Suboxone Program

Rules and Regulations

In order to receive the best treatment possible, we ask that you follow these simple rules and guidelines while participating in Clinton County Medical Center's Suboxone Program:

- Attend weekly counseling sessions throughout entire program
- Be on time for appointments (later than 15 minutes will result in having to reschedule)
- Be honest in your treatment and actively participate in your sessions
- Attend physician/nurse appointments as scheduled
- Co-pay and/or fees are paid prior to each appointment
- A late fee will be assessed if you no show or cancel an appointment without 24-hour notice
- Cell phones are to be turned of during any office visit or counseling session
- Keep Suboxone in a safe place (preferably locked up)
- CCMC will not replace lost or stolen prescriptions
- Take Suboxone as prescribed by your physician
- No use of narcotics unless approved by CCMC physician
- No use of Medical Marijuana while in the program
- At any time, you may be asked to bring in your Suboxone prescription (within a 24-hour period)
- A missed office visit will result in not getting your prescription (no prescription will be called in)
- Do not sell or share your Suboxone
- A urine drug screen is required before receiving your prescription. Positive drug screens require you to set up an ADDITIONAL individual counseling session
- Always conduct yourself in a courteous, respectful manner in our offices
- Always respect confidentiality. Information seen or heard while at CCMC facilities is to remain confidential
- Same day appointments will not be made

There are no exceptions to these rules.
Not following the above rules may result in being discharged from the program.

Suboxone Financial Agreement

Your signature below forms a binding agreement between Clinton County Medical Center (CCMC – the provider of medical services) and the patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills. All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. While our staff will try to aid you in working with your insurance company, ultimately it is your responsibility to check with your insurance.

The person signing on behalf of the client as the Responsible Party must:

- Inform CCMC of the current address and phone number for the patient and the responsible party.
- Picture identification is required at each visit.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Deductibles and co-pay's are required to be paid at the time of service or you may be asked to reschedule your appointment.
- Pay any additional amount owing within 30 days of receiving a statement from our office.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that CCMC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% ARP, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Cancelation – No Show Policy

Please note the providers at CCMC are in direct contact with the counselors at CCMC Psychological Services to make sure we give you the best care.

- If you have not had a counseling appointment, you will not receive your prescription and will still be responsible for the office visit charge.
- If you no show an appointment, you will be charged for the entire office visit. (Office visit fees start at $50 and are subject to change without notice.)

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

_____
Responsible Party Name (Please Print)

_____ _____
Responsible Party Signature Date

Patient Intake: Medical History

(To be completed by patient)

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

Name: _____

Address: _____

Phone (w): _____ (h) _____ (c) _____

DOB: _____ Age: _____ SS#: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Date of last physical: _____ Have you ever had an EKG? □ No □ Yes Date: _____

Current or past medical conditions. (Check all that apply):

IF there is a family history of any of the illnesses below, **please put an "F" next to the illness**

□ Asthma/Respiratory □ Cardiovascular (heart attack, high cholesterol, angina)

□ Hypertension □ Epilepsy or seizure disorder □ GI disease

□ Head Trauma □ HIV/AIDS □ Diabetes

□ Liver Problems □ Pancreatic problems □ Thyroid Disease

□ STD's □ Abnormal Pap smear □ Nutritional deficiency

Other (please describe): _____

_____

Family History of Illness not listed above? (Please explain): Use back side of paper

Have you ever had **surgery** or been **hospitalized**? (Please describe):_____

_____

_____

Childhood Illnesses:

Measles □ Yes □ No Mumps □ Yes □ No Chicken Pox □ Yes □ No

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness?**
(Please describe):_____

Have you ever taken or been prescribed **antidepressants?** □ No □ Yes For what reason?
_____

Medication(s) and dates of use: _____
Why did you stop? _____

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day) DO **NOT** include medication you may be currently misusing (that information will be covered later)

_____
_____
_____

Please list all **current herbal medicines**, **vitamin supplements**, etc. and how often you take them.

