Recovering Hope Together.

Patient Name: ____ DOB _____/______/______ (Month / Day / Year) M F

Drug Allergies: ____

Tobacco Use: Y N If yes, type: __________ Packs/day _________ How long? ________________

Alcohol Use: Y N Number: _________ per day per week

Current Prescribed Medications

____

____

____

____

____

Surgeries

____

____

____

____

____

Medications used before treatment

____

____

____

____

____

Family

Alcoholism
Arthritis
Cancer Type / Who ____________
Diabetes
Depression
Heart Attack Who? ______ Age ____
High Blood Pressure
Obesity
Other (specify)

Patient Medical Problems

____

____

____

____

____

Insurance Information

____

____

____

____

INTERNAL USE ONLY: Staff Updates

____

____

____

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Recovering Hope Together.

Please take a few minutes to answer the following questions so we may better assist you with your health care needs.

Patient Information

Patient Name (Last) ________________________________ (First) ____________________________ (MI) ____

Name you prefer to be called _________________________ Email ____________________________________

Date _____/_____/______ SS# ______/______/______ DOB _____/______/______ Age____

Month Day Year Month Day Year

Patient Address ____ Home Phone ( ) ____________________

City _________________________________ State ______ Zip _________ Cell ( ) ____________________

Sex: M F

Status: Minor Single Married Long Term Partner Divorced Widowed Separated

Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate
(Check the highest level achieved)

Employment Information

Employer ____ Business Phone ( )____________

Business Address ____

Occupation ____________________ City ____________________________ State ______ Zip ______________

Who should we thank for referring you? ____

In case of emergency who to contact? _______________________________ Phone ( ) __________________

Medical Information & History

Reason for your visit: ____

____

____

When was your last physical exam? ______/______ Physician's Name ___________________________________

Month Year

Drug Allergies? ____

All drugs used in the past six months: ____

WATAUGA Recovery Centers

Recovering Hope Together.

Patient Information: Page 2

Have you had any surgical procedures? If so, please list: ____

____

	Father	Mother	Self	Other		Father	Mother	Self	Other
Heart Disease					Asthma				
High Blood Pressure					Pneumonia				
Stroke					Abdominal Disease				
Cancer					Prostate Disease				
Glaucoma					Frequent Infections				
Diabetes					Anemia				
Epilepsy/Convulsions					Arthritis				
Kidney Disease					Dizziness / Fainting				
Thyroid Disease					Depression				
Mental Illness					Scarlet Fever				
Headache/Migraines					Chronic Rashes				
Shortness of Breath					Rheumatic Fever				
Heart Palpitations					Gout				
Heart Murmur					Hepatitis				
Chest Pain					High Cholesterol				
Bronchitis					Nervousness				

Pregnant? Y N Planned Pregnancy? Y N

Do you smoke? Y N If yes: Packs Daily ________ No. of Years _______
If you have quit smoking, how long has it been since your last cigarette? ____________________

Do you drink alcohol? Y N If so, what type do you drink (Check all that apply): Liquor Beer Wine

How much and how often do you drink? ____

Do you consume caffeine? Y N If so, how much daily? (cups/glasses/cans) ____________________

How would you describe your sleep pattern? ____

____

Financial Policy

Thank you for selecting Watauga Recovery Center for your health needs. We are honored to be of service to you and your family. Please be advised that payment for all services will be due at the time they are rendered, unless prior arrangements have been made. For your convenience, we accept cash, Visa, MasterCard, and Money Orders. No checks, please.

I agree that, should this account be referred to an agency or an attorney for collections, I will be responsible for all collection costs, attorney's fees and all other costs that may be incurred as part of the collection process.

By signing below, I agree that I have read and understand the above statements.

______________________________________ ______/______/_______

Patient's Signature Month Day Year

Recovering Hope Together.

Pharmacy Use Agreement

Patient Name ____ Date ____________________

I, _______________________, agree to fill my prescriptions only at the pharmacy I list below. If I change pharmacies, I will contact my doctor's office and provide them with the name, address, and phone number of the new pharmacy. Under no circumstances will I obtain medicine from more than one pharmacy at a time. In order to verify appropriate medication use, my doctor's office will provide my chosen pharmacy with a copy of this agreement.

Pharmacy Name: ____

Address: ____

____

Phone Number: ____

I understand that, by signing this agreement, I must abide by the rules reviewed above and that failure to do so will result in termination of medication prescriptions and possibly the termination of services from my doctor and his or her practice.

