WELCOME

Addiction is overwhelming. Recovery doesn't have to be.

At Angels of America, our purpose is to deliver the best individualized comprehensive outpatient treatment for drug and alcohol addiction in Columbus, Ohio.

By completing the following forms, you are declaring that you are ready to be free from the challenges, pain and problems that brought you to us. Please answer each form completely and honestly so that we can fully support you with the plan that best serves you without the fear of judgment.

This is your time. You deserve the best. Our team is here to be sure you get it.

LET'S GET STARTED

1525 Bethel Rd, Suite 100 Columbus, OH 43220 I Office 614-396-7850 I Fax 614-396-9265

Angels of America New Patient Packet

Buprenorphine/Naloxone Agreement

The purposes of this agreement are to (1) *define the terms and conditions within the Angels of America doctor-patient relationship,* ***(2)*** *provide basic information about medications you will be taking to manage Opioid Dependence (OD) and* ***(3)*** *review how Angels of America physicians must comply with state and federal regulations when prescribing buprenorphine/naloxone (B/N) using best practices. Our treatment team's goal is to help you have the best quality of life possible given the reality of your clinical condition.*

The success of your treatment *depends on mutual trust and honesty in the physician/patient relationship, following physician orders, and attending required counseling and any other modalities, i.e., psychiatric care, that may be required.* ***It is imperative you read and understand any and all documents given to you while you are an Angels of America patient.***

WHILE UNDER THE CARE OF ANGELS OF AMERICA PHYSICIANS:

1. I will use only Angels of America physicians to prescribe and monitor B/N and adjunctive medications. If my primary care physician (PCP) has already prescribed adjunctive medications (muscle relaxants, antidepressants, or other non-narcotics), it will be up to me to obtain in writing from that office, my PCPs permission to have an AA/A doctor continue these medications.

2. I will use one pharmacy to obtain all my prescriptions prescribed. I will sign a separate pharmacy agreement and it will be added to my chart. I understand that pharmacy is defined as same location; not one chain or string of stores with the same name.

3. I have been instructed to attend mandatory substance abuse counseling. I agree to obtain my initial assessment from my counseling facility ***within the first 4 weeks*** of my first B/N prescription. I will sign an information release form for my ANGELS OF AMERICA physician so s/he can follow this progress.

4. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment. I understand that my B/N must be approved by my insurance company (if I have/use insurance) before I can fill my prescription. If prior approval/pre-authorization (PA) is not made in a timely fashion, I will either have to personally pay for B/N to take until my next appointment or wait without B/N until my PA has been authorized by my insurance company.

5. Prescriptions for B/N or any other prescriptions will be handled only during an office visit. No refills of any medications will be written or called in during the evening or on weekends. Emergencies will be considered on a case-by-case basis.

6. I will bring back any medications prescribed by my physician in their original containers when:

- ***I am requested to do so OR***
- ***I voluntarily stop taking my medication for ANY reason***

The ANGELS OF AMERICA staff will expedite the PA as quickly as possible. We do not, however, have control over how quickly your insurance company will act, especially if it is Friday afternoon. We try not to schedule new appointments during this time.

Patient Initials:________

These medications will be destroyed upon their return after their amounts are reconciled. This destruction will be witnessed by the AA/A staff and I will sign a medication reconciliation form at such time. If I (or anyone else) dispose of my medication(s) I have stopped taking (i.e., flushing them down the toilet) that prevents me from returning my medications to AA/A, I will be discharged from the practice immediately.

7. I am responsible for keeping my medication in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. Stolen medications should be reported to the police and to my physician immediately. If medication is lost, misplaced or stolen, your physician will NOT replace them (even if a police report is filed).

8. I may not give or sell my medications to any other person under any circumstances. If I do, I may endanger that person's health. It is also against the law and, as such, I will be discharged as a patient and reported to the proper authorities.

9. Any evidence of drug hoarding, obtaining other opioid medication or adjunctive analgesia from other physicians (which include emergency depts.) or other persons, uncontrolled dose escalation or reduction, sale of prescription(s), or failure to follow any of my AA/A agreements will result in my termination.

10. I will communicate fully to my physician to the best of my ability at the initial and all follow-up visits, my withdrawal symptoms and functional activity along with any side effects of medications. This information allows my physician to adjust my treatment plan accordingly.

