Highland Family Medicine
A Department of Highland Hospital and University of Rochester School of Medicine and Dentistry

Hello,

This packet is the first step to our Suboxone Clinic. You may tear this page off to keep for your records and our phone contact.

In order to be accepted in this program you need to be involved in or have graduated from some type of group or counseling sessions and already being prescribed Suboxone. It is ok if you are on your way to graduating with them and being discharged and set up with other community groups.

Please read the packet in full and fill out every page completely. If you read something that does not pertain to you please fill in with N/A. The 3rd and 4th pages are Release of Information Forms. We cannot consider you for this program if these are not completed. These are very important so we can speak with your current chemical dependency counselor and doctor. Be sure to check all pertinent boxes in the Purpose and Need for Disclosure and Information to be Released.

Once we have your completed packet we will fax a Medical Information Request to your counselor. This must be returned to us by fax directly from them.

Please present your insurance information along with your photo ID to our secretaries so they can make a copy to accompany this packet. If this packet is incomplete it will hold up processing. We will try to contact you using the phone number you have provided us in the packet, so please make sure this is a reachable and accurate number.

Once your packet is reviewed, we will contact you to let you know if you have been accepted into our clinic or if more information needs to be collected.

If you have any questions please call 324-4527.

Sincerely,

Chemical Dependency/Suboxone Team
Highland Family Medicine

777 South Clinton Avenue · Rochester, NY 14620 USA
Phone: (585) 279-4800 · Fax: (585) 244-9048

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Welcome to Highland Family Medicine Suboxone Clinic

Please review the following checklist to see if you are eligible.

□ I am currently on a stable dose of Suboxone which I am receiving from:
_____
□ I have completed the attached release of records from my current/previous Suboxone providers office
□ I am currently attending a chemical dependency or behavioral health program at:
_____
□ I have completed the second attached release of records for my chemical dependency or behavioral health program
□ I acknowledge that I will not receive a script for Suboxone at my intake visit and have arranged accordingly with my current Suboxone provider
□ I am not currently taking any benzodiazepines (Xanax, Klonopin, Valium or Diazepam, Ativan or Lorazepam, and others)
□ I have signed the Approved Pharmacy Consent
□ I have signed the Pregnancy Agreement (Female patients only)
□ I have signed the Patient Agreement of Responsibilities
□ Please provide current health insurance(s), insurance name and contract #
(To obtain referral if necessary)

_____

_____

Please return your completed packet at your earliest convenience to any suite. We will contact you once your packet is reviewed.

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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 or the practice/program or about any thread 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.

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SPECIAL CONSENT FOR RELEASE OF INFORMATION/CURRENT SUBOXONE PROVIDER

Date:_____

I, _____ give permission to release and/or obtain information.
Print Last Name First Name MI

☐ Psychiatric ☐ Alcohol ☐ Medical ☐ Sexually Transmitted Disease (STD)

Regarding: _____ DOB_____ SS#_____

I hereby declare that I am the: □Patient □Parent □Legal Guardian

Check One: This information may be: □Released to □Obtained from

Current Suboxone Provider:
Agency:
Address:
City:

Purpose and Need for Disclosure:

□Treatment □Continuity of Care □Evaluation □Education Evaluation □Discharge Planning
□Referral □Disability determinations □Legal Issues □Benefit Certification

Information to be released shall include:

□Assessments □Diagnostic Impression □Discharge Summary □Education □Evaluation(s)
□Lab Tests □Medical Information □Progress Notes □Treatment Plans □Other (Med/Labs) □All

This information may be released by:

□Written □Fax □Court Testimony □Verbal Exchange □Completion of Disability Form

By NYS Mental Hygiene Law, this consent shall expire in ninety days from the date signed or by Federal Regulations for Alcohol/Drug Services, six months from date signed unless otherwise noted.

(Check only one) If no box is checked, this consent will expire as mentioned above.

☐ I authorize the periodic (ongoing) release of the above information. This consent expires when services are discontinued, or one year from this date, whichever occurs first.

