ELITE METHADONE CLINIC

Patient ID: _____

Date: _____

A. Patient Information

Name: _____ AKA/Pronouns _____

Address:_____

Cell Phone #: _____ Other Phone #: _____

Email: _____

Date of Birth: _____ Social Security #: _____ DL#: _____

Sex: ☐ M ☐ F ☐ Other _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Pregnant: ☐Yes ☐No ☐N/A

Ethnicity: ☐ Caucasian ☐African American/Black ☐Hispanic/Latino_____

☐Native American ☐Asian ☐Bi-racial ☐Other _____

Sexual Orientation: ☐ Heterosexual ☐Homosexual ☐ Bisexual ☐Other_____

Marital Status: ☐Married ☐ Single ☐Divorced ☐Widowed

Employment: ☐Employed FT ☐Employed PT ☐ Unemployed ☐Disabled ☐Retired

☐Homemaker ☐Student

B. Insurance information

Insurance: _____

Insurance ID #: _____

C. Emergency Contact

In case of emergency, notify: _____

Relation: _____

Phone #: _____

Who can we thank for sending you to us or how did you hear about our facility? _____

_____

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methadone@eliteprimarynm.com • ELITEPRIMARYNM.COM

ELITE METHADONE CLINIC

Patient ID: _____

CONSENT TO OPIOID PHARMACOTHERAPY TREATMENT

I hereby authorize and give my voluntary consent to the Program Medical Director and/or any appropriately authorized assistants (s)he may select, to administer or prescribe the drug methadone or buprenorphine as an element in the treatment for my dependence on opiate drugs. The procedures necessary to treat my condition have been explained to me, and I understand that it will involve my taking daily dosages of methadone or buprenorphine which will help control my dependence on opioid drugs.

In conjunction with methadone or buprenorphine, I will be assigned a counselor to assist me with resolving personal and/or life problems. A schedule will be established for regular counseling, group and educational sessions. I will work cooperatively with my counselor on establishing a treatment plan and strategies for obtaining my goals. Opioid treatment alone is not a total solution. I understand that active participation in my overall treatment will result in long term success. It has been explained to me that methadone/buprenorphine are narcotic drugs which can be harmful if taken without medical supervision. I further understand that methadone/buprenorphine is an addictive medication and may, like other drugs used in medical practice, produce adverse results. I have been made aware that in early phase of treatment this medication may cause me to feel drowsy or light-headed. I should request increases of my dose only as I have need during the initial phase of treatment. I will report to the medical staff, nursing staff, or my counselor if I have any questions about how I feel or my adjustment to the medication. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, but I still desire to receive methadone/buprenorphine due to the risk of my return to the use of opiate drugs.

The goal of this treatment is total rehabilitation. Eventual withdrawal from the use of all drugs, including methadone and buprenorphine, is an appropriate treatment goal. I realize that for some patient's opioid treatment may continue for relatively long periods of time, but that periodic consideration shall be given concerning my complete withdrawal from methadone/buprenorphine use. I understand that I may withdraw from this treatment program and discontinue the use of the drug at any time, and I shall be afforded detoxification under medical supervision.
Because certain other drugs do not interact well with methadone/buprenorphine, even if prescribed by a doctor, I must inform any doctor or dentist treating me of my status as a methadone patient. Notification of my doctor will assist him / her to properly prescribe medications for me as needed. I am to take my medication as prescribed by the Program doctor. This means that I am never to take more than my prescribed dose within a 24-hour period. I also understand that during treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me. I understand that these alternate procedures shall be used when in the Program Medical Director's judgment, it is considered advisable.
BUPRENORPHINE PRODUCTS: I HAVE BEEN INFORMED THAT EXTREME ILLNESS, CALLED PRECIPITATED WITHDRAWAL, COULD RESULT FROM HAVING OPIOIDS IN MY SYSTEM WHILE BEING INDUCTED ONTO BUPRENORPHINE. I WILL PROVIDE MEDICAL STAFF ACCURATE INFORMATION REGARDING MY DRUG USE AND MEDICATIONS.

