Unity Family Health Care
Sarita Bowers, FNP David Bowers, FNP
1644 Valley Rd. Ste A
Berkeley Springs, WV 25411
Ph: 304-500-2567 Fax: 304-500-2748

Patient Demographics

Welcome to Unity Family Health Care, we are pleased to have you in our office. Please take a few minutes to fill out these forms as completely as you can. If you have any questions, we will be glad to help.

Name:_____
Last First MI (Preferred)
Patient address:_____
Address City State Zip code

Birthdate_____ SS#_____ Sexual Orientation:_____
Gender at Birth :_____ Gender Identity:_____ Preferred Pronoun/s:_____Marital Status:_____
Work phone: _____Wireless Phone: _____ Home Phone: _____
Email: _____
Preferred contact method: _____
Student status if dependent over 19 (for insurance) _____

How did you hear about us? _____

Emergency Contact: _____
Phone #: _____ Relation: _____

Release of Information:
Who may we release information to over phone: _____ Relation: _____
Who may we release medical records to: _____ Relation: _____

Insurance Policy 1 (Please provide card to reception)
Subscriber Name: _____ Subscriber ID#_____
Insurance Company: _____ Phone: _____
Employer: _____ Group Name: _____ Group #_____
Relationship to Subscriber_____

Insurance Policy 2 (Please provide card to reception)
Subscriber Name: _____ Subscriber ID#_____
Insurance Company: _____ Phone: _____
Employer: _____ Group Name: _____ Group #_____
Relationship to Subscriber_____

Insurance Policy 3 (Please provide card to reception)
Subscriber Name: _____ Subscriber ID#_____
Insurance Company: _____ Phone: _____
Employer: _____ Group Name: _____ Group #_____
Relationship to Subscriber_____

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Patient History

Patient Name: _____ DOB: _____

Allergies (please list your reaction and when it started):_____
_____
_____

Current Medications/Dosage/Prescriber:_____
_____
_____
_____

Personal Medical History: (Please circle all that apply)

☐ ADHD	☐ Crohn' Disease	☐ Headache/Migraine	☐ Osteopenia/Osteoporosis
☐ Alcoholism	☐ COPD/Emphysema	☐ High Blood Pressure	☐ Parkinson'Disease
☐ Allergies, Seasonal	☐ Dementia	☐ Kidney Disease	☐ Peripheral Vascular Disease
☐ Anemia	☐ Depression	☐ Kidney Stones	☐ Peptic Ulcer
☐ Anxiety	☐ Diabetes 1 or 2	☐ High Cholesterol	☐ Psoriasis
☐ Arrhythmia (Irregular heartbeat)	☐ Diverticulitis	☐ HIV	☐ Pulmonary Embolism (PE)
☐ Arthritis	☐ DVT (Blood clot)	☐ Hepatitis	☐ Rheumatoid Arthritis
☐ Asthma	☐ GERD (Acid reflux)	☐ Irritable Bowel Syndrome	☐ Seizure Disorder
☐ Bipolar Disorder	☐ Glaucoma	☐ Lupus	☐ Sleep Apnea
☐ Bladder Problems/Incontinence	☐ Heart Disease	☐ Liver Disease	☐ Stroke
☐ Bleeding Problems	☐ Heart Attack	☐ Macular Degeneration	☐ Thyroid Disorder
☐ Cancer: _____	☐ Hiatal Hernia	☐ Neuropathy	☐ Ulcerative Colitis

Patient Name:_____ DOB:_____

Have you had any possible exposure to Hepatitis or HIV/Aids? ☐ Yes ☐ No

Other medical problems not listed above:_____
_____
_____

Family History:

Father: Living age: _____ Deceased age: _____

O Alcoholism	O Bipolar Disorder	O Depression	O High Cholesterol	O Osteoporosis
O Anemia	O Cancer: _____	O Diabetes 1 or 2	O High Blood Pressure	O Stroke
O Asthma	O COPD/Emphysema	O DVT (blood clot)	O Kidney Disease	O Thyroid Disorder
O Arthritis	O Dementia	O Heart Disease	O Migraines	

Other:_____

Mother: Living age: _____ Deceased age: _____

O Alcoholism	O Bipolar Disorder	O Depression	O High Cholesterol	O Osteoporosis
O Anemia	O Cancer: _____	O Diabetes 1 or 2	O High Blood Pressure	O Stroke
O Asthma	O COPD/Emphysema	O DVT (blood clot)	O Kidney Disease	O Thyroid Disorder
O Arthritis	O Dementia	O Heart Disease	O Migraines	

Other:_____

Siblings:
_____
_____
_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney doctor, Dentist. Etc.)
_____
_____
_____
_____

Surgical History (Do you have any implants? If yes, please explain): _____
_____
_____
_____

Patient Name:_____ DOB:_____

Social/Cultural History:

Are you or have you ever been a smoker? ☐ Yes ☐ No If yes, amount/duration of use: _____

Are you or have you ever used vaping products? ☐ Yes ☐ No If yes, amount/duration of use: _____

Are you or have you ever used recreational drugs? ☐ Yes ☐ No If yes, amount/duration of use: _____

Have you ever received a blood transfusion? ☐ Unknown ☐ Yes ☐ No
If yes, approximate year(s) ago: _____

Are you sexually active? ☐ Yes ☐ No

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate/Professional

Are there any vision problems that affect your communication? ☐ Yes ☐ No

Are there any hearing problems that affect your communication? ☐ Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐ Yes ☐ No

Are there any cultural or religious concerns you have related to delivery of care? ☐ Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No

If you marked yes to any of the above, please

explain:_____

_____

_____

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Marital Status: Are you currently married? ☐ Yes ☐ No

Patient Name:_____ DOB:_____

Occupational History:

What is your current occupation? _____

OB/GYN History:

Date of last Pap smear: _____ STIs/STDs: ☐ Yes ☐ No

History of abnormal Pap smear? ☐ Yes ☐ No Have you had an HPV Vaccine? ☐ Yes ☐ No

Sexual Problems or concerns you wish to address:

_____

Date of LMP: _____ Duration: _____Days Menstrual Cycle: ☐ Regular ☐ Irregular

Menses monthly? ☐ Yes ☐ No Flow: ☐ Light ☐ Moderate ☐ Heavy

Birth Control:

Current birth control method: _____ Desired birth control method: _____

Pregnancy History:

Age at first childbirth? _____ Number of Pregnancies: _____ Full term: _____ Living: _____

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HIPAA Privacy and Release of Information Authorization

I, _____ hereby authorize **UNITY FAMILY HEALTH CARE, INC**. and its affiliates, its employees and agents, to use and disclose protected health information (e.g. information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, and member ID number) for the purpose of helping me to resolve claims and health coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority. **If applicable, Legal Representatives, sign below:**

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____

Patient Printed Name Date

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Consent to Bill

My signature below indicates that:

- I give permission for Unity Family Health Care, Inc. (UFHC) to bill my insurance company for covered services; and to exchange information necessary to secure payment for these services. Such necessary information may include diagnosis, service dates, types of services and other information related to UFHC's services necessary to process claims.
- I understand that if an insurance payment is made directly to me for the services received at UFHC that I am responsible for immediately sending such payments to UFHC.
- I will notify UFHC of any changes to my health insurance coverage as well as any denial information.
- I understand that I am responsible for any balance that my insurance company does not authorize for payment.

Patient/Representative Signature: _____

Date: _____

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Consent for Procedure/Treatment

I hereby authorize and direct Unity Family Health Care, Inc. and assistants, as necessary to perform quality care, to perform appropriate procedure/treatment(s) on me.

The nature and purpose of the procedure/treatment(s), alternative methods of treatment, and potential risks and complications will have been fully explained to me.

I acknowledge that no guarantees have been made to me as to the outcome of the procedure(s) and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature: _____

Date: _____

Witness Signature: _____

Date: _____

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Consent for Telehealth Treatment

1. I hereby authorize Health Care Services to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

4. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.

5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.

