Carolina Pain and Weight Loss

NEW PATIENT INFORMATION RECORD

Failure to complete this entire form PRIOR to your appointment may result in rescheduling. This information is kept confidential and will be available to your health care team.

PLEASE BRING THIS COMPLETED FORM WITH YOU ON YOUR NEXT VISIT

Today's Date:____/____/_____

Last Name:_____ First:_____ MI:_____

Date of Birth:____/____/_____ Social Security #:_____ Sex:_____ Age:_____

Home Phone: _____ Mobile Phone:_ _____

Address:_____ City:_____ State:____ Zip:_____

E-mail :_____

Marital Status:_____ Spouse's Name:_____

Referring Physician: _____ **Telephone:** _____

Primary Care Physician: _____ **Telephone:** _____

PATIENT EMPLOYER INFORMATION

____Full-Time ____Part-Time _____Unemployed_____Student _____Retired ____Legally Disabled

Employer's Name:_____ Work Phone: ( )_____

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone: _____

PHARMACY INFORMATION

Name of Pharmacy_____ Phone_____

- List all things that you are **ALLERGIC** or have **BAD REACTIONS** to:

Allergic to:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

- Please list <u>all</u> your current medications below (include over-the-counterdrugs)

If you have a list, please hand to the nurse to copy (not front desk). Do not write meds down again!!

Name & Strength	**Prescribing Doctor**

SURGERIES

- List all **MAJOR Surgeries** which you have had in the past:

Name of Surgery	**Hospital/Facility and Year**

FAMILY HISTORY

Please list any **MAJOR-medical history** regarding family members:

Family Member:	**Medical History:**

CAROLINA PAIN AND WEIGHT LOSS

MEDICAL HISTORY

Cardiovascular:	YES	NO
Heart Attack	_____	_____
Stroke/TIA	_____	_____
High Blood Pressure	_____	_____
Chest pain/angina	_____	_____
Irregular heart beat	_____	_____

Gastrointestinal:		
Ulcers/gastritis	_____	_____
Frequent Constipation	_____	_____
Frequent Diarrhea	_____	_____
Hearburn/indigestion	_____	_____
Nausea	_____	_____
Incontinence of Stool	_____	_____

Hematologic		
Immune Disease	_____	_____
Hemophilia	_____	_____
Taking blood thinner	_____	_____
Frequent Nose bleeds	_____	_____
Bleeding problems	_____	_____
Liver Disease	_____	_____

Genitourinary:		
Kidney problems	_____	_____
Kidney stones	_____	_____
Problems Urinating	_____	_____
Sexual problems	_____	_____

Musculoskeletal		
Fibromyalgia	_____	_____
Arthritis	_____	_____
Syndrome	_____	_____
Skin color/temp changes	_____	_____

Constitutional			
Frequent fevers	_____		_____
Recent Weight Loss	_____	lbs.	_____
Recent Weight Gain	_____	lbs.	_____
Frequent nights sweat	_____		_____

Allerigic/Immunologic:		
Wheezing	_____	_____
Itching	_____	_____

Respiratory	YES	NO
Asthma	_____	_____
Smoking Now	_____	_____
# packs per day	_____	
Snoring	_____	_____
Chronic cough	_____	_____
Shortness of Breath	_____	_____

Neurological		
Seizures/epilepsy	_____	_____
Numbness	_____	_____
Weakness	_____	_____
Headaches	_____	_____
Dizziness	_____	_____
Restless Legs	_____	_____

Endocrine		
Thyroid Problems	_____	_____
Diabetes	_____	_____
On Insulin?	_____	_____
Liver problems	_____	_____
Hepatitis	_____	_____

Emotional/Psychiatric		
Depression	_____	_____
Anxiety/panic	_____	_____
Irritability	_____	_____
Suicidal thoughts	_____	_____

Ophthalmologic:		
Blurred Vision	_____	_____
Eye discharge	_____	_____

Ears, Nose, Throat:		
Hearing Loss	_____	
Bleeding Gums	_____	_____
Problems Swallowing	_____	_____

Integumentary:	
Rash/Hives	_____
Blistering of skin	_____
Skin Cancer	

Carolina Pain and Weight Loss

SOCIAL HISTORY

Do you have children? ( ) yes ( ) no
Number of Children: _____ Living with you:_____