_____
_____

Physician Notes:

_____
_____

Please list any **allergies** you have (penicillin, bees, peanuts, etc.):

_____
_____

Tobacco History

Cigarettes: Now? □ No □ Yes In the past? □ No □ Yes
How many per day on average? _____ For how many years? _____

Pipe: Now? □ No □ Yes In the past? □ No □ Yes
How often per day on average? _____ For how many years? _____

Have you ever been treated for substance misuse? □ No

(If YES, please describe when, where and for how long)_____

_____

_____

How long have you been using substances? _____

Substance Abuse History

	No	Yes/Past Or Yes/Now	Route	How Much	How Often	Date/Time of last Use	Quantity last used
Alcohol							
Caffeine (pills or beverage)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? □ No □ Yes (Please list):

_____

_____

_____

What was your longest period of abstinence? _____

_____

Physician Notes: _____

_____

Clinton County Medical Center

Patient's Authorization for Release of Protected Medical & Mental Health Information

This form for Authorization for Release of Protected Health Information is designed to comply with Title 42 of Federal Regulations, Part 2 (regarding alcohol and substance abuse records) and/or state laws respecting confidentiality of records and patient communications with mental health professionals, other healthcare providers and medical center support staff. I hereby authorize Clinton County Medical Center (CCMC) to use or disclose the specific information described below, only for the purposes and to the parties described below.

Patient's Name

_____

Last First Middle Initial

Address

_____

Street City State Zip Code

Telephone _____ Date of Birth _____

The undersigned hereby authorized Clinton County Medical Center to release any and all information contained in the records of the patient listed above. INCLUDING INFORMATION REGARDING DRUG AND/OR ALCOHOL TREATMENT, PSYCHOLOGICAL AND SOCIAL SERVICES RECORDS, COMMUNICATIONS MADE TO A SOCIAL WORKER, PSYCHOLOGIST, OR PSYCHIATRIST, AND HIV/AIDS-RELATED COMPLEX DOCUMENTATION, to the individual(s) or organization(s) listed below.
Name of person(s) or organization(s) to whom disclosure is to be made:

☐ Clinton County Medical Center Psychological Services, 1505 Waterford Parkway, St. Johns MI 48879

☐ Other: _____

Address: _____

For any ongoing substance abuse counseling and treatment.

_____

This information is being requested for the purpose of continuity of care.

This authorization is subject to revocation at any time, except to the extent that Clinton County Medical Center or its staff have already taken action in reliance upon it. I may revoke this authorization in writing by contacting Medical Records (information from medical record) or Patient Accounts (information from billing record) at the address below. Unless earlier revoked, consent will expire 60 days from date signed.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.

I understand that I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

I understand that if I am authorizing the release of protected health information not created by CCMC that CCMC cannot verify the accuracy or completeness of records created by other providers.

_____ _____

Signature of PATIENT or PATIENT'S LEGAL REPRESENTATIVE Date

If signed by a legal representative, indicate his/her relationship to the patient (parent, guardian, etc.) and attach legal documentation:

_____ _ _____

Witness to Signature Date

Patient: _____ Date: _____

SUBOXONE REGULATIONS
I AM SIGNING HERE TO INDICATE THAT I WILL ACTUALLY
READ ALL OF THE BELOW BEFORE INITIALLING

SIGN **WITNESS**

****

THE PURPOSE OF SIGNING THIS FORM IS TO RE-INFORM YOU OF THE ALREADY EXISTING RULES AND REGULATIONS BY WHICH WE DISPENSE AND PRESCRIBE SUBOXONE MEDICATIONS. WE DO THIS BECAUSE PATIENTS MAY AT TIMES FORGET AND WE WOULD LIKE TO MAKE THE PROCESS AS SEEMLESS AS POSSIBLE.

I HAVE BEEN LICENSED BY THE STATE OF MICHIGAN AND THE DEA (DRUG ENFORCEMENT AGENCY) TO PROVIDE SUBOXONE TO PATIENTS FOR THE TREATMENT OF OPIOD DEPENDENCE, PRACTICING ADDICTION MEDICINE REQUIRES A SPECIALIZED GOVERNMENT LICENSE AND ALTHOUGH IT IS IN EVERYONES INTEREST TO TREAT AS MANY PATIENTS AS WE CAN FOR THIS PROBLEM, THE GOVERNMENT HAS PUT INTO PLACE VERY STRICT RULES, THESE DEA REGULATIONS ARE SO RIGID THAT I MUST OBSERVE THEM IN ORDER TO PROVIDE YOU WITH THIS MEDICATION. I WILL ADHERE TO THESE RULES IN ORDER TO MAINTAIN COMPLIANCE.