Patient/Representative Signature: _____

Date: _____

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Consent for Contact

I give consent for Unity Family Health Care to contact me by:

____ Text ____ Call

I give Unity Family Health Care permission to leave messages on answering machine/voicemail.

_____ Yes _____ No

Patient/Representative Signature: _____

Date: _____

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Office Policies

- Refills: Please contact your pharmacy for refills. The pharmacy will contact us with the appropriate information. **Please allow 24 hours for this to take place**.
- Social Media: Please refrain from messaging ALL staff on office social media sources (i.e. Facebook) or their personal social media regarding any health concerns you may have. Social media is not a secure means of communication of sensitive information, also, we cannot guarantee we will be using social media and will receive your message. All patients need to call the office, regardless of the time of day and leave a message on the phone and our staff will get back to you. **All messages received by staff regarding personal medical information/concerns will not be replied to and will be discarded promptly. This includes text messaging staff.**
- Inclement weather: Staff will be in office if weather permits. If the staff deems it unsafe to travel, the office will delay opening or remain closed. The safety of our patients and staff is our priority. Should you have any questions about closures, please call the office phone number 304-500-2567 or check the office Facebook page for updates.
- No-shows: Failure to give 24-hour notice of an appointment cancellation may result in a fee of $25.
- Insufficient Funds: Should payment be returned for insufficient funds; your account will be charged a fee of $35.
- Late Arrivals: Patients arriving late for their appointment, may be rescheduled for another time. We ask that you arrive 15 minutes early for your appointment. Our office staff will try to fit you into the current schedule; however, this is not always possible, and you may be required to wait or return at a later time.
- Cell Phone Usage: Providers will not conduct ANY exam if the patient or parent/guardian of a minor child is on their cell phone in the exam room. This includes playing games or listening to music. Feel free to use your phone when staff is not in the room. This ensures the best possible evaluation and care.
- Form Completion: Forms requiring a healthcare official to complete, including short term disability, social security, FMLA, medication administration, and letters requested by the patient, will cost $25 per form. Medical records requested will cost $25. Payment is due at time of delivery.
- Copays: Copays and outstanding balances are to be paid at the time of service.
- Children of Divorced Parents: Payments are due at the time of presentation, regardless of which parent accompanies the patient during the office visit.
- Current Patient Status: To be considered an active patient at Unity Family Health Care, you must be seen at least annually for a physical exam.
- Mutual Respect: We will treat patients and family members with respect and courtesy, and we appreciate the same in return for our staff members.
- Chronic Pain/Anxiety Management: This practice does **NOT** utilize narcotics, opiates, or benzodiazepines for chronic pain management or anxiety.
- Treatment Rooms: Due to limited room size, we request that individuals in patient rooms be limited to the patient and ONE parent/guardian if patient is a child unless otherwise arranged with staff. This is to ensure there is enough room for the provider and nurse in the treatment room.
- Termination: Patients may be terminated from practice at the providers discretion should the situation warrant.

Signature_____ **Date**_____

SUBOXONE INSTRUCTIONS FOR INITIAL APPOINTMENT

1. Arrive early to complete paperwork.
2. Bring all pill bottles and strip wrappers.
3. Bring valid photo ID.
4. Bring insurance card if insured.
5. A separate charge for screening lab tests may be billed to your insurance.
6. The initial appointment may last up to 2 hours with a return to the clinic within the first 2 days after the first dose of Suboxone is taken.
7. Fill your prescription at the pharmacy after the initial visit.

Prior to taking the initial dose of Suboxone®:

A. Must be in a safe environment where you will remain for 48-72 hours so as to avoid any and all driving for the first 72 hours, and in an environment conducive to having access in contacting for prompt medical care if required.

B. **Must be in withdrawal** prior to initiation of treatment.

C. No methadone for at least 2 days; methadone dose for prior 7 days **must be less** than 31mg/day.

D. No opioids for at least 12 hours and preferably 24 hours prior to first dose of Suboxone®

Directions:

From the North/Maryland:

Take Route 522 southbound 1.6 miles from downtown Berkeley Springs. We are the second building on the left after passing McDonald's. We are located in the same building as Fox's Pizza.

From the South/Virginia:

Take Route 522 northbound approximately 11.5 miles north of the Virginia/West Virginia state line. We are located on the right next door to CNB Bank. We are located in the same building as Fox's Pizza.

SUBOXONE INFORMATION FOR PATIENTS

The Drug Addiction Treatment Act of 2000 made it legal to prescribe an opioid for treatment of addiction. An opioid addicted patient may receive opioid medication for detox or maintenance in a regular office setting, rather than a methadone treatment program. Suboxone® is the only allowed medication.

The restrictions of this law include requirements that the physician have training in opioid addiction treatment, be registered with the Secretary of Health and Human Services and be certified by the Drug Enforcement Administration to prescribe scheduled drugs.

Suboxone® is a long-acting opioid medication, which binds for a long time to the opioid receptor. Suboxone® is taken sublingually (dissolved under the tongue) because it is not absorbed well by swallowing. This sublingual tablet also contains a small amount of naloxone (Narcan®) which is an opioid antagonist, or blocking/reversing agent, which will cause withdrawal if injected.

Suboxone® has a "ceiling" which makes it safer in case of accidental overdose. In large doses, Suboxone® does not suppress breathing to the point of death in the same way as opioid or methadone. These are some of the unusual qualities of this medication, which make it safer to use outside of the strict confines of a methadone clinic. After stabilization, most patients are able to self-manage Suboxone® for up to four weeks at a time.

Suboxone® is not equivalent in maintenance strength to methadone. In order to even try Suboxone® without going into major withdrawal, a methadone-maintained patient would have to taper down to a dose of 30 mg per day of methadone or lower.

So remember the following tips. If you are offered Suboxone® by a "friend" and you are taking other opioids, the Suboxone® will force the other opioids off the receptor site and you may go into withdrawal and become very sick. If you dissolve and inject the Suboxone® sublingual tablet, it may induce severe withdrawal because of the naloxone, which is an antagonist and reverses opioids effect when injected. If you wish to transfer to Suboxone® from methadone, your dose has to be at or below 30 mg per day.

There have been deaths reported when Suboxone® is combined with benzodiazepines. (This family of drugs includes Klonopin, Ativan, Halcion, Valium, Xanax, Librium, Serax, etc.) If you are taking any of these drugs, either by prescription or on your own, Suboxone® is not a good treatment for you and should not be taken.

SUBOXONE TREATMENT INFORMED CONSENT

Please read this information carefully. Suboxone® (buprenorphine + naloxone) is an FDA approved medication for treatment of people with opioid (narcotic) dependence. It can be used for detoxification or for maintenance therapy when prescribed by qualified physicians.

Suboxone® itself is a weak opioid and reverses actions of other opioids! It can cause a withdrawal reaction from standard opioids or methadone while at the same time having a mild opioid 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 either opioids or methadone. If Suboxone® is discontinued suddenly, you will have withdrawal symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opioid withdrawal, Suboxone® may be discontinued gradually, usually over several weeks or more.

Because of its opioid-reversing effect, if you are dependent on opioids, **you should be in established opioid withdrawal when you take the first dose of Suboxone®**. You must be off methadone for at least 24 hours or off of other opioids for at least 12 hours **and** *showing signs of withdrawal before starting 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 opioid withdrawal while you are still experiencing the effect of other opioids. You will be given further instructions and a prescription for Suboxone® that can be filled at the pharmacy of your choice.

Some patients find that it takes several days to get used to the transition to Suboxone® from the opioid they had been using. After stabilized on Suboxone®, other opioids will have virtually no effect. Attempts to override the Suboxone® by taking more opioids could result in an opioid overdose. Do not take any other medication without discussing it with you physician first.

Combining Suboxone® with alcohol or some other medications may also be hazardous. The combination of Suboxone® with **any sedative**, such as alcohol, barbiturates or benzodiazepine mediations such as Valium, Librium, Ativan, Xanax, Serax, or Klonopin has **resulted in deaths**.

