Hazelwood Family Medicine
Dr Michael A Brown
1088 Brown Ave
Waynesville, NC 28786

PATIENT TREATMENT CONTRACT

Patient Name _____ **Date** _____

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.

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 a urine sample at each visit for drug screening. If there is a positive result, I understand that that is grounds for immediate dismissal from the program.

15. I understand that violations of the above may be grounds for termination of treatment.

_____ Date _____

Patient Signature

* Valium® is a registered trademark of Roche Products Inc.
† Klonopin® is a registered trademark of Roche Laboratories Inc.
‡ Xanax® is a registered trademark of Pharmacia & Upjohn Company

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PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

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

Name _____

Address _____

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

DOB _____ Age _____ SS# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

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

Current or past medical conditions (check all that apply)

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

Other (Please describe) _____

_____

_____

If there a family history of any of the illnesses listed above, **please put an "F" next to that illness**

MD NOTES _____

_____

_____

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

_____

_____

MD NOTES _____

_____

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

_____

_____

MD NOTES _____

_____

Childhood Illnesses

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

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

_____

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

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

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) _____

_____

_____

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

_____

MD NOTES _____

_____

_____

Please list any **allergies** you have (penicillin, bees, peanuts)

_____

MD NOTES _____

Tobacco History

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

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

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

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

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

_____

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

Substance Use History

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

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

What was your longest period of abstinence? _____

MD NOTES _____

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PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name _____

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

Years married/ in long-term relationship _____Times Married _____Times Divorced _____

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

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

Where are you currently living? _____

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

Education (check most recent degree):

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

( ) High School Grade _____

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

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

Have you ever been arrested or convicted? ( ) N

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

Have you ever been abused? ( ) N

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

Have you ever attended:

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

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

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

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

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CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Dr Michael A Brown at the above address to:
Patient Name (Print)

MD check all that apply

☐ Receive my medical history information from the following physicians:
(name, address)_____
(name, address)_____

☐ Receive my treatment records from the following therapist
Therapist (name, address)_____

☐ Release my treatment information/records to the following healthcare professional
(name, address)_____

☐ Release my treatment information to the health insurance company listed below for billing purposes
Insurance Provider (name, address) _____
_____

This information is for the following purposes (any other use is prohibited): _____
_____

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

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

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

_____ _____
Patient Signature Date

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

_____ _____ _____
Witness Signature Witness Name (Print) Date

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol and drug dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol or drug dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

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HIPAA Patient Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk and copies are located in the waiting room.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at our front desk. You have the right to revoke this consent at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Hazelwood Family Medicine provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operation. This request must be done in writing. Whenever possible we will honor your request.

The patient understands that:

_ We will **not** release information to any future doctor, attorney, life insurance company, workman's comp company without your written consent

_ Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operations within our office

_ Hazelwood Family Medicine has a Notice of Privacy Practices that is available for review

_ Hazelwood Family Medicine reserves the right to change the Notice of Privacy Practices

_ The patient has the right to restrict the use of their information, but Hazelwood Family Medicine does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care

_ The patient may revoke this consent in writing at any time and all future disclosures will then cease

_ Hazelwood Family Medicine may condition treatment upon the execution of this consent (for example, you may be required to pay for your visit at the time of service)

_____
Patient Printed Name

_____ _____
Patient or Patient Representative Signature Date

(Updated as of 09/30/2009)

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Call Date _____

Call Time _____

PRETREATMENT SCREENING

Completed prior to call

Name _____

Phone no. _____ Best time to contact _____

Address _____

_____

DOB _____ Age _____ Sex ( ) M ( ) F

Insurance co. _____ Insurance member # _____

Do you plan to submit a claim? ( ) Yes ( ) No

Reason for seeking treatment

Substance _____ How long using? _____

How much? _____ How often? _____

Has your drug use ever resulted in medical or legal problems? ( ) N _____

Have you ever been treated for substance dependence or misuse (eg, detoxification program)? ( ) N