FEMALE PATIENTS OF CHILD -BEARING AGE

It has been explained to me and I understand that methadone or buprenorphine may be transmitted to the unborn child and may cause physical dependence. I understand that if I am pregnant and suddenly stop taking methadone or buprenorphine, I and/or the unborn child may show signs of withdrawal which may adversely affect my pregnancy and/or the child. I shall use no other drugs without the Medical Director's or his/her assistant's approval, since these drugs may harm me and/or my unborn child. I shall inform any other physician who sees me during my present or any future pregnancy or who sees the child after birth, of my current or past participation in a narcotic treatment program in order that he/she may properly care for my child and me. I understand that for a brief period following the birth, the child may show temporary irritability or other ill effects due to my use of methadone. It is essential for the primary physician to know of my participation in a narcotic treatment program so that he/she may provide appropriate medical treatment for the child.
As the above possible effects of Methadone/Buprenorphine have been fully explained to me, I consent to its use and promise to inform the Medical Director or one of his/her assistants immediately if I become pregnant in the future. I certify that no guarantee or assurance has been made as to the results that may be obtained from opioid treatment. With full knowledge of the potential benefits and possible risks involved, I consent to Methadone treatment, since I realize that I would otherwise continue to be dependent on opiate drugs.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

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ADVISORY OF OVERDOSE RISK

It is possible to overdose on methadone. The risk of overdose increases if you take other drugs like alcohol, benzodiazepines, or other opiates when you are on methadone. All patients of the program will be provided with a prescription for Narcan to have filled at their pharmacy choice. The program advises having Narcan in your home and with loved ones to reverse an overdose.

Children and other adults: People who are not used to taking methadone can easily overdose and die on very small amounts. This is especially the case for children. If you have a take-home dose it is extremely important to keep it out of reach of children at all times.

IF YOU SUSPECT AN OVERDOSE, CALL 911 IMMEDIATELY AND ADMINISTER NARCAN, IF POSSIBLE.

Signs of overdose include:

- nausea and vomiting
- slurred speech
- unsteady on feet
- slow and shallow breathing
- confusion, extreme drowsiness and nodding off
- snoring or gurgling noises
- pale skin, blue lips and nails.

Methadone Toxicity: This may lead to collapse, loss of consciousness, and coma. As oral methadone can be slow acting, a collapse due to overdose may not occur until 3 to 24 hours after the dose.

Kidney/Liver Disease: The risk of overdose also increases when you have a disease of the kidney or liver, such as hepatitis, because drugs are cleared from your blood at a slower rate than normal.

Interactions with other drugs

It is dangerous to mix methadone with other drugs without medical supervision. Unconsciousness and death have occurred as a result of mixing methadone with some drugs. Using other drugs, whether prescription or not, while on methadone can be dangerously unpredictable. If you are taking any drugs, make sure you tell your doctor or pharmacist and ask them about any interactions these might have with your methadone. If you are going to see another doctor, dentist or pharmacist, or are going to a hospital, you must inform them of your methadone status.

Alcohol: Methadone and alcohol can be dangerous because they are both sedatives and mixing them can cause an overdose. Drinking large amounts of alcohol over a short period can make you drowsy and affect your ability to drive. Alcohol adds to the effect of methadone and increases the risk of overdose, especially when also mixed with sedatives or pills. Drinking large amounts of alcohol regularly can, over time, also shorten the length of time methadone has an effect, causing you to hang out before your next dose. If you have hepatitis C, the liver is much more sensitive to the harmfuleffects of alcohol. Pregnant women are advised not to drink at all because of the risk to the unborn child.