The form of Suboxone® given in this program is a combination of buprenorphine with a short-acting opioid blocker, naloxone. If the Suboxone® tablet was dissolved and injected by someone taking opioid or another strong opioid it would cause severe opioid withdrawal.

Suboxone® tablets must be held under the tongue, and film held on the tongue or in the mouth until completely dissolved. It is then absorbed from the tissue under the tongue and in the mouth (oral mucosa) over the following 30-120 minutes. 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, opioids, methadone, or sedatives for patients desiring maintenance or detoxification from opioids.

We also recommend that patient remain alcohol-free.

All Suboxone® must be purchased at private pharmacies. We will not supply any Suboxone®.

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 opioid abuse, or if you continue to feel like using opioids, even at the top doses of Suboxone, the doctor may discontinue treatment with Suboxone, or you may be required to enter into a higher level of addiction treatment, or you may 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.
- If appointments cannot be kept as agreed, your status as an active patient will be cancelled - no exceptions.
- Obviously, 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 may result in your discharge from the Suboxone treatment clinic. This includes patients who present in an intoxicated or impaired state or present themselves while on other opioids, alcohol, Valium, barbiturates, sedatives, or any mood-altering substance or medication.
- In the case of dangerous, or intoxicated or impaired behavior, you may be subject to physical restraint or compelled to admission to a psychiatric or detoxification treatment unit. You may also be immediately, and summarily discharged from the clinic.

Agreement for Treatment with Suboxone/Sublocade (Buprenorphine/Naloxone)

I understand that Suboxone is a medication to treat opioid addiction (for example: opioid, prescription opioids such as oxycodone, hydrocodone, methadone). Suboxone contains the opioid analgesic medication, buprenorphine, and the opioid antagonist drug, naloxone, in a 4 to l (buprenorphine to naloxone) ratio. The naloxone is present in the tablet to prevent diversion to injected abuse of this medication. Injection of Suboxone® by a person who is addicted to opioids will produce severe opioid withdrawal.

Yes No 1. I agree to keep appointments and let staff know if I will be unable to show up as scheduled.

Yes No 2. I agree to report my history and my symptoms honestly to my physician, nurses, and counselors involved in my care. I also agree to inform staff of all other physicians and dentists who I am seeing; of all prescription and non-prescription drugs I am taking; of any alcohol or street drugs I have recently been using; and whether I have become pregnant or have developed hepatitis.

Yes No 3. I agree to cooperate with urine drug testing (UDT) whenever requested by medical staff, to confirm if I have been using any alcohol, prescription drugs, or street drugs. If indicated, I will agree to same sex witnessed urine drug testing. If in question, the UDT may require supervision.

Yes No 4. I have been informed that buprenorphine is an opioid analgesic, and thus it can produce a "high"; I know that taking Suboxone regularly can lead to physical dependence and addiction, and that if I were to abruptly stop taking Suboxone after a period of regular use, I could experience symptoms of opioid withdrawal. I also understand that combining Suboxone with benzodiazepine (sedative or tranquilizer) medications (including but not limited to Valium, Klonopin, Ativan, Xanax, Librium, Serax) has been associated with severe adverse events and even death. I also understand that I should not drink alcohol with Suboxone since it could possibly interact with Suboxone to produce medical adverse events such as reduced breathing or impaired thinking. I agree not to use benzodiazepine medications or to drink alcohol while taking Suboxone and I understand that my doctor may end my treatment with buprenorphine if I violate this term of the treatment agreement.

Yes No 5. I have been informed that Suboxone is to be placed under the tongue for it to dissolve and be absorbed, and that it should never be injected. I have been informed that injecting Suboxone or any other opioid regularly could lead to sudden and severe opioid withdrawal.

Yes No 6. I have been informed that Suboxone is a powerful drug and that supplies of it must be protected from theft or unauthorized use, since persons who want to get high by using it or who want to sell for profit, may be motivated to steal my take-home prescription supplies of Suboxone.

Yes No 7. I have a means to store take-home prescription supplies of Suboxone safely, where it cannot be taken accidentally by children or pets or stolen by unauthorized users. I agree that if my Suboxone pills are swallowed by anyone besides me, I will call 911 or Poison Control at 1-800-222-1222 immediately and I will take the person to the doctor or hospital for treatment.

Yes No 8. I agree that if my doctor recommends that my home supplies of Suboxone should be kept in the care of a responsible member of my family or another third party, I will abide by such recommendations.

Yes No 9. I will be careful with my take-home prescription supplies of Suboxone and agree that I have been informed that if I report that my supplies have been lost or stolen, that my doctors will not be requested or expected to provide me with make-up supplies. This means that if I run out of my medication supplies it could result in my experiencing symptoms of opioid withdrawal. Also, I agree that if there has been a theft of my medications, I will report this to the police and will bring a copy of the police report to my next visit.

Yes No 10. I agree to bring my bottle of Suboxone in with me for every appointment with my doctor so that remaining supplies can be counted.

Yes No 11. I agree to take my Suboxone as prescribed, to not skip doses, and that I will not adjust the dose without talking with my doctor about this so that changes in orders can be properly communicated by to my pharmacy.

Yes No 12. I agree that I will not drive a motor vehicle or use power tools or other dangerous machinery during my first days of taking Suboxone or after a dosage increase, to make sure that I can tolerate taking it without becoming sleepy or clumsy as a side effect of taking it.

Yes No 13. I understand that I may not be able to drive a car or operate any form of heavy machinery during the induction phase with buprenorphine because of possible psychomotor impairment that I may have during this induction phase. I will assume all responsibility for determining the method of my transportation to and from the treatment facility during my first days of taking Suboxone. I hereby vacate any and all responsibility for any transportation issues from the treating physician, facility, and staff.

Yes No 14. I want to be in recovery from addiction to all drugs, and I have been informed that any active addiction to other drugs besides opioid and other opioids must be treated by counseling and other methods. I have been informed that buprenorphine, as found in Suboxone, is a treatment designed to treat opioid dependence, not addiction to other classes of drugs.

Yes No 15. I agree that medication management of addiction with buprenorphine, as found in Suboxone, is only one part of the treatment of my addiction, and I agree to participate in a regular program of professional counseling while being treated with Suboxone.

Yes No 16. I agree that professional counseling for addiction has the best results when patients also are open to support from peers who are also pursuing recovery.

Yes No 17. I agree to participate in a regular program of peer/self-help while being treated with Suboxone.

Yes No 18. I agree that the support of loved ones is an important part of recovery, and I agree to invite significant persons in my life to participate in my treatment.

Yes No 19. I agree that a network of support, and communication among persons in that network, is an important part of my recovery. I will be asked for my authorization, to allow telephone, email, or face-to-face contact, as appropriate, between my treatment team, and outside parties, including physicians, therapists, probation, and parole officers, and other parties, when the staff has decided that open communication about my case, on my behalf, is necessary.

Yes No 20. I agree that I will be open and honest with my counselors and inform staff about cravings, potential for relapse to the extent that I am aware of such, and specifically about any relapse which has occurred before a drug test result shows it.

Yes No 21. I have been given a copy of clinic procedures, including hours of operation, the clinic phone number, and responsibilities to me as a recipient of addiction treatment services, including buprenorphine treatment with Suboxone.

Patient Signature: _____ Date: _____

Staff Signature/Title: _____ Date: _____

Substance Use Disorder Evaluation
Initial Questionnaire for Suboxone Treatment

Patient Name:_____ Age:_____

What specifically brings you to treatment:

_____
_____
_____
_____

Opioid Use History:

Age of very first use:_____ Age it began to become a problem for you_____

What is you average use:_____ Route: Oral Nasal Injection

What has been your maximal use:_____ Route: Oral Nasal Injection

Length of continuous use:_____ Last Use:_____

What are your current symptoms:_____

_____

What treatment have you had for opioid dependence?_____

_____

Have you ever gotten pain or other prescription medicines other than from a doctor?_____

Have you ever had a drug overdose?_____

Have you been arrested for selling drugs?_____

Have you ever receive substance abuse treatment? If so, what were those dates and locations?