(Please describe setting, length) _____

_____

_____

_____

Have you ever tried to quit on your own? ( ) N (Please describe) _____

_____

Have you ever been treated by a psychiatrist? ( ) N (Please describe treatment reason, setting, and length)

_____

_____

Does anyone in your family (mother, father, brother/sister, child, aunt/uncle or grandparent) have a history of substance abuse? ( ) N _____

_____

_____

Do you have any medical conditions (diabetes, HIV+, epilepsy, STDs)? ( ) N _____

_____

_____

Are you currently taking any medications to treat these conditions? ( ) N (List medication and dosage)

_____

_____

Are you pregnant? ( ) N/A ( ) N ( ) Y ( ) Not Sure

Are there any current legal issues we should be aware of (probation, parole)? ( ) N _____

_____

Are you currently employed? ( ) N ( ) Y How many hours/week (avg.)? _____

Please describe your current living arrangements _____

_____

_____

Other _____

_____

_____ Date: _____

Patient Interviewer Signature

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EXPLANATION OF 1ST VISIT—No In-Office Supply

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

Your 1st visit is generally the longest, and may last anywhere from 1 to 4 hours.

When preparing for your 1st office visit, there are a couple of logistical issues you may want to consider.

- You may not want to return to work after your visit—this is very normal, so just plan accordingly
- Because SUBOXONE can cause drowsiness and slow reaction times, particularly during the 1st few weeks of treatment, driving yourself home after the 1st visit is generally not recommended, so you may want to make arrangements for a ride home

It is very important to arrive for your 1st visit already experiencing mild to moderate opioid withdrawal symptoms. If you are in withdrawal, buprenorphine will help lessen the symptoms. However, if you are *not* in withdrawal, buprenorphine will "override" the opioids already in your system, which will *cause* severe withdrawal symptoms.

The following guidelines are provided to **ensure you are in withdrawal for the visit.** (If this concerns you, it may help to schedule your first visit in the morning: some patients find it easiest to skip what would normally be their first dose of the day.)

- No methadone or long-acting painkillers for at least 24 hours
- No heroin or short-acting painkillers for at least 4 to 6 hours

Bring ALL medication bottles with you to your 1st appointment.

Before you can be seen by the doctor, all of your paperwork must be completed, so bring all your completed forms with you or arrive about 30 minutes early. In addition, you will need to pay the doctor's fees prior to treatment.

Urine drug screening is a regular feature of SUBOXONE therapy, because it provides physicians with important insights into your health and your treatment. Your 1st visit will include urine drug screening, and may also entail a Breathalyzer®* test and blood work. If you haven't had a recent physical exam, your doctor may require one. To help ensure that SUBOXONE is the best treatment option for you, your doctor will perform a substance dependence assessment and mental status evaluation. Lastly, you and your doctor will discuss SUBOXONE and your expectations of treatment.

After this portion of your visit is completed, your doctor will give you a SUBOXONE prescription. You fill the prescription at the pharmacy and return to the doctor's office so you can take the medication in a safe place where the medical staff can monitor your response.

Your response to the medication will be evaluated after 1 hour and possibly again after 2 hours. Once the doctor is comfortable with your response, you can schedule your next visit and go home. Your doctor may ask you to keep a record of any medications you take at home to control withdrawal symptoms. You will also receive instructions on how to contact your doctor in an emergency, as well as additional information about treatment.

CHECKLIST FOR 1ST VISIT:

- ☐ Arrive experiencing mild to moderate **opioid withdrawal** symptoms
- ☐ Bring completed **forms** (or come 30 minutes early)
- ☐ **Fees due** at time of visit (cash or ~~check~~) Credit Card
- ☐ Arrive with a **full bladder**
- ☐ Bring **ALL medication bottles**

*Breathalyzer is a registered trademark of Indiana University Foundation.

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UNDERSTANDING OPIOID DEPENDENCE

SUBOXONE® C (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:

Physical – good nutrition, exercise, sleep and relaxation.

Emotional – learning to cope with feelings, problems, stresses and negative thinking without relying on opioids.

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.

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.

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.

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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.