Prescription Medications: Many drugs combined with methadone can cause drowsiness and in some cases unconsciousness and overdose. They should not be taken while you are on methadone without your doctor's approval. These drugs include but are not limited to: benzodiazepines (like Xanax and Valium); chloral hydrate; opioids (like Oxycontin and Percocet).

I have been explained and understand the risks of overdose associated with the use of opioid pharmacotherapy and choose to begin treatment.

_____ _____

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TELEMEDICINE POLICY

1. I understand that my healthcare provider wishes me to engage in a telemedicine consultation.
2. I understand that video and audio technology will be used during the telemedicine consultation and have been explained that an approved HIPPA-compliant platform will be used to protect my privacy. I also understand that my consultation will never be recorded or stored.
3. My healthcare provider has explained to me how the video conferencing technology will be used to affect such a consultation. This will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/ physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
6. I have had the alternatives to a telemedicine consultation explained to me and am choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting healthcare provider.
7. In an emergent consultation, I understand that the responsibility of the telemedicine provider is to advise my local provider and that the telemedicine provider's responsibility will conclude upon the termination of the video conference connection.
8. I understand that billing will occur from both my telemedicine provider and as a facility fee from the site from which I am presented.
9. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

☐ **I AGREE TO TELEMEDICINE AND ACKNOWLEDGE:**

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s) and have willfully decided that the benefits of telemedicine outweigh any risks.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

☐ **I DECLINE TELEMEDICINE SERVICES AT THIS TIME.**

_____ _____

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_____ _____

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Patient ID: _____

AUTHORIZATION TO RELEASE INFORMATION FOR PAYMENT & FINANCIAL RESPONSIBILITY

Name:_____ Date of Birth: _____

Insurance Identification Card Number:_____

☐ I do not have insurance. I will notify the Program if this changes.

Authorization to Release Information for Payment

I hereby authorize and give my consent to Elite (my "provider") and its agents and employees to release to my insurance company or companies, their affiliated entities, contractors, subcontractors, and agents, and any and all parties involved in the review, processing, and payment of claims related to services provided to me by my Provider, the following medical information regarding my treatment: (1) a statement of my status in the opioid treatment program operated by my Provider, including any and all information necessary for the purpose of enrollment and/or maintenance of my eligibility for health insurance coverage; and (2) any and all information needed to substantiate and submit claims to my insurance company or companies for treatment received from my Provider.

I understand that I may revoke this authorization in writing at any time, but my Provider will continue to be authorized to make disclosures necessary to receive payment for services rendered to me on or before the date of revocation. I also understand that this authorization shall be effective for up to six (6) months after my last date of service at my provider, or until revoked by me, whichever is earlier.

Financial Responsibility

I understand that the purpose of this authorization is to permit my Provider to bill and collect payment for my treatment. Although my Provider will attempt to confirm my insurance coverage before my treatment, I acknowledge it is my responsibility to give my Provider current and accurate insurance information, including any updates or changes in coverage. I also understand that if I fail to do so and as a result, my Provider is unable to verify eligibility or receive payment from an insurer, I will be personally responsible for paying for any services or treatment provided. I understand that I am financially responsible for charges rendered in any case in which payment is denied for a failure to comply with coverage requirements or for any other reason.

Assignment of Benefits

An assignment of benefits is a patient's request that his or her health insurance benefit payments be made directly to a designated person or facility, such as a hospital or medical clinic. I hereby authorize the assignment of my health insurance benefit payments directly to my Provider, and I appoint my provider as my true and lawful attorney-in-fact, coupled with an interest, to enable my Provider to (1) receive all payments due under my insurance coverages for treatment provided to me, and (2) pursue any legal or administrative claim arising under any insurance coverages concerning medical expenses incurred as a result of the treatment I receive from my Provider.

A photocopy of this document is to be considered as effective and valid as the original. If any part or provision of this document should be held void or invalid, the remaining provisions shall remain in full force and effect.

I have red and agree to these billing and payment policies, and my responsibilities described above.