_____
_____
_____

Other Substance Use History:

Alcohol (including beer, wine, hard liquor)

Substance_____

Very first use_____

Beginning problem use_____

Recent average use_____

Highest maximal use_____

Last use_____

Sedatives (incl. benzodiazepines, barbituates, Z-drugs)

Substance Name(s)_____

Very first use_____

Beginning problem use_____

Recent average use_____

Highest maximal use_____

Last use_____

Stimulants (including cocaine, amphetamines)

Substance_____

Very first use_____

Beginning problem use_____

Recent average use_____

Highest maximal use_____

Last use_____

Marijuana/Spice/Synthetic Marijuana

Substance Name(s)_____

Very first use_____

Beginning problem use_____

Recent average use_____

Highest maximal use_____

Last use_____

Hallucinogens/LSD/Mushrooms

Substance_____

Very first use_____

Beginning problem use_____

Recent average use_____

Highest maximal use_____

Last use_____

Inhalants (glues, anesthetics, etc)

Substance Name(s)_____

Very first use_____

Beginning problem use_____

Recent average use_____

Highest maximal use_____

Last use_____

Club Drugs

Substance_____

Very first use_____

Beginning problem use_____

Recent average use_____

Highest maximal use_____

Last use_____

Bath Salts

Substance Name(s)_____

Very first use_____

Beginning problem use_____

Recent average use_____

Highest maximal use_____

Last use_____

Psychiatric and Substance Treatment History:

Inpatient Psychiatric:_____

Outpatient Psychiatric:_____

Inpatient Substance:_____

Outpatient Substance:_____

Please report any psychiatric conditions with which you may have been diagnosed: (please mark any appropriate disorders)

Attention Deficit Disorder ___ Obsessive Compulsive Disorder_____ Anxiety___

Bipolar Disorder____ Schizophrenia____

Post-Traumatic Stress Disorder ___ Depression___

Do you suffer from any visual or auditory hallucinations? Please explain_____

_____

Do you suffer from suicidal thoughts? From homicidal throughts? Please explain_____

_____

Do you have any eating disorder? Please explain_____

_____

Do you suffer from a personality disorder? Please explain_____

_____

Do you have any family members who are in recovery? Please list their relationship to you and for how long they have been in recovery?_____

_____

_____

Continued Medical History:

Chronic Pain: (please list chronic pain issues)_____

_____

Medications: (please list medications/doses below)

_____

_____

_____

_____

Allergies:_____

_____

Social and Occupational History:

Were you the victim of any abuse when you were growing up?_____

What is the highest level of education you have attained?_____

Are you currently employed outside the household?_____

If you are employed, what do you do?_____

Are you on disability?_____

Suboxone Treatment Follow-Up Appointment Protocol

Follow up appointments will be at ***least*** monthly.

The visits are focused on evaluating adherence and the possibility of relapse.

They include:

- Strip counts
- Urine testing for drug abuse
- An interim history of any new medical problems or social stressors
- Prescription of medication
- **Suboxone will be prescribed during clinic-office visits**
- Appointments do not include evaluation or care for other problems.

Dangerous behavior, relapse, and relapse prevention.

The following behavior will be addressed with the patient as soon as they are noticed:

- Missing appointments
- Running out of medication too soon
- Taking medication off schedule
- Refusing urine testing
- Neglecting to mention new medication or outside treatment
- Agitate behavior
- Frequent or urgent inappropriate phone calls
- Outbursts of anger
- Lost or stolen medication
- Non-payment of visit bills as agreed, missed appointments, or cancellations within 24 hours of your appointment.

Treatment may be discontinued if these behaviors occur

Unity Family Health Care

Sarita Bowers, FNP David Bowers, FNP
1644 Valley Rd. Ste A
Berkeley Springs, WV 25411
Ph: 304-500-2567 Fax: 304-500-2748

PHARMACY AGREEMENT

You have a choice of where you want to get your Suboxone prescriptions filled. Please complete this form with the name of the pharmacy you would like to use. Once this decision has been made you will have to stay with that pharmacy, we do not allow you to switch back and forth.

I _____ will only use one pharmacy to get my medicine.

The name of my pharmacy is: _____

_____ _____

Patient name Date

_____ _____

Staff signature Date

Unity Family Health Care
Sarita Bowers, FNP David Bowers, FNP
1644 Valley Rd. Ste A
Berkeley Springs, WV 25411
Ph: 304-500-2567 Fax: 304-500-2748

Day Report/Drug Court/Probation

Are you currently participating in Day Report/Drug Court/Probation? If yes, please specify which:
_____

Where do you have Day Report/Drug Court/Probation? _____

What day of the week are your required to meet for Day Report/Drug Court/Probation? _____

How long have you been in Day Report/Drug Court/Probation? _____

Do you have an end date for Day Report/Drug Court/Probation? _____

If you have a probation officer, what is their name? _____
Phone Number_____

Do you have any upcoming court dates? _____

If yes, when and where? _____

Unity Family Health Care, Inc. MAT Program Description

The Medicated Assisted Treatment program or MAT was created by Unity Family Health Care, Inc. and is modeled after the COAT program at West Virginia University Department of Behavioral Medicine. This is a medication assisted treatment program for patients with opioid use disorders (SUD). Opioids include both prescription medicines obtained on the by prescription or bought off the street as well as illicit opioids such as Heroin or Fentanyl. The program and MAT in general has been proven to be very effective in helping people attain long term recovery when patients are full partners in the treatment process and the rules and standards of the program are strictly adhered to.

The program has five basic parts:

1. Group visits with other patients with Opioid drug use disorders and the prescribing physician and, at times, other members of the MAT team. This visit is followed by psychoeducational therapeutic group sessions that focus on relapse prevention as well as other topics relevant to continued abstinence from all drugs of abuse as well as alcohol. The therapeutic group is led by the primary counselor, another qualified addiction counselor or a counselor under supervision by the primary counselor. Together the two sessions are a minimum 1.5 to 2.5 hours in duration. Therapeutic group attendance is required for a minimum of four hours per month for the first 365 days of continuous recovery. The frequency of mandated attendance in both the medical groups as well as the therapeutic groups is reduced over time based on continuous days without relapse into active drug or alcohol use as demonstrated by clean UDS.

2. Individual psychotherapy includes a minimum of one hour per month for the first 365 days of uninterrupted recovery as demonstrated by clean urine drug screens (UDS) free from all addictive drugs except Buprenorphine and previously approved prescription medication.

• For the first 365 days of continuous recovery, group and individual psychotherapy are required weekly (for no less than 4 hours per month) with no less than one hour of individual therapy

• After 90 days of continuous sobriety, psychotherapy can be twice monthly but still include no less than a total of four hours of therapy with one hour of that being individual therapy for next 275 days of sobriety (total of 365 days continuous sobriety).

• For the next 2 years the both group visits with the physician and psychotherapy sessions are a minimum of once a month.

3. Prescriptions for Suboxone are provided with only sufficient medication to last until the next sessions with the physician and addiction counselor.

4. Participation in a 12-Step program is required and includes attending at least four (4) AA or NA or other acceptable 12-step meetings per week for the first 365 days of continuous sobriety. Attendance after the first 365 days will be determined by the patient in collaboration with their addiction counselor.

5. Agreement to adhere to all program rules including remaining free of all controlled and illicit chemicals as well as alcohol, submitting to urine drug testing, both scheduled as well as random, not misusing the medication, NOT diverting any medication for illegal sales of the medication and observing confidentiality of all other patients participation in the program.

To participate in the MAT Program: People are eligible for participation in the MAT program if they are a patient at one of the Your Organization locations and they are referred to the program by their primary care provider. Prospective patients will have an initial session with the primary counselor for an American Society of Addiction Medicine (ASAM) assessment to verify that the criteria for Opioid Dependence are met as well as to provide other program staff with the patient's medical and drug use history and to ascertain the patient's reason(s) for seeking treatment at the present time and to determine whether the program is appropriate for the patient.

Medical Coverage and Billing: All insurance coverage is accepted, including Medicare and Medicaid. Some patients will have copayments for medical services and/or medications. Unity Family Health Care, Inc. has a sliding fee discount available. Co-payments are due before the group sessions.

