Donald R. Taylor, M.D.
Office Based Opioid Addiction Treatment
840 Church Street
Suite D
Marietta, Georgia 30060
770-421-8080

PATIENT TREATMENT AGREEMENT

Patient Name: _____ **Date:** _____

As a participant in buprenorphine treatment for opioid misuse and dependence, I *freely* and *voluntarily* agree to accept this treatment agreement as follows:

I agree to keep and be on time to all my scheduled appointments.

I agree to adhere to the payment policy outlined by this office.

I agree to conduct myself in a courteous manner in the doctor's office.

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.

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

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 Dr. Taylor's office and could result in my treatment being terminated without recourse for appeal.

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 my next scheduled visit.

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.

I agree to be honest and notify Dr. Taylor of all medications I am taking.

I agree not to obtain medications from any doctors, pharmacies, or other sources without telling Dr. Taylor.

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).

I agree to take my medication as Dr. Taylor has instructed and not to alter the way I take my medication without first consulting him first.

I understand that medication alone is not sufficient treatment for my condition. Therefore, I agree to participate in one-on-one counseling with a therapist approved by Dr. Taylor. I agree to enroll in the “Here to Help” program (This is a free program) and agree to engage in the Suboxone Group Therapy Program.

I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).

I agree to provide random urine samples for alcohol/drug testing at Dr. Taylor’s request.

I understand that violations of the above may be grounds for termination of treatment at this facility.

Patient Signature	Date
Witness	Date

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PATIENT INTAKE: SOCIAL/FAMILY HISTORY

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 CA ( ) Current ( ) Past

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

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

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PATIENT INTAKE: MEDICAL HISTORY

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

Patient Name _____

Address _____

Phone (Work) _____ (Home) _____ (Cell) _____

Date of birth _____ 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 is/has been a family history of any of the illnesses listed above, **please put an "F" next to that illness**

MD NOTES _____

_____

Patient Name _____ Date _____

Is there a family history of anything NOT listed on the previous page? (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 _____

Patient Name _____ Date _____

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 many 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							

Patient Name _____ Date _____

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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CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I, _____ authorize _____ at the above address to:
Patent 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 Date

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

_____ _____ _____
Witness Signature Witness Name (Print) Date

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TELEPHONE APPOINTMENT REMINDER CONSENT

I, _____ give Donald R. Taylor, M.D. and members of his/her staff working at the
Patient Name (Print)
location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply)

- ☐ Home _____
- ☐ Work _____
- ☐ Cell _____

Yes, this office may leave (check all that apply)

- ☐ Voice mail at my Home
- ☐ Voice mail at my Work
- ☐ Voice mail on my Cell
- ☐ Messages with people at my Home
- ☐ Messages with people at my Work

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.

_____	_____	
Patient Signature	Date	
_____	_____	_____
Patient/Guardian Signature	Patient/Guardian Name (Print)	Date
_____	_____	_____
Witness Signature	Witness Name (Print)	Date