_____ _____

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_____ _____

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PATIENT FEE AGREEMENT

Services must be paid for at the time they are received. Sunday's dosing fees must be paid on Saturday in order to receive a take-home for Sunday. Approved holiday dosing fees must also be paid the business day before the holiday. The program accepts cash, debit, and credit cards. No personal checks are accepted.

The program accepts Medicaid. Photo ID and insurance card are required at admission or registration. It is the patient's responsibility to provide the program with current, accurate, and complete insurance information. **Lapse or termination of insurance coverage or pre-authorization will result in patient's assuming responsibility for payment of services.**

FEES:

Methadone – Intake Fee	$25.00	Buprenorphine – Intake Fee	$50.00
Methadone – Daily Dose	$12.00	Buprenorphine – Daily Dose	$16.00
Methadone – Guest Dose Fee	$14.00	Buprenorphine – Guest Dose Fee	$18.00
Medication Lockbox	$20.00		

FAILURE TO PAY: All fees must be paid before services are rendered. Inability to pay may result in a humane detoxification and/or discharge after 14 consecutive days of not dosing. Patient will be provided with alternative treatment options and referred appropriately.

_____ _____

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_____ _____

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CONSENT FOR DUAL ENROLLMENT CHECKS

The program is required to notify each patient prior admission that we are unable to provide methadone or buprenorphine to a patient who is simultaneously receiving treatment from another program.

To confirm you are not enrolled in another program, the following will be sent to programs within a 100-mile radius:

1. Name, Social Security Number, and Birthdate
2. Admission Date
3. Dates of termination or re-admission

Methadone will not be provided to you if you are found to be receiving methadone at another program. If it is found that you are attempting to duplicate doses, you will be referred back to the original program with a written report describing the attempt. This includes receiving methadone from any private physician, hospital, or emergency room.

You may revoke this consent at any time except to the extent that action has been taken inreliance on it and that in any event this consent expires automatically upon completion of my treatment at Elite.

I understand and agree to the above and confirm that I am not receiving methadone from another program. I understand that if I do not sign this statement I will not be admitted to treatment.

_____ _____

Patient Signature Date

_____ _____

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PRESCRIPTION DRUG MONITORING PROGRAM

Prescription Drug Monitoring Program (PDMP) is a database for prescribers to help reduce prescription drug misuse, abuse, and diversion. This database includes a comprehensive list of an individual's prescribed and dispensed narcotic medications. Our providers will use this information to ensure that patients are not taking medications that may be contraindicated with methadone/buprenorphine treatment.

The Program's medical providers and Program Director will complete a PDMP search for the following reasons: upon intake; phase increase requests; clinical team determination; suspicion of drug abuse; medical monitoring purposes; and randomly.

This consent is valid until the patient has been discharged from treatment. Due to the danger of using more than one controlled substance at a time, patients will be required to authorize coordination of care with all prescribers to remain in treatment.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

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Patient ID: _____

PROGRAM EXPECTATIONS

I hereby request admittance to Elite for Methadone Maintenance Treatment (MMT). I understand that participation in MMT is voluntary and that may terminate at any time. As part of my treatment, I agree to the following program expectations (patient to initial each line):

- I will actively participate in the preparation of a treatment plan and in the administration of my treatment plan.
- I will attend all scheduled appointments made with the clinic staff and will meet with my counselor at least once a month.
- I will not abuse drugs or alcohol and will not come to the clinic high or intoxicated.
- I will not bring drugs or alcohol onto the clinic premises and will not try to sell or buy them on clinic premises. This includes methadone.
- I will not possess weapons on the clinic premises.
- I will not alter my UAs in any way and understand that a temperature gun will be used when a sample is submitted.
- I will not misuse or sell my methadone.
- I will not loiter on clinic premises. I will come in, pay, dose, and leave the property.
- I will not threaten or use violence towards other patients or staff. I understand that I will be terminated from this clinic immediately if I do so.
- Any non-client I bring to this clinic or is associated with me is subject to these regulations while on clinic property. Visitors in violation of clinic rules may be banned from the property.
- I understand that violation of program expectations will result in at least one of the following actions, depending on the severity of the violation:
    - Meeting with my primary counselor and signing a written contract outlining specific expectationsto address the violation.
    - Meeting with the Program Director and signing a written contract as above.
    - Termination from the Program