Signature below indicates that the particulars of the Unity Family Health Care, Inc. Medication Assisted Treatment have been explained to you and you fully agree to the terms outlined above specifying the requirements of the program.

_____ _____ Patient Signature Date

_____ _____ Unity Family Health Care, Inc. MAT Program Staff Signature Date

AGREEMENT FOR ADMISSION INTO THE MAT PROGRAM (Medication Assistance Treatment)

For admission and as a participant in the Medication Assistance Treatment (MAT) Program for opioid dependence, I _____ agree to honor this treatment agreement.

Purpose and goals of treatment:

1. I understand that the long-term goal of this treatment is to remain drug and alcohol free and to build a foundation of recovery that allows me to completely change my life.

2. I will abstain from the use of other addictive substances; including alcohol, marijuana, and all other legal and illegal substances. I understand that continuing to use other substances is potentially deadly and may result in the treatment team referring me to a higher level of care/treatment or discontinuing my treatment with Buprenorphine at this MAT program.

Treatment Requirements:

3. **I will attend clinic as required and scheduled**. I understand the MAT Clinic consists of Medical Management Appointments, Group Therapy Appointments, and Individual Therapy Appointments as required by law and by the MAT team. **Attendance is required to each appointment** unless I have notified the treatment team in advance of my need to miss an appointment and I am eligible for a makeup appointment. I recognize once I have established a solid recovery program, including a sponsor, a home group in AA or NA, and working the 12 steps) my clinic attendance may be reduced to every two weeks or once a month after an extended period of time of successful participation in the program with the understanding that this agreement will still apply.

4. I understand that it is required that I attend a **minimum of 4 AA or NA meetings per week**. I understand that my meeting lists **must be signed** by the chairperson at the meeting. Falsifying meeting lists is prohibited and may also lead to my discharge or suspension from the program. I also understand that the treatment team may require that I attend more than four meetings each week. Failing to follow through on my meeting attendance may result in termination of my treatment in the clinic.

5. I understand that I will be screened for Hepatitis B and C as well as other communicable diseases and other relevant laboratory tests as required by the treatment team. If I test positive for Hep C I will comply with Hep C follow up appointments and/or referrals.

Attendance:

6. According to the makeup policy, I understand that while in the weekly group I am allowed to cancel, leave early, or be late one time every 6 weeks; while in the bi-weekly group once every 3 months; and while in the monthly group once every 6 months. The makeup policy applies so long as absences do not become habitual. Failure to adhere may result in being discharged, going without medication, and/or doing daily/weekly check-ins.

7. I will keep and be on time for all my scheduled appointments.

8. If an emergency arises, I will call the call center to inform the Care Manager, at (304) 500-2567 and ask for David Bowers. I must call to cancel at least two hours before my scheduled appointment. The above makeup policy applies.

9. I understand that a cancelled appointment may result in my not being able to get my medication/prescription until the next scheduled visit.

10. I understand that an unexcused missed appointment or "no showing" an appointment may result in my being terminated / suspended or referred out of the program.

11. Cancellations 2 weeks in a row may result in termination from treatment. If terminated from the program for any reason, I must wait 30 days to reapply for treatment or longer depending on the waiting list. **Readmission to the MAT program is always at the discretion of the MAT Team**.

Payment:

12. If there is a co-payment or charge I will pay my fee on the day of the service. (Copayment amounts are determined by the patient's type of insurance coverage and patients will be provided information on anticipated charges (if any) at the time of enrollment.) Failure to pay for services, without prior payment arrangements, may result in suspension or termination from the program or referral to an indigent care program.

Use of Medicine:

13. I will take my Buprenorphine as my doctor has instructed (place under tongue until dissolved) and not to alter the dose or the way I take my medication. If I am required to come to the clinic, for any reason, for a daily prescription I understand that my dose for that day will be taken at the clinic and the dosing will be witnessed by a MAT team member.

14. **I will not sell, share, trade, or give away any of my Buprenorphine or any other prescription medication**. I understand that such mishandling of my medication is a serious violation of this agreement as well as illegal and **will result** in my treatment being terminated without any recourse for appeal.

15. I understand prescription brand Suboxone contains an opioid (Buprenorphine) that can be a target for people who abuse prescription medication or street drugs. I understand that the medication I receive is my responsibility and that I agree to keep it in a safe, secure place and protect it from theft. I understand that replacement prescriptions for lost or stolen medication will likely not provided. The lost or stolen medication policy also applies. Also, written prescriptions will have no refills.

16. **Medication should be kept out of sight and reach of children**. Accidental or deliberate ingestion by a child may cause respiratory depression that can result in death. If a child is exposed to your medication, medical attention should be sought **immediately**, even if the child has no symptoms and appears to be OK.

17. I will tell my treating physician about ANY other medications I receive from any doctors, dentists, and/or pharmacies. I understand it is my responsibility to tell all treatment providers about my participation in the MAT program and taking ANY medication that is addictive without prior authorization from the treatment team may result in my termination or suspension from the program.

18. **I understand mixing Buprenorphine with other medication, especially benzodiazepines, (for example Valium, Klonopin, Xanax, Ativan) and other Central Nervous System depressants (including alcohol) can be dangerous and even lethal. I have been informed that deaths have occurred from mixing Buprenorphine and benzodiazepines.**

19. I understand that I will use one pharmacy for filling the medications prescribed as part of the addiction treatment program.

20. Filling any controlled substance, such as Tramadol and/or Ambien, without first obtaining approval from the treatment team, may result in my immediate discharge or suspension from the program. Board of Pharmacy records will be monitored regularly. **A LIST OF CONTROLLED SUBSTANCES IS PROVIDED ON A SEPERATE FORM.**

Conduct in clinic:

21. I will conduct myself in a courteous manner and not engage in any illegal or disruptive activities on the clinic or pharmacy property. If I do not adhere I put myself at risk of being discharged.

22. I will provide my only own urine for random drug screens as requested. Random urine drug screens will be observed**. I understand that I have 30 minutes from my scheduled arrival time to provide a urine sample.** I understand that tampering with, buying, selling, or otherwise procuring urine will result in my immediate termination from treatment as it is an admission of a dirty urine. I also understand I am subject to random breathalyzer screens and film / package or pill counts. **I have 24 hours to report once contacted for a random pill/film count and or any other requested assessment. The only exception to this rule is agreeing to arrive within 2 hours if called on a Monday morning**. Failure to comply may result in being discharged from clinic.

23. **I understand bringing any children to my appointments is prohibited**. It is my responsibility to find arrangements for my children to be watched while in my appointments. If this becomes an issue that results in my missing my appointments, I understand it may result in my discharge from the program.

24. I understand **USAGE OF TOBACCO and/or NICOTINE PRODUCTS IS PROHIBITED** while on clinic property. Failure to comply may result in immediate termination or suspension from the program. Confidentiality:

25. I understand that those I see and what I hear in treatment is strictly confidential. Violation of confidentiality will likely result in immediate discharge and may subject me to other penalties and sanctions as prescribed by laws and regulations governing the protection of individual confidential information.

26. Confidentiality extends to all forms of social media. Any posting on Facebook, Twitter or any other social media about any participation in the MAT program is strictly forbidden and any mention of any other patient or participant of the MAT program is a **blatant** violation of patient confidentiality and will result in immediate discharge may subject me to other penalties and sanctions as prescribed by laws and regulations governing the protection of individual confidential information.

27. I understand that my **health issues may be discussed in the group**, especially as it pertains to drug-related complications. For this manner of openness within the group,

I **give** consent _____ I **do not** give consent _____ for sharing of my information.
Initials Initials

I have read and understand the above agreement and my questions have been addressed. I received a copy of this agreement.