- Do you drink alcohol? ( )yes ( ) no
- Do you ever have suicidal thoughts? ( ) yes ( )no
- Marital Status? ( ) Married ( )Single ( )Divorced ( )Widowed
- Work Status? ( )Full Time ( )Part Time ( )Unemployed ( )Retired ( )Disability
- Do you use recreational or illegal substances? ( )yes ( ) no
- Do you smoke tobacco? ( )yes ( ) no
- Have you ever been treated for addiction? ( ) yes ( )no

Carolina Pain and Weight Loss

Patient Name_____

1. Reason for visit.
   Substance(s)_____
   Last time used? _____ How often used?_____
2. Have you been treated with Suboxone in the past? ____yes ____no
   When was your last treatment?_____
   Who were your providers?_____
3. Is there any reason why your will not be able to provide routine urine samples? ____
   If yes please explain_____
4. List all past and present drug and/or alcohol treatment centers where you have been treated. _____ _____ _____
5. Why did you start taking opioids?_____
   _____
6. Are there reasons in the last question above still a problem? _____
   _____
7. How will you prevent a relapse?_____
   _____
8. Are you currently seeing a counselor for substance abuse?_____
   How often are you being seen?_____
9. Is anyone that you are living with addicted to drugs or alcohol?___yes ___no
   Who_____ What substance?_____
10. Who is your primary care provider? _____
11. Are you in any legal trouble that we should be aware of such as on parole or probation?___yes ___no
12. Please describe your current living arrangements._____
    _____

13. Does anyone in your family have a history of substance abuse? ____yes ____no
    If yes, please describe_____
14. Are you currently employed?____yes ____
    If yes, how many hours per week?_____

Are you pregnant? ____N/A ____yes ____no

The safety of your Suboxone medication or prescription is your responsibility. Requests for refills of your medication will not be honored without an appointment. We will not provide additional medication if your medication has been lost or stolen. It is at the discretion of the provider if you can continue in the program after lost or stolen medication.

I have completed this form truthfully and to the best of my ability.
Signature_____ Date_____

Carolina Pain and Weight Loss

Patient Treatment Agreement

Patient Name_____
Date_____

As a participant in treatment for a disease(s) of addiction with **CAROLINA PAIN AND WEIGHT LOSS**, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to be truthful and forthcoming with information regarding my medical conditions and behaviors, and I understand that this information may affect my treatment.
2. I agree to keep and be on time to all scheduled appointments.
3. I agree to conduct myself in a courteous manner in the provider'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 may result in my treatment being terminated without recourse for appeal.
5. I agree not to use any illicit substances or to use any prescription medications in any way other than that which is indicated by the healthcare provider during treatment with this office. I further understand that illicit or unapproved use of drugs and/or medication may result in serious negative health effects including but not limited to overdose, seizure, impairment, intoxication, and death.
6. I agree not to conduct any illegal or disruptive activities in or near the provider's office.
7. I agree that my medication/prescription can be given to me only at my regular office visit. A missed visit may result in not being able to get my medication/prescription until the next scheduled visit. I acknowledge that prescriptions will not be called in by phone.
8. I agree that the medication I receive is my responsibility and I agree to keep it safe and secure. I agree that lost medication will not be replaced for any reason.
9. I agree not to obtain medications from any providers, pharmacies, hospitals, or other sources without telling my treating healthcare provider.
10. I agree to take my medication as my provider has instructed and not alter the way I take my medication without first consulting my provider.
11. (Females only) I will inform my treating healthcare provider immediately if I become pregnant or decide to become pregnant. I am aware that if I become pregnant while taking these medicines, the baby will be physically dependent on opioids. I am aware that there is a chance my baby will have a birth defect while I am taking an opioid.
12. (Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This could affect my mood, sexual desire, and physical and sexual performance. I understand that my provider may check my blood to see if my testosterone level is normal.
13. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my provider.
14. I agree to provide random urine samples and have my provider test my blood alcohol level.
15. I understand that violations of the above conditions may be grounds for termination of treatment.

Patient Signature_____
Date_____

CAROLINA PAIN AND WEIGHT LOSS

SUBOXONE TREATMENT MAINTENANCE

Suboxone treatment may be discontinued for several reasons:

- Suboxone controls withdrawal symptoms and is an excellent maintenance treatment for many patients. If you are unable to stop your drug abuse or if you continue to feel like using narcotics, even at the top doses of Suboxone, the provider will discontinue treatment with Suboxone and you will be required to seek help elsewhere.

