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 **Methadone/Buprenorphine Treatment Demographic Form**

**Do you require any special accommodations (equipment or interpreting services)? YES NO**

**Have you had any suicidal thoughts in the last 72 hours? YES NO If yes, STOP here, refer to CRISIS/Counselor**

**Are you currently using Opioids? YES NO If Yes, How Long? \_\_\_\_\_\_\_\_\_\_\_**

**Are you currently enrolled in a Medication Assistance Treatment? YES NO If Yes, Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please Fill out Form completely ON BOTH SIDES, mark N/A if not applicable:**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there any chance you could be pregnant? YES NO If Yes, What is the expected DUE DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip-code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How do you identify yourself: MALE FEMALE TRANSGENDER (M-F) TRANSGENDER (F-M)?**

**Race:** African American **Ethnicity:** Hispanic **Education:** 6 7 8

 Asian Non-Hispanic 9 10 11 12

 Caucasian Other Trade School

 Hispanic Some College

 Native American 2 Yr. - Associates Degree

 Other: \_\_\_\_\_\_\_\_\_\_\_ 4 Yr. – Bachelor’s Degree

Master’s DegreePh. D

**Marital status:** Married Separated Divorced Single

**Family Size: \_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_ Eye Color: \_\_\_\_\_\_\_\_\_\_\_\_ Hair Color: \_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Income: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID# \_\_\_\_\_\_\_\_\_\_\_**

**Status: Referral:** TV

Disabled Social media (Facebook, Instagram, Twitter, etc.)

Full Time Employment Radio Word-of-mouth

Homemaker Medical office other addiction facility

Part Time Employment Court Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Not Employed

Retired

**Emergency Contact:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PCP:** (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatrists:** (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_

**OB/GYN:** (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_

**Other M.D.:** (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse/Partner:** (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Household members that are OMR patients:** (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Clinics that you have attended** (Buprenorphine 12 months/ Methadone 10 years)

 (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION NAME***(Brand or Generic Name)* | **DOSAGE***(mgs, units, puffs or drops)* | **WHEN DO YOU TAKE IT?***(How many times per day?**Morning & Night? After Meals?)* | **PURPOSE & PRESCRIBING DOCTOR** |
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**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that my alcohol/drug records are protected under the Federal Regulations governing Confidentiality of Substance Use Disorder Patient records 42 CFR part 2 and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”); 45 CFR parts 160 & 164. The Federal regulations governing Confidentiality of Substance Use Disorder Patient Records 42 CFR part 2 will continue to protect the confidentiality of the information that identifies me as a patient in an alcohol or other drug program from-re-disclosure. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and in any event that this consent expires. This consent will automatically expire upon discharge from the program.**

 REGISTRATION CONSENTS

AND PRIVACY ACKNOWLEDGEMENTS

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment, test results or for Diversion Call Backs?

\_\_\_\_\_Yes \_\_\_\_\_No if no, is there another number at which we may try to reach you? ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I hereby consent to receive autodialed calls and/or text messages to the phone number provided, and consent to pre-recorded or artificial voice calls, which may include, without limitation, messages to remind me of upcoming appointments and about available healthcare services from or on behalf of Overmountain Recovery. If the telephone number I have provided is changed or re-assigned to another person, I agree to promptly notify Overmountain Recovery of the change.

\_\_\_\_\_Yes \_\_\_\_\_No

3. May we mail to the address you provided information regarding your appointment or test results?

\_\_\_\_\_Yes \_\_\_\_\_No if no, is there another address at which we may send you information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you wish us to share health information such as your upcoming appointments, test results, scheduled tests/procedures, and/or medications with a family member or friend?

\_\_\_\_\_Yes \_\_\_\_\_No if yes, please provide name of person(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **RELEASE OF RECORDS**

I understand a request of my records will not include psychotherapy notes. All records requests will be reviewed by the medical director and a summary of care may be provided if appropriate.

**CONSENT TO PHOTOGRAPH**

I understand that photographs, videotapes, digital or other images may be made or recorded to document my care. I understand that Overmountain Recovery will retain ownership rights to these recordings or other images, but that I will be allowed to view them or obtain copies. I understand that these images will be stored in a secure manner to protect my privacy and that they will be kept for the time period required by law or Overmountain Recovery policy. Images that may identify me may be disclosed for treatment, payment, or health care operations (e.g., for purposes of training medical students), or when required by law.

 REGISTRATION CONSENTS

AND PRIVACY ACKNOWLEDGEMENTS

**CONSENT TO TREAT**

I authorize the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant, and nurse practitioner, and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

I agree and consent to the withdrawal and testing of my blood, without further consent by me, in the event that there is an accidental blood borne pathogen exposure to any medical, nursing or other clinical staff, in order to test such blood for the presence of Hepatitis B virus or HBV, Hepatitis C virus or HCV, and Human Immunodeficiency Virus or HIV. I understand and agree that the results of such laboratory testing shall be maintained confidential, except to my treating healthcare providers, any clinical staff so exposed, and as may be allowed by any applicable state or federal statute, regulation or rule of law.

This means that if any medical practice personnel or physicians are exposed to my blood through a needle stick, blood splash or other means while I am being treated, I agree to allow my blood to be drawn and tested for HIV or Hepatitis. The results will be kept confidential except to my physician, any healthcare personnel caring for me, the medical practice personnel exposed or as required or allowed by law. This will be at no charge to me.