I have also received copies of the following forms:

- 1. Copy of consent
- 2. Hepatitis C information
- 3. Prohibited Drug list while in MAT

- 4. Benzodiazepine practice
- 5. Make-up policy
- 6. Urine drug screen policy
- 7. Lost or stolen medication policy
- 8. Voluntary and Involuntary withdrawal policies
- 9. Social Media policies
- 10. My relapse prevention plan
- 11. Patient Rights information

Patient Signature X_____Date ___/___/___

Witness Signature X_____Date ___/___/___

Benzodiazepine Use Policy

● If a patient arrives for a first intake appointment and the urine drug screen is positive for Benzodiazepine's, the patient will not be started on Suboxone given the risk of this combination of medications. The patient may come one time to be screened before next appointment and can receive a prescription for Suboxone if the urine drug screen is negative for Benzodiazepines. If the UDS is still positive, the patient must then wait until next appointment to be screened again.

● If at any point, a patient tests positive for Benzodiazepines but denies using, the patient may be given the previously planned prescription. However, if Benzodiazepines are confirmed, the patient will likely be suspended from clinic for up to 30 days.

● If the patient screens positive for Benzodiazepines and admits to using, the following applies:

- If a patient is already established in the MAT Program and receiving medication but screens positive for Benzodiazepines, the patient will must come back the next day to complete another UDS but will not be given a prescription for Suboxone given the risk of the combination of these two medications. The patient will continue to come for daily UDS until the patient screens negative for Benzodiazepines. Once screened negative for Benzodiazepines the patient will receive a prescription for Suboxone sufficient to last until the next appointment.
- If the patient lives a distance away, he/she will have the option of taking an order for a UDS to a local facility to be performed the following day. The patient then comes to the clinic when the UDS is negative for Benzodiazepines. When an outside facility performs a UDS, the facility must fax the results to the MAT Clinic in order for the patient to get his/her prescription for the balance of medication to last until the patient's next scheduled appointment.

NOTE: This policy is at the discretion of the doctor and may be modified at any time.

Signature of Patient _____ Date_____

Staff signature: _____ Date _____

Involuntary Withdrawal Procedure

When a patient involuntarily withdrawals (is dismissed) from the program, it can be for various reasons:

1. Multiple relapses (depending on how often the relapses occur and on what substance the patient relapses) which are indicative of the need for a more intensive level of treatment and appropriate referral options will be provided.

2. Continual use of benzodiazepines which constitutes a serious health risk. Continued use of benzodiazepines, as with other repeated relapses, is indicative of the need for a more intensive level of treatment and appropriate referral options will be provided.

3. Continual misuse of alcohol constitutes a serious health risk and, as with other repeated relapses, is indicative of the need for a more intensive level of treatment and appropriate referral options will be provided.

4. Continual use of marijuana, as with other repeated relapses, constitute repeated relapses and are indicative of the need for a more intensive level of treatment. Should the program physician and the MAT team determine, with the patient's input, that withdrawal from the MAT program is best, appropriate referral options will be provided.

5. Habitual absences from group meetings, both in the clinic and 12 step meetings, are a violation of the program rules that were agreed upon during the admission process. Various treatment alternatives will be provided for you to choose from and recommendations will be provided. A referral will be done for you.

6. Missing individual counseling sessions repeatedly which are a violation of the program rules that were agreed upon during the admission process. Various treatment alternatives will be provided for you to choose from and recommendations will be provided. A referral will be done for you.

7. Missing a random drug screen or any occurrence or information which leads to serious suspicions of diversion or misuse may result in involuntary withdrawal. Generally, no taper will be given during the process of offering a referral to another appropriate program. or if there is other information which is suspicious for diversion or alcohol misuse

8. Being abusive or disrespectful to the staff or other patients which is completely unacceptable and are a violation of the program rules that were agreed upon during the admission process. Various treatment alternatives will be provided for you to choose from and recommendations will be provided. A referral will be done for you, but any provider you select will be advised of the reason for your dismissal from the MAT program.

The dismissal is always at the discretion of the physician and the MAT team. You will be provided with a 7 day supply of their current dose of Suboxone with the understanding that this is their "tapering dose" and that this

prescription should be used to slowly taper themselves off Suboxone. As you have been provided with a list of alternative treatment providers, unless a referral was arranged for you with an initial appointment scheduled, you will immediately begin to identify another Suboxone or comparable MAT program to enter into. If Intensive Outpatient Treatment or Residential Treatment was recommended for you, MAT staff can assist you in identifying an appropriate program if you have not chosen one upon dismissal from the program. No tapering dose will be written for patients who relapse on benzodiazepines because of the risk of death when Suboxone and benzodiazepines are used together. A detoxification referral will be offered to you and arrangements will be made for your admission.

You will be provided with a prescription for naloxone. Many health departments offers a 30 minute training for Naloxone and provides free Naloxone during the training. Call your local health department for information.

Readmission to the MAT Program is always at the discretion of the MAT Team and can be discussed with you should you so desire.

Medical Withdrawal

When a patient voluntarily withdraws from the MAT Program, it can be for various reasons:

1. The patient has chosen to titrate their dose of Buprenorphine down gradually and has decided to discontinue the medication all together.

2. The patient has reasons such as work or school that necessitates that Buprenorphine be discontinued.

Medical withdrawal occurs as a voluntary and therapeutic withdrawal in accordance with approved national guidelines. In some cases, the withdrawal may be against the advice of clinical staff or against medical advice yet the patient wants or needs to discontinue Buprenorphine.

The MAT program shall supply a schedule of dose reduction well tolerated by the patient. The program shall continue to offer supportive treatment, including increased counseling sessions and recommendations for 12-self groups or other counseling services as appropriate. The MAT Director and Medical provider will work with the patient to devise a plan for gradually decreasing doses of Buprenorphine until the dose of medication is low enough that cessation of the medication will not result in severe withdrawal symptoms and / or induce cravings.

If the patient leaves the MAT program abruptly against medical advice, the program may re-admit the patient within 30 days without a formal reassessment procedure. However, the program must perform a physical assessment and a biopsychosocial assessment upon re-admission after 30 days of departure. The program shall document attempting to assist the patient with any issues which may have triggered his or her abrupt departure.

The MAT program shall offer continuing care of each patient following the last prescription given for Buprenorphine. The patient will be encouraged to continue with counseling as warranted and agreed to by the patient and their primary therapist for any length of time needed and desired by the patient.

Re-entry to maintenance treatment will be available to the patient who has voluntarily withdrawn if the patient feels at risk for relapse or a relapse has occurred or if the patient has reconsidered withdrawal and decided voluntary withdrawal is not in their best interest.

Female patients shall have a negative pregnancy screen prior to the onset of medically supervised withdrawal. Should a pregnant patient decide to voluntarily withdrawal from the MAT program, the patient will be advised of the potential impact on the fetus as well as the risks for themselves. Should a pregnant patient determine to

withdrawal against medical advice, the dose will be gradually titrated in accordance with approved national guidelines for pregnant patients.

The MAT program shall provide an individually tailored detailed relapse prevention plan developed by the primary counselor in conjunction with the patient and in accordance with approved national guidelines. The prevention plan shall be given to the patient in writing prior to the administration of the final dose of medication.

_____ _____

Patient Signature Date

_____ _____

MAT Program Staff Signature Date

Lost or Stolen Medication Policy

If a patient's Medication / Prescription is lost or stolen, the following applies:

1. The patient must provide a **police report** if the medication is stolen and the following provisions may also apply at the discretion and clinical judgement of the Program Medical Director and the MAT team.

2. If the police refuse to provide a police report about the stolen medication, a signed statement, including the officer's badge number, from the police stating that a stolen medication report will not be completed.

    a. If the patient is currently scheduled for weekly clinic visit, the patient may either be required to go without medication for a week or be offered a prescription that they would have to pay for out-of-pocket as insurance will not pay for this medication.

    b. If the patient is currently scheduled for bi-weekly visits to the clinic, he or she may have to go without medication if the next scheduled appointment is less than a week from the date of lost medication. If the patient's next scheduled appointment is more than 7 days from the date of report, the patient may be required to go without medication until 7 days prior to the next scheduled appointment at which time medication will be provided daily for the balance of remaining week, with the patient being required to check in daily. If patient does not check in daily, either by reporting or calling in, the patient may then be discharged from the program.

    c. If the patient is currently scheduled for monthly visits to the clinic, he or she may be required to go without medication until one, two or three weeks prior to the next scheduled appointment. At that point, the patient will be required to check in either daily or weekly until the next scheduled appointment. Sufficient medication will provided until the next required visit for the remainder of the time until the scheduled appointment. If patient does not check in daily or weekly as required, either by reporting or calling in, the patient may then be discharged from the program.