- There are certain rules and patient agreements that are part of Suboxone treatment. All patients are required to read and acknowledge these agreements by signature upon admission to the treatment panel. If you do not abide by these agreements you may be discharged from the Suboxone treatment program.

- Prompt payment of clinic fees is part of this program. If your account does not remain current, as agreed, appointments cannot be scheduled. If appointments cannot be kept as agreed, your status as an active patient will be cancelled – no exceptions.

- In the rare case of an allergic reaction to medication, Suboxone must be discontinued.

- Dangerous or inappropriate behavior that is disruptive to our clinic or to other patients will result in your discharge from the Suboxone treatment. This includes patients who come to the clinic intoxicated or on other narcotics, Valium, barbiturates or Xanax like medications.

- In the case of dangerous behavior there will be no two-week taper. You will be discharged and asked not to return to the clinic.

CAROLINA PAIN AND WEIGHT LOSS

INFORMED CONSENT

Please read this information carefully. Suboxone (buprenorphine + naloxone) is an FDA approved medication for treatment of people with opiate (narcotic) dependence. Suboxone is a weak opiate and reverses actions of other opiates. It can cause a withdrawal reaction from standard narcotics or Methadone while at the same time having a mild narcotic pain relieving effect from the Suboxone.

The use of Suboxone can result in physical dependence of the buprenorphine, but withdrawal is much milder and slower than with heroin or Methadone. If Suboxone is suddenly discontinued, patients will have only mild symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opiate withdrawal, Suboxone may be discontinued gradually, usually over several weeks or more.

Because of its narcotic-reversing effect, if you are dependent on opiates, **you should be in as much withdrawal as possible when you take the first dose of Suboxone. If you are not in withdrawal at the time of your first visit, you may not be given Suboxone,** as it can cause severe opiate withdrawal while you are still experiencing the effect of other narcotics. You will be given the first dose in our clinic and you must return to the office after two hours. After that, you will be given further instructions.

Some patients find that it takes several days to get used to the transition to Suboxone from the opiate they had been using. After stabilized on Suboxone, other opiates will have virtually no effect. Attempts to override the Suboxone by taking more opiates could result in an opiate overdose. Do not take any other medication without first discussing with your provider.. Combining Suboxone with alcohol or some other medications may also be hazardous. The combination of Suboxone with mediation such as Valium, Librium, Ativan, or Xanax has resulted in death.

Should Suboxone be prescribed, it is a combination of buprenorphine with a short- acting opiate blocker, naloxone. If the Suboxone Film was dissolved and injected by someone taking heroin or another strong opiate it would cause severe opiate withdrawal.

Suboxone Film must be held under the tongue until completely dissolved. If swallowed, Suboxone is not well absorbed from the stomach and the desired benefit will **not** be experienced.

We do not prescribe, under any circumstances, narcotics, Methadone, or sedatives for patients desiring maintenance or detoxification from narcotics. All Suboxone must be purchased at private pharmacies. We will not supply any Suboxone.

CAROLINA PAIN AND WEIGHT LOSS

SUBOXONE TREATMENT FINANCIAL POLICIES

We accept private Insurance, Medicare, Medicaid or Cash payments for your visits. We will verify your insurance medical benefits. Once your deductible has been met, *we* require you to pay your co-pay in advance and your account to be paid in full to schedule follow up appointments.

We accept credit card, debit card or cash. No checks.

We require a deposit of $200 to schedule your **first appointment.** When you arrive for your appointment, your deposit will be refunded to you. At that time, you may choose to use your insurance or pay cash for your visit. If you do not show up to your appointment, your deposit will not be refunded. For cancellations with less than 24 hours notices, there is a $85 cancellation fee.

We require a pre-payment of $100 and your account to be paid in full to schedule follow up appointments.

After your visit, you will be asked to reserve your next visit. We do not wish you to undergo sudden withdrawal from your medication. You will experience withdrawal if you fail to keep your appointment.