____

Patient's Signature

To All Patients of Watauga Recovery Centers, Inc.

Here at Watauga Recovery Center we use random urine drug screens. These drug screens are sent to an outside laboratory for confirmation analysis.

By law, the lab is required to create a bill for the testing performed. Your insurance company will receive a bill from the laboratory for processing your urine drug screen.

Your insurance company is prohibited by federal regulation from disclosing to your employer any information concerning your visit here, including the billing or results or urine drug screening.

If you are uninsured, you will receive a bill in the mail. If you do not have the means to pay the bill, you may contact the lab directly for assistance.

Sincerely,

Watauga Recovery Center Staff

____

Patient's Signature:

Recovering Hope Together.

Patient Name ____ Date _______________________

As a participant in the buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments and adhere to the payment policy of the office.
2. I agree to conduct myself in a courteous manner in the doctor's office.
3. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal. Additionally, I agree not to deal, steal, or conduct any illegal or disruptive activities.
4. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
5. I agree that the medication I receive is my responsibility and I agree to keep it in a safe and secure place. I agree that lost medication will not be replaced regardless of why it was lost. No exceptions.
6. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
7. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example: Valium, Klonopin, Xanax), can be dangerous and/or FATAL.
8. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
9. I understand that medication alone is not sufficient treatment for my condition, therefore, I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
10. I agree to abstain from alcohol, opioid, marijuana, cocaine, and other addictive substances (except nicotine).
11. I agree to submit to random drug screens.
12. I understand that violations of the above may be grounds for termination of my treatment.

____ ___________________________

Patient Signature Date

Recovering Hope Together.

NOTICE OF PRIVACY PRACTICES

Substance Abuse Programs 42CFR Part 2

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Watauga Recovery Center is required to abide by the terms of this notice. The medical information we maintain may come from any of the providers from whom you have received services. The medical information we record and maintain is known as Protected Health Information, or PHI. We will not use or disclose your PHI without your permission, except as described in this notice.

Information regarding your healthcare, including payment for healthcare, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 42 U.S.C. 1320d et seq., 45 F.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C 290dd-2, 42 C.F.R. Part 2. Under these laws, Watauga Recovery Center may not say to a person outside Watauga Recovery Center that you attend the program, nor may Watauga Recovery Center disclose any information identifying you as an alcohol or drug abuser, or disclose any other PHI except as permitted by federal law.

We reserve the right to change our practices and to make the new provisions effective for all medical information we maintain. Should our medical information practices change, we will amend this notice and post a notice of the changes, which will be made available to anyone upon request. This notice is effective as of February 01, 2012.

USES AND DISCLOSURES

Watauga Recovery Center must obtain your written consent before it can disclose information about you for payment purposes. Generally, you must also sign a written authorization before Watauga Recovery Center can share information for treatment purposes or for healthcare operations. However, federal law permits Watauga Recovery Center to disclose information without your written permission for the following:

- Pursuant to an agreement with a person or agency that provides services to Watauga Recovery Center
- For research, audit or evaluation
- To report a crime committed on Watauga Recovery Center premises or against Watauga Recovery Center personnel
- To medical personnel in a medical emergency
- To appropriate authorities to report suspected child abuse or neglect
- As allowed by court order

Before Watauga Recovery Center can use or disclose any information about your health in a manner which has not been described above, it must first obtain your specific written authorization allowing it to make the disclosure. You may revoke any such written authorization in writing, except that we have already acted on it.

WHAT ARE YOUR RIGHTS? YOU HAVE THE RIGHT TO:

- Request restrictions on certain uses and disclosures of your Protected Health Information (PHI)
- Receive reasonable confidential communication of PHI, e.g. contact you at your place of choosing
- Inspect and copy your medical record by written request, with some exceptions. Watauga Recovery Center reserves the right to deny the request, to which you may make further appeal.
- Receive an accounting of Watauga Recovery Center's disclosures of your PHI during the six years prior to your request. Accounting of disclosures start as of April 14, 2003 and are unavailable prior to that time.
- Receive a paper copy of this notice.

HOW CAN YOU REPORT A PROBLEM?

If you feel your privacy rights have been violated, you may file a complaint with the Watauga Recovery Center Privacy Officer (423)631-0432, the TN Department of Health Information at (615)741-6350 or the Secretary of the United States of Health and Human Services (DHHS) Office for Civil Rights (ORC) at: U.S. DHHS,OCR, J.F. Kennedy Federal Building – Room 1875 Boston, Massachusetts 02203 1-617-565-1340 TTD: (617)565-1343 Fax (617)656-3809

WATAUGA Recovery Centers

Recovering Hope Together.

