8. I understand that continued use of other drugs can interfere with my attempts at recovering from opioid dependence. I also understand that buprenorphine (as found in Suboxone) is designed to treat opioid dependence, not addiction to other classes of drugs. Therefore, I will work with the MAT provider to design an individualized treatment program to assist me in discontinuing the use of any other drugs I am using.

9. My medication must be protected from theft or unauthorized use. I understand that Suboxone must be stored safely and securely where it cannot be taken accidentally by children, pets, or be stolen. If my medications are stolen, I will file a report with the police and bring a copy to my next visit. If another person ingests my Suboxone, I will immediately call 911 or Poison Control at 1-800-222-1222. I agree to take full responsibility for the safekeeping of my Suboxone. Lost or stolen Suboxone will not be refilled before the date it was due to be renewed unless I can give the clinic a copy of the police report of the loss. I understand my physician reserves the right to refuse refills.

10. 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.

11. If I alter or forge a prescription, I understand that my MAT provider has the right to terminate my care immediately and will inform the pharmacy and legal authorities of this felony act.

12. I agree to participate in a regular program of professional counseling as recommended by my MAT health care team. If the program or counseling substance abuse counselor is located outside of the clinic. Resources include, NA, AA, smart recovery, talkspace.com or other app or online counseling services.

13. I agree to receive support from peers as recommended by the MAT clinic staff and agree to invite significant persons in my life to participate in my treatment.

14. I agree that a network of support and honest communication are important parts of my recovery. I will provide authorization to allow telephone, email, or face-to-face contact between the MAT clinic staff and physicians, therapists, probation or parole officers, the Department of Social Services, and parents to discuss my treatment and progress. I consent to allow the staff of the MAT clinic to provide others with information regarding my medication usage as needed for my treatment or as otherwise permitted or required by law.

15. I understand that buprenorphine can only be prescribed by a specially licensed physician (buprenorphine provider). I can only get buprenorphine refills as scheduled. I will not be able to obtain buprenorphine refills during walk-in visits, after regular clinic hours or on weekends.

16. I must take my medications as instructed by my buprenorphine provider. I cannot change the way I take my medications or adjust the dose until approved by my buprenorphine provider.

17. I agree to see my buprenorphine provider on a regular basis. The frequency of visits will be up to my buprenorphine provider and will be explained to me.

18. If I miss an appointment or if I need to reschedule an appointment for a later date, I understand that my medications will not be refilled until the time of my next scheduled appointment with a buprenorphine provider. I understand that if I miss or am late to three appointments and did not call the clinic in advance and provide at least 24hr notice I will be dismissed from the buprenorphine maintenance clinic and I will not be given any refills for my medication. I may also be given a lower dose, enough to avoid withdrawal.

19. I understand my Suboxone provider will monitor my compliance by counting my Suboxone tablets or films. I agree to bring my Suboxone medication to each Suboxone clinic visit. I agree to virtual tablets or films counts if being seen via telemedicine.

20. I understand that I may be asked to bring in my Suboxone medication to be counted at any time and will come into the office within 24 hours of receiving such a request.

21. I understand that my Suboxone provider will monitor my medication compliance by doing urine or blood drug screens at each visit at my cost. I consent to testing for this purpose and I understand that it is a requirement of my participation in the buprenorphine clinic. Drug screens will be “supervised,” and a staff person will be required to be present in the restroom with me in order to ensure that the test specimen is coming from my body.

22. I agree to notify the clinic immediately in case of relapse to opioid drug abuse. Relapse can be life threatening, and an appropriate treatment plan must be developed as soon as possible. I understand the physician should be informed about relapse before any urine test shows it.

23. My provider has recommended that I obtain my Suboxone from a single pharmacy. The pharmacy I would like to designate is:

    Pharmacy Name/location: _____

    Pharmacy Phone: _____

24. I agree to conduct myself in a courteous manner in the physician's or clinic's offices.

25. I agree to pay all office fees for this treatment at the time of my visits. Failure to do so is cause for immediate termination of services.

26. I understand that if I do not uphold this agreement, I will be dismissed from the program.

Date: _____

Patient's name (Print): _____ Date of birth ____ / ____ /_____

Patient's signature_____

Provider's name (Print):_____

Provider's signature _____