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
### PATIENT INTAKE: SOCIAL/FAMILY HISTORY

**Patient Name**

<table>
<thead>
<tr>
<th>(Circle one)</th>
<th>Married</th>
<th>Single</th>
<th>Long-term relationship</th>
<th>Divorced/Separated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years married/ in long-term relationship</td>
<td>Times Married</td>
<td>Times Divorced</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Children?**
- ( ) N
- ( ) Y

**Residing with you?**
- ( ) N
- ( ) Y

**Where are you currently living?**

**Do you have family nearby?**
- ( ) N
**Please describe**

**Education**
- ( ) Graduate school
- ( ) College
- ( ) Professional or Vocational school
- ( ) High school

**Years in education**

**Are you currently employed?**
- ( ) N

**What type of work do/did you do?**

**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
- ACOA
- NA
- OA
- CA

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

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

**Date of birth**

**Age**

**SS#**

**Emergency contact**

**Relationship to patient**

**Primary care physician**

**Date of last physical**

**Have you ever had an EKG?**

**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**
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) ________________________________

MD NOTES ___________________________________________________________

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 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

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes/Past Or Yes/Now</th>
<th>Route</th>
<th>How Much</th>
<th>How Often</th>
<th>Date/Time Of Last Use</th>
<th>Quantity Last Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
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<tr>
<td>Caffeine (pills or beverages)</td>
<td></td>
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<tr>
<td>Cocaine</td>
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<tr>
<td>Crystal Meth-Amphetamine</td>
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<tr>
<td>Heroin</td>
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<tr>
<td>Inhalants</td>
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<tr>
<td>LSD or Hallucinogens</td>
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<tr>
<td>Marijuana</td>
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<tr>
<td>Methadone</td>
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<tr>
<td>Pain Killers</td>
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<td>PCP</td>
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<tr>
<td>Stimulants (pills)</td>
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<tr>
<td>Tranquilizers/ Sleeping Pills</td>
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<tr>
<td>Ecstasy</td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>
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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4 of 4
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
TELEPHONE APPOINTMENT REMINDER CONSENT

I, ______________________, give Donald R. Taylor, M.D. and members of his/her staff working at the 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