3. The patient will be drug tested at the time of the report of stolen or lost medication. If the patient provides a clean UDS, the patient will not be considered to have relapsed and days clean will remain as is. If the UDS tests dirty with any drug other than Buprenorphine, the patient will have relapsed and the policy for a dirty urine drug screen will apply.

***NOTE: The above policy does not pertain to pregnant patients. Please see below:**

- If the patient is pregnant and reports medication being stolen, she must provide a police report or a signed statement from the police as described above.

- For a pregnant woman, follow the police report or signed statement, the patient will receive enough medication until the next scheduled visit. Daily or weekly check-ins may be required, with medication being provided that is sufficient until the next required visit.

_____ _____

Patient Signature Date

_____ _____

Your Organization Program Staff Signature Date

MAT Social Media Policy

This policy is intended to help MAT patients make appropriate decisions about the use of social media such as blogs, wikis, social networking websites, podcasts, forums, message boards, or comments on web-articles, such as Twitter, Facebook, LinkedIn or other social media websites.

This policy outlines the standards we require MAT patients to observe when using social media, the circumstances in which we will monitor your use of social media and the action we will take in respect of breaches of this policy.

This policy covers all patients. Patients who are active in treatment, including but not limited to weekly, bi-weekly, monthly, and bi-monthly patients and patients who have left the program or who have been dismissed from the program for any reason.

The Scope of the Policy

All patients are expected to comply with this policy at all times to protect the privacy, confidentiality, and interests of MAT patients, both current and former.

Breach of this policy will be dealt with on a case by case basis and, in serious cases, may be treated as gross misconduct leading to dismissal from the MAT program. Failure to adhere to this policy, whether active or inactive in the MAT, program may result in deleterious action.

Implementation of the Policy

Implementation of this policy is effective upon the signature of the patient and becomes the responsibility of the patient.

Prohibited on social media:

1. Use of a current or former patient's name, or other identifiable feature, in connection with their participation with this treatment program.

2. Use of a current or former employee's name, or other identifiable feature, in connection with a current or former patient's name, or other identifiable feature, with this treatment program.

3. Any statement which is likely to create a liability (whether it be criminal, civil and whether it be for you or for the MAT program).

4. You are personally responsible for content you publish into social media tools – be aware that what you publish will be public for many years.

5. If you are aware any misuse of social media by other patients in the MAT program that are in breach of this policy please report it to the Care Coordinator or your counselor.

_____ Date _____

Patient Signature

_____ Date _____

Mat Team Member

MAT Program

Procedure for Urine Drug Screen/Chain of Custody

New patients and patients who are seen on a weekly basis are drugged screened in the following manner:

1. New Drug Screen Cup and packaged lid are taken from the box

2. The cup is unwrapped.

3. Patient's first initial and last name are written on the cup

4. The employee takes the patient into the bathroom. The bathroom is scanned for any articles that may have been left in the room.

5. Staff should stand near but should never touch the patient

6. The patient is instructed to adjust the clothing in a manner that the employee may view the urine leaving the body.

7. The cup is handed to the patient.

8. As the employee is watching the urine leave the body, the employee opens the package containing the lid.

9. Then the patient hands the cup to the employee the lid is then placed on the cup.

10. The patient is then allowed to readjust then clothing accordingly.

11. The patients washes their hands while the employee takes the specimen into the lab to set the appropriate timer. At no time is the patient in control of the specimen.

12. After the appropriate time has expired the drug screen is read and the results noted.

13. If there is a question regarding the results of the UDS the employee who has collected the specimen asks another trained employee to read the results.

14. Physician will receive a written copy of all drug screen results prior to the beginning of the group meeting.

a. If the urine contains a substance other than or a prescribed medication (buprenorphine and norbuprenorphine) **and the patient has <u>admitted</u> using, the physician is notified** before group starts.
b. If the urine contains a substance other than buprenorphine or a prescribed substance and the patient **<u>denies</u>** using, the physician is notified before group and a decision is made on the next step to make based on sound MEDICAL practice.

15. A breathalyzer test may be performed on a patient if the physician or staff deem it necessary.

16. If the patient cannot provide a urine sample within 30 minutes of arrival to the clinic medicine will not be dispensed that day and the patient must return the next day for a UDS and prescription.

Patients who have been "clean" for a period of 90 days or longer are screened in the following manner:

1. New Drug Screen Cup and packaged lid are taken from the box.

2. The cup is unwrapped.

3. Patient's first initial and last name are written on the cup.

4. The cup is handed to the patient with the instruction to place the cup in the "lab door" in the bathroom when finished. (The patient will be screened in the New Patient scenario monthly, or more often if the staff feels it may be necessary).

5. The employee retrieves the test from the "lab door" and places the lid on the cup and sets the timer.

6. After the appropriate time has expired the screen is read and the results noted.

7. If there is a question regarding the results of the UDS the employee who has collected the specimen asks another trained employee to read the results.

8. If there is a question regarding the results of the UDS the employee who has collected the specimen asks another trained employee to read the results.

9. Physician will receive a written copy of all drug screen results prior to the beginning of the group meeting.

10. A breathalyzer test may be performed on a patient if the physician or staff deem it necessary.

11. If the patient cannot provide a urine sample within 30 minutes of arrival to the clinic medicine will not be dispensed that day and the patient must return the next day for a UDS and prescription.

INITIAL RELAPSE PREVENTION PLAN

PATIENT NAME: _____

DATE: _____

The Stages of Relapse

Relapse is a process, it's not an event. In order to understand relapse prevention you have to understand the stages of relapse. Relapse starts weeks or even months before the event of physical relapse. In this page you will learn how to use specific relapse prevention techniques for each stage of relapse. There are three stages of relapse.

• Emotional relapse

• Mental relapse

• Physical relapse

Emotional Relapse

In emotional relapse, you're not thinking about using. But your emotions and behaviors are setting you up for a possible relapse in the future.

The signs of emotional relapse are: Restless, Irritable and Discontent

• Anxiety

• Intolerance

• Anger

• Defensiveness

• Mood swings

• Isolation

• Not asking for help

• Not going to meetings

• Poor eating habits

• Poor sleep habits

The signs of emotional relapse are also the symptoms of post-acute withdrawal. If you understand post-acute withdrawal it's easier to avoid relapse, because the early stage of relapse is easiest to pull back from. In the later stages the pull of relapse gets stronger and the sequence of events moves faster.

Early Relapse Prevention

Relapse prevention at this stage means recognizing that you're in emotional relapse and changing your behavior. Recognize that you're isolating and remind yourself to ask for help. Recognize that you're anxious and practice relaxation techniques. Recognize that your sleep and eating habits are slipping and practice self-care.

If you don't change your behavior at this stage and you live too long in the stage of emotional relapse you'll become exhausted, and when you're exhausted you will want to escape, which will move you into mental relapse.

Practice self-care. The most important thing you can do to prevent relapse at this stage is take better care of yourself. Think about why you use. You use drugs or alcohol to escape, relax, or reward yourself. Therefore you relapse when you don't take care of yourself and create situations that are mentally and emotionally draining that make you want to escape.

For example, if you don't take care of yourself and eat poorly or have poor sleep habits, you'll feel exhausted and want to escape. If you don't let go of your resentments and fears through some form of relaxation, they will build to the point where you'll feel uncomfortable in your own skin. If you don't ask for help, you'll feel isolated. If any of those situations continues for too long, you will begin to think about using. But if you practice self-care, you can avoid those feelings from growing and avoid relapse. (Reference: www.AddictionsAndRecovery.org)

MY SELF-CARE PLAN INCLUDES:

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Mental Relapse

In mental relapse there's a war going on in your mind. Part of you wants to use, but part of you doesn't. In the early phase of mental relapse you're just idly thinking about using. But in the later phase you're definitely thinking about using.