I have been given a copy of the program expectations and understand all of the rules and regulations as noted above.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

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PATIENT RIGHTS

1. Is admitted to treatment without regard to race, color, creed, national origin, religion, sex, sexual orientation, marital status, age, or disability.
2. Is reasonably accommodated in the event of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences.
3. Is treated in a manner sensitive to their individual needs such as age, gender, sex, social preference, cultural orientation, psychological characteristics, sexual preferences/orientation, physical situation, and spiritual beliefs.
4. Is treated in a manner that promotes dignity and self-respect, including adequate space to accommodate the need for privacy during visits, therapeutic interventions, and urine drug screening collections.
5. Is involved in all aspects of their individual plans, including but not limited to treatment planning, transition planning, treatment termination, and medication changes.
6. Is protected from unwarranted invasion of privacy except that clinic staff may conduct reasonable searches to detect and prevent possession or use of contraband on clinic premises.
7. Has the right to refuse to participate in any experimental or investigative research without written and informed consent and has the guarantee that the organization will adhere to research guidelines and ethics when persons served, if applicable.
8. Has all clinical and personal information treated in accord with federal and state confidentiality laws, regulations, and guidelines and as outlined in the organization's policies and procedures.
9. Has the opportunity to review his/her own patient treatment records in the presence of the clinic director of his/her designee. Also, has the right to a timely response to requests for copies of records.
10. Has the opportunity to know the identification and professional status of the persons providing services and to have clinical contact with a same-gender counselor if so requested and determined appropriate by the supervisor, either at the clinic or by referral.
11. Has the right to provision of care in the least restrictive environment and has the right to adequate and humane care.
12. Has the right to be protected from the behavioral disruptions of other patients.
13. Is fully informed regarding fees charged for treatment services and methods of payment available, which will include information such as fees for copying records, etc.
14. Is provided reasonable opportunity to practice their religion of choice as long as the practice does not infringe on the rights and treatment of other patients or clinic staff. The patient has the right to refuse participation in any religious practice.
15. Is protected from abuse by staff or other patients who are on clinic premises at all times, including protection from:
    a. Sexual abuse or harassment
    b. Financial or other forms of exploitation
    c. Racism or racial/ethnic harassment
    d. Psychological abuse
    e. Physical abuse or punishment
    f. Retaliation
    g. Humiliation
    h. Neglect
16. Receives a copy of the patient complaint and grievance procedures upon request. The procedures will be prominently displayed and posted in clinic waiting areas. Any patient may file a grievance for any reason without fear of reprisal or punitive action.
17. In the event of clinic closure each patient shall be:
    a. Given thirty days' notice
    b. Assisted with relocation
    c. Given refunds to which the patient is entitled

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   d. Advised on how to access records to which the patient is entitled
18. Investigation and resolution of alleged infringement of rights.
19. A patient is entitled to all of the following:
   a. Services in accordance with standards of professional practice
   b. Services appropriate for the patient's needs
   c. Services designed to afford a reasonable opportunity for the patient to realize and attainindividualized treatment goals and objectives.
20. A service provider shall inform all patients of the following:
   a. The general nature of the treatment which is proposed and available
   b. The known effects of receiving and not receiving the treatment
   c. Evidence based information about alternate treatments, medications, and modality of treatment, if any.
21. Is made aware of the informed consent or refusal or expression of choice regarding concurrent services if applicable.
22. A patient will be given the opportunity to have any restrictions of their rights or privileges that have been lost while in treatment (due to rule violations, etc.…), reevaluated by staff in order toassess how the patient may regain lost rights or privileges. In addition, staff should routinely evaluate the purpose or benefit of any restriction of rights or privileges.
23. Information pertinent to the person served in sufficient time to facilitate his/her decision making.
24. Access or referral to:
   a. Legal entities for appropriate representation
   b. Self-help support groups
   c. Advocacy support services
25. Access to an interpreter if English is not the patient's first language.
26. Other legal rights as may exist or be identified.

