Today's Date:

Physician - Patient Contract for Narcotic Medication or Buprenorphine Treatment

DOB:

I, ________________________________, agree to the following conditions:

- I understand that I have a chronic pain problem or opioid dependence problem that currently requires the prescription of narcotic medication or buprenorphine to increase my function. The risks, side effects, and benefits of the medication have been discussed with me in detail.
- I will obtain prescriptions for narcotics and other controlled medicines only from Dr. Lee or Other Alt-med Practitioners.
- I will have prescriptions filled at only one pharmacy (Pharmacy Name & Location: ____
- I will take the medication only as prescribed and will promptly notify Dr. Lee or other Alt-med Practitioner, if I do not.
- I may not combine narcotics/buprenorphine with alcohol.
- I agree to random urine and blood tests to assess my compliance.
- I agree to random pill counts.
- I understand the eventual goal of tapering the narcotic/buprenorphine medication.
- I agree to attend regular N/A-A/A meetings or meet with a private counselor/therapist if I am in the buprenorphine program. My logsheet will be brought to each office visit.
- I will meet regularly with Alt-med Practitioner to assess my progress. Lost, misplaced, or stolen medications/prescriptions will not be replaced. **Refills will not be given early for any reason**. If I deviate from the above guidelines, I will be permanently discharged from all care provided by Altmed Medical Center providers.
- I understand when my treating doctor deems it necessary, that I may be asked to under-go psychological evaluation and/or counseling.
- I have read the above document, or have had it read to me. I have asked all questions necessary and wish to proceed with the treatment plan.

I will also immediately inform you if my contact information has changed.

___________________________________	________	___________________________	________
Patient Signature	Date	Provider Signature	Date
___________________________________	________		
Witness	Date		

QUALITY CARE PATIENT INTAKE

Name ____ Date____________________

1. How long has the patient been using opioids?

____

List opioids or any other substance that the patient has misused, what quantity, what route, and for how long.

____

____

2. Does the patient have a history of substance abuse in his or her family? D N D Y

Family member(s)____

3. Has the patient ever been treated for substance misuse? D N D Y

Experience ____

4. What is the patient's experience with withdrawal?

____

5. What is the patient's experience with relapse?

____

6. Comorbid medical or psychiatric conditions that may have contributed to opioid misuse? D N D Y

Condition ____

7. List current prescription medications taken under a physician's supervision and how often they are taken.

____

8. Does the patient have a support network (family, non-drug using friends, spouse, significant other, etc)? D N D Y

Educate the patient about:

D Nature of the disease (Physical & behavioral components; chronic in nature)
D How medication works
D Taking medication as prescribed
D Conditions of safe storage of medication
D Moderate withdrawal in preparation for induction
D Importance of counseling
D Treatment expectations
D Signed patient contract

Office Policies for Suboxone Treatment and Medical Office Visit

In the event of a crisis situation, go to your nearest emergency room or call 911.

Appointment Scheduling and Cancellation General Medical Office Visit

- Please note that the doctors are not in the office every day and their schedules fill up quickly. You are strongly encouraged to schedule your appointments two weeks in advance.
- **If you need to cancel a appointment, you must call or email *at least one day prior*, or you will be charged the full fee for the office visit.**
- If you need disability forms or lengthy forms completed, this must be done during an office visit.

Medications/Refill Requests

- **Controlled substances will NOT be refilled without an office visit.**
- To request a refill, your pharmacy must fax a refill request form to 703-361-0346.
- Please allow 72 hours for refill requests to be completed.
- Please schedule your follow-up appointment BEFORE your medication runs low.
- No refill requests will be processed on a weekend or holiday.
- Some medications require pre-authorization from your insurance company. This may take up to a week depending on your insurance plan.
- New symptoms will require an appointment; the physicians will not diagnose via telephone.