NOTICE OF PRIVACY PRACTICES
Substance Abuse Programs 42 CFR Part 2

THE WATUGA RECOVERY CENTER NOTICE OF PRIVACY PRACTICES ON THESE TWO PAGES DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- Watauga Recovery Center is federally mandated to maintain the privacy of your medical information and wants you to know about our practices for protecting your Protected Health Information (PHI).
- Watauga Recovery Center is required to abide by the terms of the Notice of Privacy Practices provided on the attached pages.
- Authorized Uses and Disclosures: In general, it is our policy to obtain written authorization at any time.
- Non-authorized Uses and Disclosures: Under certain circumstances we may make disclosure of your medical information without your authorization. These conditions are listed on the attached pages.

WHAT ARE YOUR RIGHTS? YOU HAVE THE RIGHT TO:

- Request restrictions on certain uses and disclosures of your Protected Health Information (PHI)
- Receive reasonable confidential communications of PHI
- Inspect and copy your medical record by written request, with some exceptions. Watauga Recovery Center reserves the right to deny the request, to which you may make a further appeal
- Receive an accounting of Watauga Recovery Center's disclosures of your PHI during the six years prior to your request. Accounting of disclosures starts as of April 14, 2003 and are unavailable prior to that time.
- Receive a paper copy of this notice.

HOW YOU CAN ASK A QUESTION, LEARN MORE OR REPORT A PROBLEM.

Watauga Recovery Center urges you to read the complete Watauga Recovery Center Notice of Privacy Practices found on the attached pages of this document. The Watauga Recovery Center Privacy Officer, @ (423)631-0432, the TN Department of Health Information (615)741-6350, or the Secretary of the United States Department of Health and Human Services are ready to assist you. There will be no Retaliation for filing a complaint.

I hereby acknowledge receipt of the Watauga Recovery Center Notice of Privacy Practices:

____ ____________________

Patient Signature Date

____

PATIENT Name (please print)

____

Witness Signature

_________Patient refuses to sign Notice of Privacy Practices

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Recovering Hope Together.

NOTICE

It is the policy of Watauga Recovery Center to **NOT** prescribe Subutex®.

If you feel that there are no alternatives to your treatment other than being prescribed Subutex®, we must ask you seek another facility to meet your needs.

If you check-in with us as a patient, participate in our services and decide you want a refund because we will not prescribe Subutex®, you will only receive half of your initial visit fee back.

If at some point in the future you decide that our services may be right for you, you are welcome to return to Watauga Recovery Center.

By signing this document you acknowledge and understand Watauga Recovery Centers policy on Subutex®.

I hereby acknowledge receipt of the Watauga Recovery Center Subutex® policy:

____ ________________________

Patient Signature Date

____

PATIENT Name (please print)

Recovering Hope Together.

WEAPONS POLICY

It is the policy of Watauga Recovery Centers, Inc. that weapons of any kind are not allowed on Watauga Recovery Center property at any time. The term 'weapon' includes firearms, knives, pepper spray, stun-guns or any other object intended to cause bodily harm to another person.

Watauga Recovery Centers, Inc. does not allow employees to bring a weapon of any kind on to the property though the employee may be licensed by the state to carry a concealed weapon. Employees must leave weapons of any kind off site.

Patients of Watauga Recovery Center may not bring weapons onto the property at any time.

Watauga Recovery Center staff reserves the right to ask a patient in possession of any weapon to immediately leave the premises.

I hereby acknowledge receipt of the Watauga Recovery Center Weapons policy:

____ ____________________

Patient Signature Date

____

PATIENT Name (please print)

Recovering Hope Together.

TEXT MESSAGING POLICY

Watauga Recovery Centers, Inc. and our associated practices, utilize an automated text messaging system to inform patients of upcoming appointments and other important non- clinical information. Patient participation is voluntary. Patients may have their number removed from the system at any time by request. Watauga Recovery Centers, Inc. and our associated practices will not share patient telephone numbers or other information without the express permission of the patient except when legally required to do so.

I hereby acknowledge receipt of the Watauga Recovery Center Text Messaging Policy:

____ ____________________

Patient Signature Date

____

PATIENT Name (please print)