11. I will not use any illicit drugs, such as cocaine, marijuana, etc. while taking my medications. This will place my treatment in jeopardy. Either a safe discontinuation schedule of my medication will be used or a one-to-four week supply of medicine will be provided until a complete termination of the doctor/patient relationship occurs.

12. The use of alcohol is also UNACCEPTABLE. If it is discovered I am using alcohol, my treatment as a B/N patient will be jeopardized. It will be up to my AA/A physician to determine if I will continue as a patient. This also applies to the use of other drugs mentioned above in number 11.

13. I agree and understand that my physician will perform urine drug testing at each office visit and I understand this may include the possibility of collecting a directly observed specimen. When requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor will consider this a "positive test" unless an oral drug screen is agreed to. If not, this may result in complete termination of the doctor/patient relationship. The presence of any unprescribed drug(s) or illicit drug(s) in my urine is grounds for my termination; this is at the discretion of my physician.

14. S**ide effects with B/N therapy** may include, but are not exclusively limited to: skin rash, itching, constipation, sexual dysfunction, sleeping abnormalities, sweating, and other signs of withdrawal. I understand that the first week is when I may have the most of these side-effects due to the dose of B/N being up-titrated. The likelihood of overdosing with B/N is small; however, there still exists a small danger of this if I abuse such medications.

15. I will inform my physician of all medications I am taking. This includes herbal remedies, over-the-counter medications, and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.

16. I understand that although B/N contains a narcotic, it also contains naloxone which helps prevent the full effect of the opioid component. While unlikely to cause significant drowsiness, which may delay my response/reaction times, I will still exercise care if and when driving or operating any machinery while on B/N, especially if my dose has just been increased.

Patient Initials: _______

17. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that withdrawal is quite uncomfortable, but not a life-threatening condition.

18. If I have a history of alcohol or drug misuse/addiction, I must notify the AA/A physician of such history.

19. I agree to allow my physician to contact anyone: health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if the physician feels it is necessary.

20. I agree to a family conference or a conference with a close friend or significant other if the physician feels it is necessary.

21. I agree to be pregnancy tested should my physician deem this necessary. I understand that if I am pregnant or become pregnant while taking B/N medications, this will alter my care and I will be referred to another specialist immediately.

22. I understand that it is the primary goal of AA/A physicians in using B/N medications is to treat my opioid dependence and NOT necessarily my pain condition (if I have one).

23. My dose will NOT be raised to accommodate pain issues, rather only to augment the suppression of withdrawal signs and symptoms, should they be present.

24. I understand and agree that I MUST have a primary care provider (PCP) while a patient at AA/A Clinic. If I do not have a PCP, for whatever reason, I understand I have 60 days to find AND visit my PCP. If I do not establish a doctor-patient relationship with a PCP within 60 days, I will be discharged as a patient from AA/A.

25. I understand I will receive B/N medication at my initial visit as part of an up-titration schedule. I also understand I may not obtain a dose that I think will be the best for me or a dose that I was getting previously or "off the street".

26. I agree to random pill counts. It is my responsibility to supply AA/A with functional phone numbers and a correct address where I live so I can be contacted for a pill count. Also, I agree to all conditions related to pill counts at AA/A outlined elsewhere.

27. I agree to store my prescribed medication safely out of sight and reach of all children. Buprenorphine can cause severe, possibly fatal, respiratory depression in children. Patient Initials: ________

I have read each page of this Buprenorphine/Naloxone agreement and my initials on each page testifies to this. Questions I had, have been explained to me. I agree to its terms and conditions fully and I appreciate that these terms and conditions are set forth in this agreement so that I may be provided a responsible opioid dependence management experience when using B/N therapy to help increase my daily function and improve my life.

Patient's Signature:____**Date**:______________

Printed Name:____

Witness Signature:____**Date:**______________

Printed Name:____

Pharmacy Agreement

I,____, the undersigned and patient of Angels of America of America (AA/A), have been instructed to use only **ONE pharmacy** while I am under the care of the physicians at AA/A.

One pharmacy is defined as ***a single location***, not a chain of stores having a pharmacy such as Kroger's, Walgreen's, or CVS, where multiple locations exist and may be used.