_____ _____

Patient Signature Date

_____ _____

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ELITE METHADONE CLINIC

Patient ID: _____

CONFIDENTIALITY OF PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and Regulations. Generally, the program may not say to a person outside this program that a patient attends the program, nor disclose any information identifying a patient as an alcohol or drug user.

However, the exchange of confidential patient information in the absence of patient consent is allowed under the following circumstances:

1. The patient consents in writing; OR
2. The disclosure is allowed by court order; OR
3. The disclosure is made to medical personnel in a medical emergency; OR
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program; OR
5. The patient provides suicidal or homicidal threats to any person at the clinic; OR
6. Release of a Qualified Service Organization Agreement; OR
7. Notification of law enforcement and warning of intended victims (Tarasoff warnings)
8. Mandated reporting of suspected elder or child abuse.

Release of confidential patient information is not allowed by Federal law in the course of elder (versus child) abuse reporting. Elder abuse reports must be made anonymously, without disclosing confidential patient information.

Federal Law and Regulations do not protect any information about suspected child abuse or neglect from being reported under state law to the appropriate state and local authorities.

Government agencies that fund or regulate a program, private agencies that provide financial assistance or third-party payments to a program, and peer review organizations that review utilization or quality control may have access to program records without patient consent in order to conduct an audit or evaluation. Any person or organization that conducts an audit or evaluation must agree in writing that it will re-disclose patient-identifying information ONLY:

A. Back to the program; OR
B. Pursuant to a court order to investigate or prosecute a program (NOT A PATIENT); OR
C. To a governmental agency/Regional Accountable Entity (RAE) that is overseeing a Medicare or Medicaid audit or evaluation.

The Program Director determines if the agencies qualify for auditing and evaluations.

Violations of the Federal Law and Regulations by a program are a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. (See 42 U.S.C—290dd3—42. U.S.C.—290ee3—2.53 (c) (d) for Federal Law and 42 CFR, Part 2 for Federal Regulations.)

The confidentiality and exceptions of confidentiality of my records have been explained to me.

Patient Signature:_____ Date: _____

Staff Signature:_____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 amount the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that NMTS has the right to change its Notice of Privacy Practices from time to time and that I may contact NMTS 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.

Patient Signature:_____ Date: _____

Staff Signature:_____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice or Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reasons:

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ELITE METHADONE CLINIC

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EMERGENCY PROTOCOL

CONSENT TO EMERGENCY TREATMENT

I understand that a medical emergency may occur while on clinic premises. I therefore give my consent for the program to provide basic First Aid or CPR as necessary. I also consent for the Program to contact outside medical facilities or providers to provide emergency treatment. I understand that this may require that the outside provider be informed of:

1. My status as a methadone/buprenorphine patient
2. My current dosage
3. Any other relevant information necessary to provide effective medical treatment

IMPAIRED DRIVING/SAFE DRIVER DESIGNATION

1. I understand that during the induction phase of treatment on methadone or buprenorphine, the medical staff will be working very closely with me to achieve a balance between adequate relief of withdrawal symptoms and avoidance of over-sedation or toxicity from the medications, which means that extra time may be required in the facility.
2. I understand that methadone will accumulate in my system for the first five to seven days until my system achieves "steady state dosing".
3. I understand that the medical staff will be administering a low dose and increasing my dose slowly for the first week to protect me from possible toxicity.
4. I understand that if I feel over-sedated at any time during the course of my treatment, I will alert a staff member and will remain on site until assistance has been provided. If I am off site, I will await instruction from a staff member, prior to leaving my current location.
5. I understand that combining medication may have an adverse effect and result in over-sedation. I am responsible for informing a staff member, if I have taken any un-prescribed medication or if I have used medication outside of the prescribed frequency or dose.