Buprenorphine (Suboxone, Zubsolv and Bunavail)Program Guidelines

- **Photo identification with current address is required.**
- **You are required to submit to routine urinalyses while on buprenorphine.**
- **No prescription will be replaced if lost, stolen, damaged or misplaced.**
- **You must provide us with your pharmacy name and phone number.**
- Our practice will only prescribe Suboxone® film (no subutex), Zubsolv and Bunavail in most cases.
- Fees for Urine Drug Tests are the responsibility of the patient.
- The physician may require that you attend counseling while on buprenorphine.
  - If you are attending support groups, you will need to bring proof of attendance.
  - If you are under the care of a therapist, you will be required to sign a medical release form so that we may verify that you are in ongoing treatment while on buprenorphine.
  - If you attend groups at New Leaf Counseling, the fee is $30.00 per session
- **Inability to adhere to the buprenorphine program guidelines will result in termination of the patient-physician relationship.**

Confidentiality

- The staff adheres to a strict confidentiality policy. We require specific written authorizations to release information to anyone.
- In order to maintain your privacy, our staff members will not accept 'friend requests' on facebook or any other social networking site.
- A copy of our Notice of Privacy Practices is available upon request.
- If you have questions or concerns, please call the Privacy Officer at 703-361-4357.

Communication

- The administrative staff handles all requests for appointments and correspondence. If you have a need that cannot be fulfilled by the administrative staff, a written message will be given to the physician. Every attempt will be made to return your call within one business day. However, please note that the doctors are not in the office every day.
- If you need a phone session with your physician, you will be billed at the standard office rate.

Fees & Professional Services

- Payment is due at the time service. If you are unable to pay at the time of service, your appointment will need to be rescheduled.
- We are under no obligation to render services if you have an outstanding balance.

Initial Evaluation	$200.00
Follow up	$180.00
If Physician see you weekley	$80.00

If Physician see you Byweekley	$120.00
Every Three week	$160.00
We do not accept Checks	Outside Lab fee is Pt Responsibility

Mandated Reporting

- Please note that physicians are mandated reporters. This means they are required to notify the proper officials if we suspect abuse or neglect of a child or a compromised adult.
- Even if abuse or neglect happened years ago, if it occurred when you were a child, and you reveal that to your physician, he or she is required to report the issue to legal authorities.

I understand and agree to the above policies:

______________________________ __________________________ ________

Print Name **Signature** **Date**

Addictions Help MD
8708 Sudley Road
Manassas, VA 20110
Phone 703-361-4357
Fax 703-361-0346

Addictions Help MD
8714 Sudley Road
Manassas, VA 20110
Ph: 1-877-241-3596
Fax 703-361-0346

Addictions Help MD
842 N. Shenandoah Ave
Front Royal, VA 22630
Ph: 540-636-9100
Fax: 540-636-6002

Addictions Help MD
11885 Holly Lane #3
Waldorf, MD 20601
Ph: 301-868-2760
Fax 703-361-0346

Name/Practice Name: Addiction Help MD
Address: 8708 Sudley Road
City, State, ZIP: Manassas, VA 20110
Phone: 703-361-4357
Fax: 703-361-0346

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 no.: ______________

Emergency contact: ______________________________

Relationship to patient: ______________ Phone: ______________

Primary care physician: ______________ Phone: ______________

Date of last physical: __________ Have you ever had an EKG? ( ) N ( ) Y 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 (
) Liver problems
( ) HIV/AIDS
( ) Diabetes
( ) 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**.

MDNOTES: ______________________________

____

____

Name: DOB:

Is there a family history of anything NOT listed here? ( ) N ( ) Y (Please explain) ______________________

____

____

MDNOTES: ____

____

Have you ever had **surgery** or been **hospitalized**? ( ) N ( ) Y (Please describe) ______________________

____

____

MDNOTES: ____

____

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**? ( ) N ( ) Y (Please describe) ____

Have you ever taken or been prescribed **antidepressants**? ( ) N ( ) Y 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: __________

____

MDNOTES: ____

____

____

Please list any **allergies** you have (eg, penicillin, bees, or peanuts): ______________________________

____

MDNOTES: ____

Name: DOB:

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 ( ) Y (Please describe when, where and for how long)

____

How long have you been **misusing 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							

Name: DOB:

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

____

____

What was your longest period of abstinence? ____

____

Are you receiving, or have you ever received counseling support? ( ) N ( ) Y (Please describe when and for howlong) ____

____

MD NOTES:

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 (Please list) ____

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

Where are you currently living? ____

Do you have family nearby? ( ) N ( ) Y (Please describe) _________________________________