The Pharmacy I will use is:____.

The Address is:____.

The Phone Number is:____.

There may be circumstances when my pharmacy has either run out of my medicine or does not have the strength of medication prescribed by my doctor. ***If this is the case, I will ask the pharmacist to call AA/A and report this problem right away to uphold the transparency required of me as part of my doctor-patient relationship concerning the prescribing of my medications***. The pharmacist can then inform AA/A staff if I was sent to another pharmacy for my medicine.

I will be subject to random pill counts where I will receive a call from AA/A. I will be instructed to take the medication I receive that day from AA/A to my selected pharmacy above (preferred) OR, to another pharmacy, OR to bring the medication into AA/A by the end of business to be counted and reconciled. If I go to a pharmacy, the pharmacist on duty will call AA/A to disclose the count verbally. If AA/A is closed (after 6pm), I will ask the pharmacist to fax this information to (614) 396-9265 by 10pm (the fax must be time-stamped by 10pm).

If, for any reason, I change my primary pharmacy indicated above on this form, I must inform AA/A of this change as soon as possible (within 72 hrs.) and report the reason for changing pharmacies. I accept the responsibility that I may be discharged from care if it is discovered that I have used more than one pharmacy for my medications.

Failure to fulfill any of these conditions outlined above will more than likely result in my discharge from care at AA/A. I understand the above terms and I am in agreement with the conditions as mentioned.

I have been given a copy of this agreement for my records. I agree to present a copy of this contract to the pharmacist when I am participating in the pill count review.

____ _________________

Patient Signature **Date**

____ _________________

Witness Signature **Date**

<u>Adjunctive Medication Agreement</u>

Occasionally, medicines referred to as "adjunctive" are prescribed with primary medications for an added benefit. However, these are intended for short-term use and should be discontinued after one month or several weeks, at a maximum. These medications include benzodiazepines (such as Valium®), the muscle relaxer Soma®, and sleep aid drugs as Ambien®.

AA/A physicians will not be prescribing these categories of medications even if you have received such medicines from other physicians.

<u>The reasons for this are multiple including:</u>

- These medications, in some, can be dangerous when combined with certain opioids, especially buprenorphine.
- These medications should be used short term (1-4 weeks) in acute situations, depending upon what is needed, i.e., muscle relaxer or a sleep aid medicine;
- These medications should only be used long-term by psychiatrists due to their side effect profile and high addiction potential;
- Benzodiazepine can be used for severe anxiety and this diagnosis must be established by a psychiatrist and then these medications can be prescribed by that same doctor who will manage your severe anxiety problem;
- If any of these medicines are being used for sleep, then you must be seen by a sleep specialist for an evaluation of why you cannot sleep and what part of your sleep is being affected.

Every patient using these types of medications is required to have a psychiatrist prescribe, if it is deemed necessary. The medications listed above are NOT allowed in our program. Exceptions will not be considered unless written consent and explanation has been given by the prescribing psychiatrist and/or sleep specialist.

Patient Signature:____Date: ________________

Patient Printed:____

Witness Signed:____Date:_________________

Witness Printed: ____

Telephone Appointment Reminder Consent

I, _________________________________,DOB_____/____/____,give ____,
Patient Name (Print) Physician Name (Print)

and members of his/her staff working at Angels of America permission to call me prior to an appointment to remind me of the appointment date and time.

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

( ) Work: ____

( ) Cell: ____

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. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw me consent during my treatment. This consent will expire 365 days after I complete my treatment.

____ ________________________________ _______________
Patient Signature Patient Name (Print) Date

____ ________________________________ _______________
Witness Signature Witness Name (Print) Date

PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

Use the opposite side of the page if necessary to complete your answers. Please print legibly.