☐ I authorize the ONE-TIME release of the above information. This consent expires when acted upon or 90 days from this date, whichever occurs first.

I, the undersigned, have read the above and authorize staff at the facility named to release/obtain such information as indicated. I understand that this consent may be withdrawn by mu, by phone or written notice, at any time except to the extent that action has already been taken. I understand the disclosure of mental health related clinical records is bound by NYS Mental Hygiene Law and Alcohol/Drug records are bound by Federal regulations governing confidentiality, 42CFR Part 2 and that disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Client/Parent/Legal Guardian Date:

Client has withdrawn consent: □By phone □By written notice Date:

Signature of staff member receiving this information:_____
File in Correspondence

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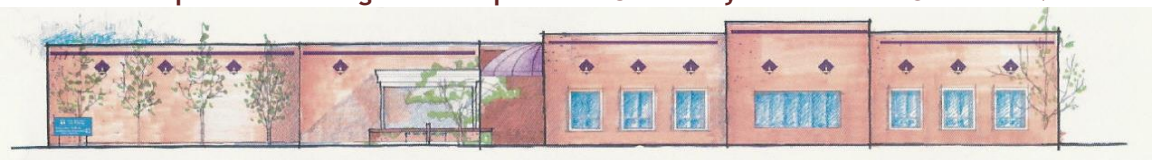

SPECIAL CONSENT FOR RELEASE OF INFORMATION/COUNSELING PROVIDER

Date:_____

I, _____ give permission to release and/or obtain information.
Print Last Name First Name MI

☐ Psychiatric ☐ Alcohol ☐ Medical ☐ Sexually Transmitted Disease (STD)

Regarding: _____DOB_____ SS#_____

I hereby declare that I am the: □Patient □Parent □Legal Guardian

Check One: This information may be: □Released to □Obtained from

Counseling Provider:
Agency:
Address:
City:

Purpose and Need for Disclosure:

□Treatment □Continuity of Care □Evaluation □Education Evaluation □Discharge Planning
□Referral □Disability determinations □Legal Issues □Benefit Certification

Information to be released shall include:

□Assessments □Diagnostic Impression □Discharge Summary □Education □Evaluation(s)
□Lab Tests □Medical Information □Progress Notes □Treatment Plans □Other (Med/Labs) □All

This information may be released by:

□Written □Fax □Court Testimony □Verbal Exchange □Completion of Disability Form

By NYS Mental Hygiene Law, this consent shall expire in ninety days from the date signed or by Federal Regulations for Alcohol/Drug Services, six months from date signed unless otherwise noted.

(Check only one) If no box is checked, this consent will expire as mentioned above.

□ I authorize the periodic (ongoing) release of the above information. This consent expires when services are discontinued, or one year from this date, whichever occurs first.

□ I authorize the ONE-TIME release of the above information. This consent expires when acted upon or 90 days from this date, whichever occurs first.

I, the undersigned, have read the above and authorize staff at the facility named to release/obtain such information as indicated. I understand that this consent may be withdrawn by mu, by phone or written notice, at any time except to the extent that action has already been taken. I understand the disclosure of mental health related clinical records is bound by NYS Mental Hygiene Law and Alcohol/Drug records are bound by Federal regulations governing confidentiality, 42CFR Part 2 and that disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Client/Parent/Legal Guardian Date:

Client has withdrawn consent: □By phone □By written notice Date:

Signature of staff member receiving this information:_____
File in Correspondence

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TELEPHONE APPOINTMENT REMINDER CONSENT

Date: _____

I, _____ give _____(HFM)
Patient Name (Print) DOB Physician Name (Print)

_____ _____
Home Address City State Zip

and members of his/her staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply): □ Home # _____
□ Work # _____
□ Cell # _____

Yes, this office may leave (check all that apply):

□ Voice mail at my home □ Voice mail on my cell □ Messages with people at my home

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (print) Date

_____ _____ _____
Witness Signature Witness Name (print) Date

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APPOINTED PHARMACY CONSENT

I,_____ do hereby: (MD check all that apply)
Patient Name (Print)

Authorize _____(HFM) at the above address to disclose my treatment for opioid
Physician Name (Print)
Dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but May not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine
prescriptions directly to the pharmacy.