The signs of mental relapse are:

• Thinking about people, places, and things you used with

• Glamorizing your past use

• Lying

• Hanging out with old using friends

• Fantasizing about using

• Thinking about relapsing

• Planning your relapse around other people's schedules

It gets harder to make the right choices as the pull of addiction gets stronger.

Techniques for Dealing with Mental Urges

Play the tape through. When you think about using, the fantasy is that you'll be able to control your use this time. You'll just have one drink. But play the tape through. One drink usually leads to more drinks. You'll wake up the next day feeling disappointed in yourself. You may not be able to stop the next day, and you'll get caught in the same vicious cycle. When you play that tape through to its logical conclusion, using doesn't seem so appealing.

A common mental urge is that you can get away with using, because no one will know if you relapse. Perhaps your spouse is away for the weekend, or you're away on a trip. That's when your addiction will try to convince you that you don't have a big problem, and that you're really doing your recovery to please your spouse or your work. Play the tape through. Remind yourself of the negative consequences you've already suffered, and the potential consequences that lie around the corner if you relapse again. If you could control your use, you would have done it by now.

Tell someone that you're having urges to use. Call a friend, a support, or someone in recovery. Share with them what you're going through. The magic of sharing is that the minute you start to talk about what you're thinking and feeling, your urges begin to disappear. They don't seem quite as big and you don't feel as alone.

Distract yourself. When you think about using, do something to occupy yourself. Call a friend. Go to a meeting. Get up and go for a walk. If you just sit there with your urge and don't do anything, you're giving your mental relapse room to grow.

Wait for 30 minutes. Most urges usually last for less than 15 to 30 minutes. When you're in an urge, it feels like an eternity. But if you can keep yourself busy and do the things you're supposed to do, it'll quickly be gone.

Do your recovery one day at a time. Don't think about whether you can stay abstinent forever. That's a paralyzing thought. It's overwhelming even for people who've been in recovery for a long time.

One day at a time, means you should match your goals to your emotional strength. When you feel strong and you're motivated to not use, then tell yourself that you won't use for the next week or the next month. But when you're struggling and having lots of urges, and those times will happen often, tell yourself that you won't use for today or for the next 30 minutes. Do your recovery in bite-sized chunks and don't sabotage yourself by thinking too far ahead.

Make relaxation part of your recovery. Relaxation is an important part of relapse prevention, because when you're tense you tend to do what's familiar and wrong, instead of what's new and right. When you're tense you tend to repeat the same mistakes you made before. When you're relaxed you are more open to change. (Reference: www.AddictionsAndRecovery.org)

MY MENTAL RELAPSE RESPONSE PLAN:

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Physical Relapse

Once you start thinking about relapse, if you don't use some of the techniques mentioned above, it doesn't take long to go from there to physical relapse. Driving to your dealer.

Driving to the liquor store.

It's hard to stop the process of relapse at that point. That's not where you should focus your efforts in recovery. That's achieving abstinence through brute force. But it is not recovery. If you recognize the early warning signs of relapse, and understand the symptoms of post-acute withdrawal, you'll be able to catch yourself before it's too late.

WHO DO YOU REACH OUT TO IF YOU DO USE:

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_____
_____
_____

References 1) The stages of relapse were first described by Terence Gorski. Gorski, T., & Miller, M., Staying Sober: A Guide for Relapse Prevention: Independence Press, 1986.

Know Your Patient Rights

Which Laws Protect People in a Medication-Assisted Treatment Program?

1**. First, Americans with Disabilities** Act –"ADA." Applies to: Private employers if 15+ employees (Title I); Local and State governments (Title II);Places of Public Accommodation" – private places open to the public, e.g. hospitals, doctors' offices, day care, hotels. ("Title III")

2. **Second, Rehabilitation Act of 1973 ("Rehab Act")** - Applies to Federal Government, Federally funded State/local government activities, and federally funded private programs or activities.

State **Laws Protect People in a Medication-Assisted Treatment Program?**

WV TITLE 69 LEGISLATIVE RULE SERIES 12 REGARDING MEDICATION ASSISTED TREATMENT

3. The Patient Rights section states:

18.1. Each OBMAT program shall develop and implement policies and procedures which guarantee the following rights to patients:

18.1.a. To be informed, both verbally and in writing, of **program rules and regulations and patients' rights and responsibilities**. The rights and responsibilities shall be posted prominently and reviewed with the patient at admission, at the end of a stabilization period, at the time of an annual treatment review and at any time changes in the rights and responsibilities occur;

18.1.b. To receive **treatment provided in a fair and impartial manner** regardless of race, sex, age, sexual orientation or religion;

18.1.c. To receive an **individualized plan of care or treatment strategy** developed according to guidelines established by a nationally recognized authority and approved by the secretary.

18.1.d. **To receive medications required by the individualized plan of care or treatment strategy** on a schedule developed in accordance with applicable federal requirements and approved guidelines and protocols that is the most accommodating and least intrusive and disruptive method of treatment for most patients;

You will also have the right to **discuss the dose of your medication** with the prescribing physician and the treatment team at every medical group meeting. Any decrease in the dose of medication will be with your knowledge.

18.1.e. **To be informed that random drug testing of all patients shall be conducted** during the course of treatment as required in this rule, and that any refusal to participate in a random drug test shall be considered a positive test. The patient shall be informed of the consequences of having a positive drug screen result;

18.1.f. To be entitled to participate in an OBMAT program that provides an **adequate number of competent, qualified and experienced professional staff** to implement and supervise the individualized plan of care or treatment strategy;

18.1.g. To **be informed about potential interactions with and adverse reactions to other substances**, including alcohol, other prescribed medications, over-the-counter pharmacological agents, other medical procedures, and food;

18.1.h. To be informed about the **financial aspects of treatment**, including the consequences of nonpayment of required fees;

18.1.i. To be **given a copy of the initial assessment, written acceptance into the program; or, in the case of denial of admission a referral to an appropriate treatment program** based upon the results of the initial assessment;

18.1.j. To **ensure confidentiality in accordance with federal regulations**, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996, as amended;

18.1.k. **To be informed of the extent of confidentiality, including the conditions under which information can be released without consent**, the use of identifying information for the purposes of program evaluation, billing and statutory requirements for reporting abuse;

18.1.l. To **give informed consent prior to being involved in research projects** and the right to retain a copy of the informed consent form; 18.1.m. To receive full disclosure of information about treatment and medication, including accommodation for those who do not speak English, or who are otherwise unable to read an informed consent form; and

18.1.n. To be **entitled to protection from other patients' disruptive actions or behavior**. The program shall attempt to determine the cause of that behavior so that an appropriate referral to an alternative method of care can be made.

18.2. The OBMAT **program shall have patient grievance procedures** which shall be displayed in the patient care area in a conspicuous place and easily available to patients. They should include program rules, consequences of noncompliance and procedures for filing a complaint or grievance. The procedures shall inform the patients of the following:

18.2.a. **The right of a patient to express verbally or in writing his or her dissatisfaction** with or complaints about treatment received;

18.2.b. The right of a patient **to initiate grievance procedures without fear of reprisal**;

18.2.c. The right of a patient to be **informed of the grievance procedure** in a manner that can be understood by the patient; and

18.2.d. The right of a patient to **receive a decision in writing** with the reasoning articulated.

18.3. Administrative withdrawal shall be used only as a sanction of last resort. It is the responsibility of the program to make every attempt before a patient is discharged to accommodate the patient's desire to be referred to an alternative treatment program as appropriate.

4. Federal Laws that do not directly involve the MAT program:

a. Fair Housing Act: applies to most housing providers (landlords), and others who sell or rent housing (brokers)

b. Workforce Investment Act: applies to federally funded workforce development programs

Patient Signature X_____Date ___/___/___

Program Staff Signature X_____Date ___/___/___