Sunil Nayyar, M.D.
Internal Medicine

Roxanne Lewis, PhD
Clinical Psychologist

Hope Recovery Center
387 County Line Rd. West, Ste 225 Westerville Ohio, 43082
P: 614-882-4411 F: 614-882-4475

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
( ) 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: _____

_____

_____

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Klonipin®[2]is a registered trademark of Roche Laboratories Inc.
Xanax®[3]is a registered trademark of Pharmacia & Upjohn Co.

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

_____

_____

MD NOTES: _____

_____

Have you ever had **surgery** or been **hospitalized**? **( )** N **( )** Y (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**? **( )** 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: _____

_____

MD NOTES: _____

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_____

_____

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

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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 **( )** 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 how long) _____

_____

MD NOTES: _____

_____

_____

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PATIENT TREATMENT CONTRACT

Patient Name:_____Date:_____

Please read each numbered item, and initial in the space provided, acknowledging, and agreeing to each term.

As a participant in medication 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 understand that failure to keep my scheduled appointments, will result in a $25 No Call/No Show fee, if not canceled and rescheduled at least 24 hours ahead of the scheduled appointment. Any unpaid fees will be sent to collections, and I will be responsible for all fees associated with the collection process.

_____3. I agree to adhere to the payment policy outlined by this office. This means that if you do not have the money to pay for the visit in full, you are unable to receive your prescription. YOU WILL BE UNABLE TO "OWE" AT THE NEXT VISIT. You may discuss what your options are with Hope Recovery Staff.

_____4. I agree to conduct myself in a courteous manner in the doctor's office, and with all staff of the clinic. **Raising my voice, or any other aggressive or threatening behavior towards clinic staff will not be tolerated and can result in my treatment being terminated without any recourse for appeal.**

_____5. 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.

_____6. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.

_____7. I understand that if dealing, stealing, or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication 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.

_____8. 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. Medications **WILL NOT** be called in.

_____9. 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.

_____10. I agree not to obtain opioids from any doctors, pharmacies, or other sources without telling my treating physician.

_____11. I understand that mixing this medicine with other medications, especially benzodiazepines (for example: Valium®[t], Klonipin®[i], or Xanax®[y]) 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).

_____12. I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events.

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_____13. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without consulting my doctor first.
_____14. 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.
_____15. I understand that I am responsible for getting counseling notes to Hope Recovery Center (if counseling is done with an outside agency) in order for Hope Recovery Center to perform Prior Authorizations for my medication. I understand that failure to provide counseling notes could result in delay of Prior Authorization approval.
_____16. I understand that it is MY responsibility to know when I need a prior authorization renewal. I agree to stay in contact with Hope Recovery staff PRIOR to when a renewal is needed. **I understand that if I come into my appointment, and need a prior authorization for the same day, it will be addressed AFTER all scheduled patients are seen for the day. IT WILL NOT BE DONE RIGHT AWAY.**
_____17. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except for nicotine). I understand that failing urine drug screens can cause delay in Prior Authorization, and termination of treatment with Hope Recovery Center.
_____18. I agree to provide random urine samples and have my doctor test alcohol levels from the urine drug screens.
_____19. I understand that it is at the discretion of Hope Recovery Center staff that I can be terminated at any time for reasonable cause**. I understand that violations of the above may be grounds for termination of treatment.**

Patient Signature:_____Date:_____

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CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I, _____, authorize_____ at the above address to:
Patient Name (Print) Physician 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 on 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	Patient Name (Print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Name (Print)	Date
_____	_____	_____
Witness Signature	Witness Name (Print)	Date

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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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CONSENT TO NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- For judicial & administrative proceedings according to specific requirements.

I have been informed by you of *your Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that the Notice of Privacy Practices covers all entities of Hope Wellness and Recovery Center. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Unless you object, we will call to confirm an appointment and / or leave a message, call you regarding your account (at the phone # provided by you), call and / or leave a message regarding treatment and / or test results.

Patient Name: _____ SSN: _____

Patient Signature: _____Date: _____

Name of the Patient Representative (or Guardian):
_____

Relationship to Patient: _____ Sign & Date:_____

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