Education (check most recent degree):

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

( )High School Grade ___________

Are you currently employed? ( ) N ( ) Y 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 ( ) Y (Check all that apply)

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

Have you ever been abused? ( ) N ( ) Y

( )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 ( ) Y (Please describe)

Name/Practice Name: Addiction Help MD
Address: 8708 Sudley Road
City, State, ZIP: Manassas, VA 20110
Phone: 703-361-4357
Fax: 703-361-0346

SUBSTANCE DEPENDENCE ASSESSMENT

(For complete substance use history, see Patient Intake: Medical History)

Patient Name: ____________________________ Date of Birth: _____________ Date: ______

BP__________________ Pulse ________________ BAL _______________ Urine Drug Screening

Has patient experienced withdrawal symptoms in the past (check all that apply)**:**

Blackouts	( )	Anxiety	( )
ETOH Seizures	( )	Diarrhea	( )
Tremors	( )	Nausea/vomiting	( )
DTs	( )	Body cramps	( )
Sweats	( )	Body aches	( )

Has patient ever been treated for substance misuse? ( ) N ( ) Y (Please describe when, where, and for how long)

____

MD NOTES:

Presenting problem

Substance: _________________________ Route: ____________________

Quantity/Dose: __________________________________ Frequency: _________________________

Last Usage: _________________________

MD NOTES:

Name/Practice Name: Addiction Help MD
Address: 8708 Sudley Road
City, State, ZIP: Manassas VA, 20110
Phone: (703)-361-4357
Fax: (703)-361-0346

PATIENT INTAKE: PHYSICAL EXAM

Patient Name: ______________________________ **Date:**
Date of Birth: ________**Date of last physical:** ________

T _______P ________BP______ R ________WT _______ HT _______Appearance

TB______ HIV_____ STD (specify) ______________________________Hep-C_____ Hep-B_____ BAL______

Skin	GI	Lymph
HEENT	GU	Neuro
Neck	GYN	Locomotor
CVS	Musculoskeletal	Psych
Resp	Extremities	Nutrition/hydration

Signs of intoxication? ( ) N ( ) Y

NOTES:

ALTMED MEDICAL CENTER, INC
8708 Sudley Road, Manassas, VA 20110
Phone: 703-361-4357 Fax: 703-361-0346

Authorization for Use and Disclosure of Protected Health Information

Patient Name: ____
(Please print) (Last) (First) (Middle)

Address: ____
(Street) (City) (State) (Zip)

Phone: ____________ Date of Birth: ____________ SS#: ____________

I authorize ______________________ to disclose protected health information to:

Name: Phone: ____________ Fax: ____________

Address: ____
(Street) (City) (State) (Zip)

Purpose for use/disclosure: ______________________________

Date(s) of service to be used/disclosed: ______________________________

Information to be used/disclosed (check all that apply):

- ☐ Entire Medical Record
- ☐ Emergency Room Record
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation Report(s)
- ☐ Operative/Procedure Report
- ☐ Lab Reports
- ☐ Pathology Report
- ☐ Radiology Reports/Films
- ☐ Other ______________________________

Specific Authorization to Disclose Sensitive Records

I understand that this authorization is to include use/disclosure of (please initial):

_______ Alcohol and/or drug abuse records
_______ Psychiatric records
_______ Sexually transmitted disease information
_______ HIV/AIDS information

*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that Physician Group of Utah has already relied on this authorization.
- I understand that I may revoke this authorization by mailing or faxing a written notice to the Regional Compliance and Privacy Officer, at Altmed Medical Center, Inc 8708 Sudley Road, Manassas, VA 20110 or fax to 703-361-0346, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is “none” unless otherwise specified here: Expiration: ____________.
- I understand that Altmed Medical Center, Inc may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the Federal privacy law, if the recipient is not a “covered entity.”

SIGNATURE ______________________________ DATE ____________
(Patient or Patient’s Legal Representative)

Printed Name of Legal Representative: ______________________________

Legal Representative’s Authority to Act for Patient: ______________________________

PLEASE NOTE: THIS FORM MUST BE COMPETED IN ITS ENTIRETY. THANK YOU FOR YOUR COMPLIANCE.