The following conditions must be agreed to as terms of admission and continued treatment:

- I will not arrive at or leave facility impaired.
- I will designate a "safe driver" and sign a consent to this safe driver at time of intake.
- A taxi cab will be called in at my expense if my "safe driver" is not available.
- Authorities will be called if I leave the facility impaired.

SAFE DRIVER DESIGNATION

I agree to have my EMERGENCY CONTACT designated as my "safe driver."

DOSING & IMPAIRMENT:

Patients who are suspected to be under the influence when they present at the clinic will be required to have an Impairment Assessment completed by medical staff and/or a breathalyzer to determine whether they are appropriate for dosing.

PLAN FOR UNEXPECTED EVENTS

Our program will avoid closing its doors or interrupting dosing services at all costs. In the event that an unusual and/or unexpected event occurs, the Program will implement the following procedures:

1. Alternate Site Dosing
2. Extended Dosing Hours

Please review your Patient Handbook for alternate site dosing locations.

Patient Signature:_____ Date: _____

Staff Signature:_____ Date: _____

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Patient ID: _____

TAKE HOME REQUIREMENTS

The State regulation is that take home Methadone will only be approved when the patient is adhering to the requirements of theprogram and where daily attendance would be incompatible with gainful employment, education and/or homemaking. The Federal regulation is the same as the State regulation including loss of step level for unexcused absences. To receive take home medication, you must agree to the following provisions, to remain in compliance with all Federal, State, and Clinic regulations, and understand that you are responsible for any take home medications you receive from Elite.

Safety of Take-Home Medication:

1) You must take your medication only as prescribed.
2) You must store all medication in a safe, locked area, away from others, especially children.
3) Empty take-home bottles are to be brought back to the clinic on the first day you return for in-person dosing. It is your responsibility to black out/remove any identifying information and you must assume responsibility if any of your identifyinginformation is visible when take home bottles are disposed of.
4) There is to be no sharing, borrowing, or giving of lock boxes with or to others for any reason. If it is determined that you are engaging in such, you and the other patient may lose take-home privileges.
5) Once completed dosing, counseling, submitting of UAs, meeting with the doctor, nurse, or any other requirements on any givenday, you must leave the property and grounds immediately. Loitering on clinic grounds is strictly prohibited.

Security of Take-Home Medication:

1) A metal lock box with my patient number is required before any take home medication will be issued.
2) Misplaced, lost, or stolen Methadone must be reported to the clinic immediately and may result in loss of the current step level.Stolen Methadone must be reported to the police and verification of the police report will be given to the clinic. This does not mean that the Methadone will be replaced by the clinic.
3) Spillage of take-home dose must be reported immediately to the clinic. Replacement must be approved by the medical/staffing committee. This may not be approved.
4) If it is discovered that you are selling your take homes, you will lose y our privileges for an indefinite period of time, and you mayjeopardize your continued treatment with the program.

Take Home Requirements:

1) Regular attendance is required.
2) Regular counseling appointments are required (minimum of one time per month).
3) You must request dose increases from the Nurse (from your counselor first if it is after the induction period), but you will not begranted a dose increase until the pharmacy is able to process the request and you will not be able to increase on a Friday or Saturday.
4) You agree not to exhibit behavioral problems on clinic property.
5) You must agree to not engage in criminal activity while in treatment.
6) You are not able to receive take-home medication if you cannot keep it safely stored in your home.
7) You are required to pay in full for your medication at the time of pick-up.
8) All other Federal and State regulations need to be met and maintained for take-home privileges.