Name: ____ DOB: ________________

Age: ________________ SS#:____

Address: ____

City: _________________________ State: _______________________ Zip Code: _____________________

Phone: (w) _____________________ (h) ______________________ (c) ____________________________

Emergency Contact: ____

Relationship to patient: ____________________________ Phone: __________________________________

Primary Care Physician: ______________________________ Phone: _________________________________

Date of last physical: _____________________ Have you ever had an EKG? ( ) N ( ) Y Date:__________________

Current of past medical conditions (check all that apply):

( ) Asthma/ respiratory ( ) Cardiovascular (heart attack, high cholesterol, angina)

( ) Hypertension ( ) Epilepsy or seizures disorder ( ) GI disease

( ) Head trauma ( ) HIV/AIDS ( ) Diabetes

( ) Liver problems ( ) Pancreatic problems ( ) Thyroid disease

( ) STDs ( ) Abnormal Pap smear ( ) Nutritional deficiency

Other (Please describe):

____

____

If there is a family history of any of the illnesses listed above, please put an “F” next to that illness.
Is there a family history of anything NOT listed here? ( ) N ( ) Y (please explain)______________________________

____

____

Have you ever had **surgery** or been **hospitalized**? ( ) N ( ) Y (please describe) ____________________________

____

____

Childhood Illnesses

Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

Have you or a family member even been diagnosed with psychiatric or mental illness? ( ) N ( ) Y

(Please describe) ____

Have you ever taken or been prescribed antidepressants? ( ) N ( ) Y

For what reason?____

Medication(s) and dates of use: ____________________________ why stopped? ____________________________

Please list all current prescription medications and how often you take them (example: Dilantin 3x/day)

DO NOT include medications you may be currently misusing (that information is needed later):

____

____

Please list all herbal medications, vitamin supplements, etc. and how often you take them:

____

____

Have you ever been diagnosed with a **Seizure?** Yes / No

If Yes, when? ______________________ and by whom? ____

Do you recall the name given to your type of seizure? ____

What medications were you placed on? ____

Are you still using those medications? Yes / No

If No, why not? ____

Please list any allergies you have (e.g., penicillin, bees, and/or peanuts):

____

____

Patient Name: ____ DOB: ________________________

Angels of America of America Initial Visit Questionnaire

Patient Name: ____ DOB: ____________________

Substance Abuse History :

I originally started my use of narcotics in (month/year) ________________________ at age _____________

I started using opioids like oxycodone: ☐ To Get High ☐ To treat pain ☐ After Surgery

Fill out all that apply ((Please write (C) for current and (P) for past))

Substance (C) or (P)	How Used	Amount	Last use
Heroin		Grams/day	
Cocaine		/day	
Opioids		Mg/ Day	
Marijuana		Joints/Day	
Alcohol		Drinks/Day	
Tobacco		Packs/Day	
Other Drugs			
Buprenorphine(Suboxone)		/Day	

Substance Abuse Counseling (SAC) History: (Check what applies)

☐ I am not attending SAC currently.

☐ I am trying to set up SAC currently

☐ I am attending SAC currently at: ____

- I attend ________________/ week for individual counseling
- I attend ________________/week for group counseling

☐ I have attended SAC in the past. Last attended (mo./yr.): ____________/____________ at _____________

☐ I have NEVER attended any kind of SAC

Have you ever been to Individual Counseling: ( ) N ( ) Y

If you are not currently in counseling what made you stop attending and/or attend originally?
____
____

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name: ____ DOB__________________

Living Arrangements:

(Circle one)
I live in: An Apartment House Trailer Other________________

I live with: Spouse My Children Significant Other Friend Other

I live with "users" currently I do NOT live with "users" currently

Employment History:

☐ I am currently working ☐ FT ☐ PT at__________________________________.

☐ I am not working now but I will be seeking: ☐ Employment ☐ Disability

☐ I am already disabled due to ____.

(Circle one) Married Single Long-term Relationship Divorced/Separated

Years married/ in long-term relationship: __________ Times Married: __________ Times Divorced: ____________

Children? ( ) N ( ) Y Current ages (please list)

____

Residing with you? ( ) N ( ) Y If no, where?

____

Where are you currently living?

____

Do you have family nearby? ( ) N ( ) Y (please describe)

____

Education (check most recent degree):

( ) Graduate School ( ) College ( ) Professional or Vocational School

( ) High School Grade ____________________

Have you ever been arrested or convicted? ( ) N ( ) Y (Check all that apply)

( ) DWI ( ) Drug-related ( ) Domestic violence ( ) other ______________________

Have you ever been abused? ( ) N ( ) Y

( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally ( ) Emotionally