If your UDS shows illicit substances, you may be required to confirm that you have a driver until the next random UDS shows compliance with the program. This is at the discretion of the Medical Director. In addition, if you appear to be impaired, you may not be allowed to dose or may be dosed at a lower amount at the discretion of the medical director. If you are allowed to dose, you must provide confirmation that you have a driver. If you do not have a driver, you may not be allowed to dose at any amount.

**BY SIGNING AND DATING THIS ATTACHED SPACE, I ACKNOWLEDGE NOTICE AND RECEIPT OF THE ABOVE INFORMATION, AND RECEIPT OF THE NOTICE OF PRVACY PRACTICES.**

Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Authorized Representative Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Authorized Representative, relationship to Patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

*I understand that my alcohol/drug records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient records 42 CFR part 2 and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”); 45 CFR parts 160 & 164. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR part 2 will continue to protect the confidentiality of the information that identifies me as a patient in an alcohol or other drug program from-re-disclosure. I understand that I have the right not to sign this consent, but by doing so I may be denied admittance to this treatment program. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and in any event that this consent expires. This consent will automatically expire upon discharge from the program.*

**patient rights & RESPONSIBILITIES**

* 1. All patients at Overmountain Recovery have the following rights:
		1. In regards to Confidential Records:
			1. All applications, certificates, records, reports and all legal documents, petitions and records made or information received pursuant to treatment in an OTP directly or indirectly identifying a client shall be kept confidential and shall not be disclosed by any person except the individual identified
			2. As a court may direct upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make such disclosure would be contrary to the public interest or detrimental to either party to the proceedings, consistent with the provisions of 42 C.F.R. Part 2.
		2. Nothing in this Rule shall prohibit disclosure, upon proper inquiry, of information as to the current medical condition of a client to any members of the family of a client or to his relatives or friends providing that conditions of 42 C.F.R. Part 2 and HIPPA have been met.
		3. Patients shall not be abused or neglected.
		4. Patients shall receive a copy of his/her rights.
		5. Other patient rights include the:
			1. Right to a humane treatment environment that affords reasonable protection from harm, exploitation and coercion
			2. Right to be free from physical and verbal abuse
			3. Right to be informed about the individualized plan of treatment and to participate in the planning, as able
			4. Right to be promptly and fully informed of any changes in the plan of treatment
			5. Right to accept or refuse treatment
			6. Right to confidentiality of client records
			7. Right to be informed of the facility’s complaint policy and procedures and the right to submit complaints without fear of discrimination or retaliation and to have them investigated by the program within a reasonable period of time
			8. Right to receive a written notice of the address and telephone number of the Tennessee State licensing authority, i.e. the Tennessee Department of Mental Health and Substance Abuse Services
			9. Right to obtain a copy of the facilities most recent completed report of licensing inspection from the facility upon written request. The facility is not required to release a report until the facility has had the opportunity to file a written plan of correction for the violations as provided for in these rules.
	2. Patients also have the right to:
		1. Privacy, except as it pertains to diversion control and drug screening. Every attempt will be made to ensure the client’s dignity in conducting drug screens.
		2. Freedom from:
			1. Financial or other exploitation
			2. Retaliation
			3. Humiliation
			4. Abuse
			5. Neglect
		3. Access to information pertinent to the person served in sufficient time to facilitate his or her decision making
		4. Informed consent or refusal and expression of choice regarding:
			1. Service delivery
			2. Release of information
			3. Concurrent services
			4. Composition of the service delivery team
			5. Involvement in research projects
		5. Access or referral to legal entities for appropriate representation
		6. Access to self-help and advocacy support services
		7. Adherence to research guidelines and ethics when persons served are involved
		8. Investigation and resolution of alleged infringement of rights
		9. Provision of care in the least restrictive environment
		10. Adequate and humane care
		11. Evidence-based information about alternative treatments, medications and modalities
		12. Access to the record by the person served with clinical staff supervision
		13. Timely response to requests for copies of the records of the persons served. Patients will make written request for copies and staff will comply with requests within three business days. Patients may be required to pay for such copies.
		14. Protection from the behavioral disruptions of other persons served
		15. Equal access to treatment for all persons in need regardless of race, ethnicity, gender, age (with specific reference to policies for minors), sexual orientation and sources of payment
		16. Be notified that individuals have the right to:
			1. Be informed of appeal procedures
			2. Initiate appeals
			3. Have access to grievance procedures posted in conspicuous places
			4. Receive a decision in writing
			5. Appeal to unbiased sources
	3. Patients are responsible for the following:
		1. To provide complete and accurate information about medical history, previous hospitalizations, current health and to report effects of treatment provided.
		2. Consider the rights of other patients
		3. Follow all reasonable instructions of the physician and other staff to the best of your ability.
		4. Provide the clinic with a copy of Advance Directive or the substance of those documents if you did not bring them with you.
		5. Request explanation of services provided.
		6. Fulfill the financial obligations of your care.
		7. Keep appointments and give notification if unable to do so.
		8. Abide by the smoking policy which is reviewed in the handbook and discussed in orientation.
		9. Abide by the program expectations which are reviewed in the handbook and discussed in orientation.
		10. Read the handbook and sign the patient agreement

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient signature Date