Hello,

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

In order to transfer to our telemedicine program you need to be involved in or have graduated from some type of group or counseling sessions and already being prescribed Suboxone/buprenorphine. 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 **4th page is a Release of Information Form. We cannot consider you for this program if this is not completed**. This is very important so we can speak with your current chemical dependency counselor and/or doctor. Be sure to **check all pertinent boxes in the Purpose and Need for Disclosure and Information to be Released.**

The last page of this packet is the questionnaire we need completed by either your current Suboxone provider, counselor, or program leader. This must be faxed back directly from them to 585-279-4754.

Once we have your completed packet- if the questionnaire is not already faxed to us, we will fax the Medical Information Request to your counselor with the questionnaire. 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 an intake appointment can be scheduled or if more information needs to be collected.

If you have any questions please call 324-4527. Please fax completed packet to 585-279-4754

Sincerely,

Chemical Dependency Suboxone/buprenorphine Team

Highland Family Medicine

**Welcome to Highland Family Medicine Telemedicine Suboxone/buprenorphine Program with CASA Trinity**

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

□ I am currently on a stable dose of Suboxone/buprenorphine which I am receiving from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I have completed the attached release of records from my current/previous Suboxone/buprenorphine 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/buprenorphine at my intake visit and have arranged accordingly with my current 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)

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

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Please fax completed packet to 585-279-4754

We will contact you once your packet is reviewed.

|  |
| --- |
| **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. |

**SPECIAL CONSENT FOR RELEASE OF INFORMATION**

**CURRENT SUBOXONE/BUPRENORPHINE PROVIDER/COUNSELOR**

 **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/Buprenorphine Provider: |
| Agency: |
| Address: |
| City: |

Purpose and Need for Disclosure-Please select any that pertain to you:

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

Information to be released shall include-Please select any information you would like shared with us:

|  |
| --- |
| □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-Please select how you would like the information to be shared:

|  |
| --- |
| □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.

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| 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 |

**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.

 □ Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would prefer to be called at (check all that apply): □ 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

**Please provide current health insurance(s), insurance name and contract #**

|  |
| --- |
| 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

**Patient Agreement of Responsibilities (PLEASE INITIAL EACH STATEMENT)**

\_\_\_\_\_ I agree to take the medication (Suboxone/Subutex/buprenorphine) 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 that recovery support is a vital part of my health care. I will be asked to identify a formal support program that may be individual or group based. If I do not currently have a formal support program, I will work with the buprenorphine providers to identify one and participate in it at least weekly***.***

\_\_\_\_\_ I agree to notify my provider immediately should any use of substance of abuse occur. Relapse or lapse 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 use immediately, and not wait until the next clinic appointment, and before urine testing confirms it. HFM seeks to work with you and does not routinely dismiss patients for one time use.

\_\_\_\_\_ I understand that at each clinic visit I will be asked to give a urine sample, which will be tested for substances of abuse. I understand that if the urine test ever shows any opioid substance -heroin, morphine, methadone, oxycodone, Oxycontin, hydrocodone, Vicodin, or any other substances of abuse (e.g. cocaine, THC, Benzodiazepines, amphetamines, etc.) orif my urine test fails to show the presence of buprenorphine, I may be dismissed from the program. 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 may end 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 routine payment policy outlined by this office.

\_\_\_\_\_ 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 to be respectful and not disruptive per the general patient code of conduct at HFM.

\_\_\_\_\_I understand that if disruptive activities are observed by employees of HFM or of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my clinician’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 controlled substance prescriptions (opioids, benzodiazepines, stimulants, hypnotics) from any doctors, pharmacies, or other sources without discussing prior with my treating buprenorphine clinician.

\_\_\_\_\_I understand that violations of the above may be grounds for termination of treatment.

\_\_\_\_\_I agree to special consent for release of information, and updated annually as needed

\_\_\_\_\_I will call during daytime office hours with any questions or concerns about my Suboxone/buprenorphine. I understand the on call clinicians are not Suboxone/buprenorphine providers.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUBOXONE CLINIC MEDICAL INFORMATION REQUEST**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This portion is to be completed by either your counselor, current Suboxone provider, or program leader:**

**Counselor or program leader fill out and fax to the attention of Suboxone Coordinator. Once completed and sent back we can move forward with patient care.**

1. Does this patient attend regular appointments?
2. Have there been any positive urine screens for non Rx’D substances? YES NO
3. Is this patient involved in other programs and if so which ones?
4. Will this patient be graduating from your program? When?
5. Current prescribed Suboxone dosage? Our max dosage is 16 mg of buprenorphine daily. If patients are on higher doses we will work with them to taper down over a few months if they are willing.
6. We offer 1-2 clinical sessions a week for patients on Suboxone. At this time, we do not have on site addiction counseling so we are unable to best serve patients requiring more intensive recovery support. Do you think this patient will be a good fit?
7. Comments/Concerns
8. Please provide current health insurance(s), insurance name and contract #

**Name of counselor completing form (PRINT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This consent is for all telehealth services provided for the following condition(s):

\*

\*

**SH 419TELE MR**

**TELEHEALTH CONSENT**

**H**

**IGHLAND**

**H**

**OSPITAL**

**S**

**TRONG**

**M**

**EMORIAL**

**H**

**OSPITAL**

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1. I understand that my health care provider wishes me to engage in a telehealth appointment/consultation to evaluate myhealth condition.
2. My health care provider has explained to me that either video conferencing technology and/or electronic transmission ofmy health information such as radiologic images, photos and sounds will be used during this appointment/consultation and it 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.
3. I understand that there are risks associated with use of this technology such as interruptions, technical difficulties, andinability to obtain information sufficient for decision making about my health problem and that all possible precautions will be taken to minimize these risks. In addition, my health care provider or I can discontinue the telehealth visit if it is felt that the information obtained through the telemedicine connection is not adequate for diagnostic decision-making or for implementing management of my health problem. In that event, we will endeavor to facilitate access to a site where adequate care can be provided, such as a doctor’s office or other source of in-person care.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Othersmay also be present during the consultation other than my health care provider and consulting health care 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 appointment/consultation and thus will have the right to request the following:
	1. Omitting specific details of my medical history/physical examination that are personally sensitive;
	2. Asking non-medical personnel to leave the telemedicine examination room; and/or(c) Terminating the consultation at any time.
5. The alternatives to a telehealth appointment/consultation have been explained to me. In choosing to participate in atelehealth appointment/consultation, I understand that some parts of the visit, such as the physical exam, may be conducted by individuals at my location at the direction of the consulting health care provider, as indicated.
6. In an **emergent** consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist’s responsibility will conclude upon the termination of the video conference connection.
7. I understand that depending on factors such as my location, my health insurance, and the services I am receiving, billingmay occur from both my health care provider and the facility at which I am presenting for my appointment. If my health insurance is Medicaid and I am receiving telepsychiatry services in a location that is licensed by the New York State Office of Mental Health, I understand that billing will only occur from the facility at which I am presenting.

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1. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regardto 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.

**By signing this form, I certify that:**

* I have read or had this form read and/or had this form explained to me
* I fully understand its contents including the risks and benefits of the telehealth appointment/consultation
* I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction.
* I consent to this telehealth appointment/consultation.

|  |  |  |
| --- | --- | --- |
| Patient/Parent/Guardian SignatureTO BE COMPLETED BY STAFFNo signature was obtained due to:V Impractical, verbal consent givenV Patient’s condition/capacityV No representative | Date | Time |
| Staff Signature | Date | Time |

* I have been provided with the University of Rochester Medical Center and Affiliates Notice of Privacy Practices.

419TELE (Rev 6/19)