Agree to purchase all SUBOXONE, SUBUTEX, and other medications related to my treatment from the pharmacy specified below.

Agree not to use any pharmacy other than the one specified below for the duration of my treatment with the physician specified above, unless specific arrangements have been made with the physician.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

APPOINTED PHARMACY: Name: _____ Phone: _____

Address: _____

_____

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Holly Ann Russell, MD
Elizabeth Loomis, MD
Kevin Kless, MD
Amy Potter, MD
Deborah Pierce, MD
Sachiko Kaizuka, MD

Suboxone Pregnancy Agreement:

Please read the below statement and sign if you are in agreement.

"My physician has explained to me that Suboxone (Buprenorphine/Naloxone) had not been FDA approved for use in pregnant women. My physician has counseled me on the importance of using reliable contraception to prevent pregnancy. My physician has discussed this with me, and offered to prescribe contraceptive medication.

I understand that I will have a pregnancy tested performed at my initial visit and at subsequent visits on occasion. I agree to contact my Suboxone provider immediately if I do become pregnant to discuss treatment alternatives."

_____
Patient Name

_____ _____
Patient Signature Date

_____
Provider Name

_____ _____
Provider signature Date

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Patient Agreement of Responsibilities (PLEASE INITIAL EACH STATEMENT)

_____ I agree to take the medication (Suboxone/Subutex) only as prescribed and to store it properly. The indicated dose should be taken daily, and I understand that I am not to change my dose on my own.

_____ I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree to notify my buprenorphine provider in case of lost or stolen medication. If I suspect my medication has been stolen, I will file a police report, and will bring a copy of the report for my physician. Lost mediation will not be replaced.

_____ I understand the drug counseling is a vital part in my recovery process, and is also a legal requirement to receive Suboxone. I will be asked to enroll in a formal drug counseling program, which may involve individual counseling, group sessions, or both. I understand that I must comply with the recommendations of the counseling program. Repeated cancellations or missed counseling sessions must be addressed; failure to do so can result in dismissal from the Suboxone program. ***Upon completion of counseling, I will attend an aftercare program.***

_____ I agree to notify my provider immediately on case of relapse to drug abuse. Relapse may be life threatening, and an appropriate treatment plan has to be developed as soon as possible. I understand that I am to inform my provider of a relapse immediately, and not wait until the next clinic appointment, and before urine testing confirms it.

_____ I understand that at each clinic visit I will be asked to give a urine sample, which will be tested for drugs of abuse. I understand that if the urine test ever shows any opioid substance -heroin, morphine, methadone, oxycodone, Oxycontin, hydrocodone, Vicodin, or any other drugs of abuse (e.g. cocaine, THC, Benzodiazepines, amphetamines, etc) or if my urine test fails to show the presence of Suboxone, I will be dismissed for the program immediately. At some visits I may be expected to produce an observed urine sample by one of our staff members.

_____ I understand that I am not to take benzodiazepine medication (Xanax, Klonopin, Valium or diazepam, Ativan or Lorazepam, and others).

_____ I understand that if I am arrested and in jail, my treatment will end immediately and I will have to go through withdrawal from my buprenorphine. I agree to have my physician notified if I am arrested.

_____ I agree to keep and be on time to all my scheduled appointments.

_____ I agree to adhere to the payment policy outlined by this office.

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_____ I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication would result in my treatment being terminated.

_____I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.

_____I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated.

_____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.

_____I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.

_____I understand that violations of the above may be grounds for termination of treatment.

_____I agree to special consent for release of information, and update annually

_____I will call during daytime office hours with any questions or concerns about my Suboxone. I understand the on call doctors are not Suboxone providers.

Signature: _____ **Date:** _____

Physician: _____ **Date:** _____

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