

Rehabilitation Care Group, Inc.

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# _____

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)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma/respiratory | <input type="checkbox"/> Cardiovascular (heart attack, high cholesterol, angina) | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Epilepsy or seizure disorder | <input type="checkbox"/> GI disease |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Pancreatic problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> STDs | <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> 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 _____

Is there a family history of anything NOT listed here? (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 _____

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 (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							

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

What was your longest period of abstinence? _____

MD NOTES _____

Rehabilitation Care Group, Inc.

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 (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

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

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

Financial Policy

This is an agreement between Rehabilitation Care Group, Inc. as creditor, and the patient/debtor named on this form.

In this agreement the words “you,” “your” and “yours” mean the patient/debtor. The word “account” means the account that has been established in your name to which charges are made and payments are credited. The words “we,” “us” and “our” refer to Rehabilitation Care Group, Inc.

By executing this agreement, you are agreeing to pay for all services that are rendered to you. This program is not in contract with any insurance; however, as a courtesy, a claim form with appropriate codes and fees relative to your treatment can be provided to you for you to file with your insurance for possible reimbursement.

Treatment and Payment:

___ The first phase of the Buprenorphine Program is \$2,000.00. This phase of the program will last three (3) months, and will include an induction visit which includes a consultation, comprehensive history and physical, urine drug screening, and administration of Suboxone, as well as all follow-up appointments during the three month period. Also included are six (6) Group Counseling Sessions and one (1) Individual (one-on-one) Counseling Session. Payments will be accepted in five (5) \$400.00 increments, with the initial payment due at the time of the induction visit, and the following four (4) payments every two to three weeks thereafter.

___ If you are currently participating in private counseling, the program fee is \$1,500, and can be paid in four (4) payments of \$375. However, a letter from your counselor indicating participation must be provided to your RCG program physician.

___ Modified Maintenance Program: (*Patients who are currently being **prescribed** Suboxone; transferring from another program*) Fee: \$500/First Month (*includes two visits during first month*); then \$250/visit (*usually monthly follow-up visits*)

At the conclusion of the 3-Month Program, Phase Two--Maintenance Phase will begin at the discretion of the patient and the physician. Follow-up visits are usually once a month and may last three approximately (3) to six (6) additional months. During Phase Two the fee for each appointment will be \$250.00, and payable at the time of each appointment. At the end of each appointment, your next appointment will be scheduled. This pattern will continue until the end of the program.

Drug Testing and Lab Services: Included in the established fee are three (3) urine drug screenings. If more drug screenings are required, the fee of \$25 is your responsibility.

Methods of Payment: Payment is to be made by **cash or credit/debit card only**.

Effective Date: Once you sign and date this agreement, you agree to all terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____

Other Responsible Party: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____

Rehabilitation Care Group, Inc.

PATIENT TREATMENT CONTRACT

Patient Name _____

Date _____

As a participant in buprenorphine 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 agree to adhere to the Financial Policy which I signed prior to the beginning of treatment.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. 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.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. 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 my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. 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.
8. 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.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. 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).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition. I agree to participate in 6 group counseling sessions, and 1 individual counseling session within 3 months of beginning treatment. I understand that failure to participate in these sessions may result in my treatment being terminated.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except for nicotine).
14. I agree to provide random urine samples and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment.

Patient Signature

Date

*Valium[®] is a registered trademark of Roche Products Inc.

†Klonopin[®] is a registered trademark of Roche Laboratories Inc.

‡Xanax[®] is a registered trademark of Pharmacia & Upjohn Company

Rehabilitation Care Group, Inc.

6164 CLEVELAND AVENUE, COLUMBUS, OH 43231

(614) 901-0590 (614) 901-0539-FAX

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) _____
- Release my treatment information to: _____

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 in 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

Parent/Guardian Signature

Parent/Guardian Name (Print)

Date

Witness Signature

Witness Name (Print)

Date

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