ACKNOWLEDGEMENT OF POLICIES AND PRIVACY PRACTICES

INSURANCE AUTHORIZATION
I hereby authorization Carolina Pain and Weight Loss to share information with hospitals and physicians, my insurance carriers, worker's compensation companies, attorneys, etc. concerning my illness and treatment.

ASSIGNMENT OF BENEFITS
I hereby assign to Carolina Pain and Weight Loss all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

TREATMENT AUTHORIZATION
I hereby authorize Carolina Pain and Weight Loss to render health care to me during my visit.

PRIVACY NOTICE
I have been given the option to review Carolina Pain and Weight Loss "Notice of Privacy Practices" that explains how my personal health information will be used. I am also aware that I may request a copy of the "Notice of Privacy Practices" at any time.

Signature: _____ Date: _____
Witness: _____ Date: _____

MEDICAID-CAROLINA ACCESS WAIVER

I, _____, am aware that I may be financially responsible for a
(Print Patient Name)
visit(s) at Carolina Pain and Weight Loss for any or all reasons listed below:

- If Carolina Pain and Weight Loss cannot verify my Medicaid eligibility coverage at the time of my appointment or if my coverage is terminated retroactively after my scheduled appointment.
- For any deductible, co-insurance and/or copayments as specified by Medicaid
- In the event that I do not have my Medicaid card as proof of coverage with me at the time of any appointment
- If there is no referral on file allowing me to seek the services of Carolina Pain and Weight Loss
- For any non-covered service in which Carolina Pain and Weight Loss have given me proper notification that the service is a non-covered benefit
- Any visit(s) in excess of the legislative annual visit limit for provider visits for the state's fiscal year as determined by NC Medicaid

I have been informed by Carolina Pain and Weight Loss that due to the listed circumstance(s) above, I may be financially responsible for all charged incurred at the time of my visit(s). By deciding to keep my scheduled appointment(s) and seeking the services of Carolina Pain and Weight Loss, I agree to pay any charges related to my appointment that are not covered by Medicaid in full at the next scheduled office visit for services previously incurred.

_____ _____
Printed Patient Name Date

_____ _____
Parent Signature Date

_____ _____
Witness Date

Carolina Pain
& Weight Loss

Patient Update Form

Patient Name_____ **Date of Birth**_____

Address_____

City_____ **State**_____ **Zipcode**_____

Primary Phone_____ **Secondary Phone**_____

Primary Care Doctor_____

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each box that can be given to person/entity listed on the left.
Voice Mail Use ☐ Home # ☐ Cell #	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Spouse (provide name & phone number) Name Phone	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Parent (provide name & phone number) Name Phone	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Other (provide name & phone number) Name Phone	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Email (provide email address)	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial ☐ Breach notification I elect to receive email and understand that email may not be sent in an encrypted manner and there is a risk it could be accessed inappropriately.

- I have the right to revoke this authorization at any time.
- I may inspect or copy the PHI to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I authorize the individual(s) listed above to have access to my medical information.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ _____

Patient Signature or Personal Representative **Date**

Carolina Pain and Weight Loss

PATIENT APPOINTMENT POLICY

Striving to Get You In, Out, and On Your Way

Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.

Definition of a "No-Show" Appointment; Carolina Pain and Weight Loss defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 2 hours' notice
- Arrives more than 5 minutes after an appointment time and is consequently unable to be seen

In an attempt to cut down on costs and frustration for everyone, Carolina Pain and Weight Loss has implemented a new appointment policy. It is appreciated that patients call ahead if you will be running late so we can reschedule or offer you a later appointment if available. If you are unable to make the appointment entirely, you will need to call us **no later than 2 hours prior to your appointment time.** In the event that you fail to provide us with the requested 2 hour cancellation notice or miss your appointment altogether (see reasons above), there will be a **$50.00 charge due at the time you reschedule the missed appointment.**

"No-Show" appointment has a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire staff

Multiple no-shows and excessive cancellations may results in your being discharged.

Always **arrive 15 minutes prior to your scheduled visit.** This allows time for you and our staff to address any insurance, balance or billing questions and or to complete any necessary paperwork before the scheduled visit.

By signing below you acknowledge that you have read and accept the above policies and will adhere to them to the best of your ability aside from extenuating circumstances.

_____ (patient name printed)

_____ (patient signature)

____/____/____ (date)

____/____/____ (patient date of birth)