Take Home Schedule:

1) Your take-home schedule and/or change in schedule must be approved in advanced by your counselor and depending on the request, possible by the medical/staffing committee.
2) There is no drinking of take-home medication allowed in the clinic.
3) You must notify the clinic when you are unable to make your scheduled visit. If you do not notify the clinic, you are at jeopardy of losing your step/steps. If you are incarcerated, you will lose all take-home step levels until the clinic receives and reviews the documentation related to your incarceration. Approval for step levels to be reinstated needs to go through the medical/staffing committee and it is not guaranteed that you will be able to regain them.

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4) You will lose all step levels if incarcerated for selling, distributing, or otherwise being involved with illicit drugs.

Exceptions and Guest/Courtesy dosing:

1) Federal exceptions are allowed only once every 90 days.
2) Exceptions cannot be processed with less than a minimum of 7 working days.
3) To be eligible, you must meet the requirements for step level take-outs, and you cannot be approved if there is reasonable ability to courtesy guest dose at another clinic.
4) If a Federal Exception is approved, you will need to bring back supporting documents that verify that you engaged in the activities and at the time specified in the request.
5) Courtesy/ guest dosing requires a minimum of 7 working days to process. For emergency set-up, you must notify the clinic within at least one hour of closing (dosing hours) and it is not guaranteed that your request will be granted due to the receiving clinic's ability to accommodate you. You may be required to bring in proof of the emergency in order to be granted future emergency guest dosing.

Urinalyses (UAs):

1) You must submit to a UA when it is requested. If you refuse to submit a UA that is requested, you are at risk of losing your take-home privileges and if it occurs more than once you may be jeopardizing your treatment with the program.
2) Your UA must be submitted to the nurse prior to dosing.
3) Any foreign substance reported in the test results will result in 30 days of probation for the first offense. If there is a second offence within the next 30 days, or the next UA sample, you will lose your current Step Level and will need to meet all regulations/requirements/policies to start re-graining take-home privileges.
4) A pattern of multiple probationary periods may result in loss of step levels/take-home privileges.

Personal Information Updates:

1) The clinic must be notified as soon as possible of any changes regarding contact information including: home phone number, cellphone number, home address, and emergency contact information.
2) If you are going to be out of town for any reason, notify your counselor prior to leaving.

Call Backs:

1) When contacted by the clinic for diversion checks, you must return to the clinic within 24 hours if you live within a 50-mile radius, or 48 hours if you live beyond a 50-mile radius.
2) You will need to bring in all empty take-home bottles and unused medication bottles that are properly labeled and intact,showing no evidence of being tampered with or misused.
3) If you cannot be contacted due to not keeping a contact number current with the clinic, or are unable, or refuse to return within the specified time frame, you will lose my take-home privileges for a minimum of 90 days. Return of the take-home privileges willbe at the discretion of the medical/staffing committee.
4) A UA sample may be requested on your return and an inability to provide or refusal to submit may result in the outlinedconsequences.

I agree to keep my number up to date with clinic staff and will expect calls from the clinic for a diversion check at any time. I understand and agree to comply with the above rules and regulations.

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Staff Signature:_____ Date: _____

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ELITE METHADONE CLINIC

Patient ID: _____

CONSENT FOR FOLLOW-UP

I give the program permission to contact me and follow-up at the number on file should I be needed, be absent from treatment, or post-discharge. I also give my permission for my emergency contact to be contacted if I cannot be reached at the listed phone number. The designated family member or friend will be contacted only for the purpose of locating me. No other information will be provided.

I understand that I may revoke this consent at any time, except where disclosure has already been made. Notice of my revocation ay be given verbally or in writing. I also understand that my refusal to follow to allow a follow-up will not impair my ability to receive treatment with Elite, and that withdrawing my consent for follow-up will not have any bearing on my continuance in my treatment.

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PATIENT HANDBOOK

I have received a copy of the Patient Handbook. I agree to read the handbook fully and agree to abide by its contents.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

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