ALTMED MEDICAL CENTER, INC

Statement of Patient Financial Responsibility

Patient Name: ____ DOB: _______________________

The ALTMED MEDICAL CENTER, INC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to The ALTMED MEDICAL CENTER, INC, for providing _____________ services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to The ALTMED MEDICAL CENTER, INC, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature ____ Date ___________________________

Guarantor Signature ____ Date ___________________________

(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature ____ Date ____________________________

Workers Compensation Injury:

If you believe you are being seen for an injury/illness because of your job, you need to provide written authorization from your employer to confirm this, & direction from your employer on who ALTMED should bill. If you do not provide this information at the time services are provided, ALTMED may bill you &/or your insurance company.

Payment Options:

If you are unable to meet your financial obligations, payment arrangements can be made. Financing options may be available. Contact our Billing Department to discuss payment options, before your account becomes overdue. In cases of financial hardship, please ask about the practice's hardship policy. Hardship policies vary by practice; limitations & restrictions apply.

Making Payments

Patients generally may pay by cash, money order or personal credit card. This includes cards for "flexible spending accounts" &/or "health savings accounts". Card information may be kept on file by ALTMED to facilitate billing. If you have a credit balance, ALTMED may apply it to any outstanding balances on your account or the accounts of your dependents. Some locations may restrict payment by cash or check.

Fees Assessed by ALTMED

You may be charged fees for: (1) Returned Checks, (2) Completion of Forms (e.g. Disability or Family Medical Leave), (3) Copies of Medical Records, & (4) Failure to Cancel Appointments in Advance ("No Show"). Notify ALTMED of cancelations at least 48 hours in advance to avoid No Show fees. The No Show fee may be assessed up to the amount in our current Fee Schedule.

Termination of Services

If you fail to keep your account current or fail to respond to 3 notices to the address we have on file for you, you agree that ALTMED may terminate your relationship with any or all its offices. In such event, you agree that you are no longer a patient, & ALTMED will not offer you a future appointment. You will have deemed yourself as terminating our relationship if you do not obtain services from ALTMED for 3 years or if you notify us that you will no longer be a patient. Acceptance back into the practice is at the discretion of ALTMED. ALTMED may terminate your relationship with us for other reasons, such as disruptive behavior or non-compliance with care plan, or for no reason.

Authorization to Release of Medical Information

The authorizations described in this Financial Policy may include records about infectious diseases & drug & alcohol abuse treatment. You authorize the release of information by ALTMED to third party payers (including insurance companies & their contractors), health care institutions, physicians & others involved in your medical care. You agree that as appropriate for your care, ALTMED may share information with family members & friends. You agree that ALTMED may provide your medical records to third party payers, review agencies, employers, welfare departments & others for treatment, payment or healthcare operations purposes.

ALTMED participates in one or more Health Information Exchanges. Healthcare providers can use these electronic networks to securely provide access to your health records for a better picture of your health needs. With this authorization, you agree that ALTMED and other healthcare providers, may allow access to your health information through the Health Information Exchanges for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt out at any time by notifying an ALTMED Practice Manager or Compliance Officer. You opt out notice needs to be in writing.

Accidents & Motor Vehicle Injuries

ALTMED 's providers have the discretion to decide whether to see patients injured in motor vehicle accidents or for other liability injuries. ALTMED 's providers also have discretion to decide whether to bill the liability insurance involved (i.e. home, auto, etc.). ALTMED does not have to agree to subrogate or accept liens. You must provide accurate information about the injury & may be required to complete an injury questionnaire. In all cases, you bear responsibility for the costs of your care & must pay them promptly at any time that location decides which may include requiring payment in full at time of service.

Continuing Agreement

I have read this information carefully & agree that everything in this Agreement applies to current & future health care services provided by ALTMED. I acknowledge that ALTMED may change these terms without notice to me.

Interest and Attorney's Fees:

For any past due amounts, ALTMED shall be entitled to payment from you of interest at the rate of 2% per month (24% per annum), & you shall be responsible for all costs & expenses incurred in efforts to collect past due amounts from you, including interest charges, court costs, & reasonable attorney's fees. If a check is returned for insufficient funds, all charges incurred by ALTMED shall be your responsibility.

Patient/Guarantor Signature ____ Date __________________________