PLEASE DO NOT ASK FOR EXCEPTIONS AS THEY WILL NOT BE GRANTED.

****

-You may NOT make any adjustment to your Suboxone without my prior approval. Doing so may cause discharge from the program. **Initial_____**

-You must make office visits as directed by your physician, no exceptions, for all refills. DEA requires this. **Initial_____**

-We will under NO circumstance EVER prescribe more than ONE month's worth of medication ever. We do not send prescriptions to ANY mail-away prescription service. **Initial_____**

-If you fail to show for 3 office visits, you may be discharged from the program. There are too many patients waiting in line that really want this treatment. You must be serious and committed to this cause and demonstrate this. **Initial_____**

-Please do not call in the last minute when you run out of medications and expect us to get you in anytime. Please plan accordingly. Withdrawals are not fun so please plan ahead. We can accommodate your needs almost anytime, but maybe not in the last minute. **Initial_____**

-We will follow-up with you as needed to make adjustments to your medications regimen. If deemed necessary, we will call you back for any issues. We will only call back after hours if it is truly needed for the purpose of adjustments. Do not expect call after hours or weekends unless it's an emergency. **Please note that losing your medicine is not an emergency.** **Initial_____**

-Guard your medications like your cash. They will NOT be refilled. If you lose them or if they are stolen, you will go thru withdrawal until your next refill. This will not be fun. Guard them extremely well. The DEA doesn't care about why you lost it. **Initial_____**

-We are obligated by the DEA to do random urine drug tests. I will ask you what other drugs I will find on the urine test before doing this. Additional drug use or non-compliance will lead to termination at my discretion. I never judge patients for relapses but I do expect honesty and compliance and an effort at remaining drug free. If you fail a drug test expect to give me a written explanation that I can log for the DEA so I can even consider continuing you on Suboxone. **Initial_____**

-We expect you to understand (and sign) that you realize that Suboxone is a form of narcotic and that if you drive any vehicle (motor or otherwise) you may cause accidents that can harm or kill you or others. In addition, you may be charged with a DUI if you drive while on any narcotic including Suboxone. We are telling you here and now that you may NOT drive within 12 hours of taking Suboxone. If you feel you can drive safely, that is your choice but it is against our medical advice. **Initial_____**

-You will NOT share this medication with anyone else EVER. If you do, we will discharge you immediately and we are obligated to report this to the police and the DEA as this puts providers at CCMC profession and license on the line. This will not be tolerated, even once. **Initial_____**

-We may request random urine testing throughout the program. If we call you to drop off a urine specimen, We will expect a sample within 12 – 24 hours. We must do this to prove to the DEA that we are in compliance. If you fail to provide the requested samples as directed, you may be discharged from the program. **Initial_____**

-Please note that it is your responsibility to check with your insurance and see if they will pay for Suboxone. A few insurance require prior authorizations. If your insurance requires a prior authorization, you will be required to schedule a visit with the nurse in order for the prior authorization to be completed. **Initial_____**

-SIGNING BELOW INDICATES THAT I HAVE READ EVERY LINE ITEM ABOVE, UNDERSTAND THE WRITTEN ENGLISH LANGUAGE AND HAVE HAD A CHANCE TO ASK QUESTIONS ABOUT EVERY ITEM. YOU UNDERSTAND THAT AT ANYTIME IF YOU HAVE ANY QUESTIONS AT ALL ABOUT THESE REGULATIONS YOU MAY CALL OUR OFFICE AT 989-224-3000 AND GET AN ANSWER.

Patient Name: _____ Date: _____

Patient Signature: _____

Physician Name: _____

Physician Signature: _____

PATIENT TREATMENT CONTRACT

Patient Name: _____ Date: _____

As a participant in 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.

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

3. I agree to conduct myself in a courteous manner in the doctor's office.

4. 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.

5. I agree not to deal drugs, steal, or conduct any illegal or disruptive activities in or around the doctor's office.

6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.

7. 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.

8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.

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

10. I understand that mixing this medicine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®**, Xanax®***), can be dangerous. I also recognize that several deaths have occurred among person mixing buprenorphine

and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).

11. 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.

12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plans.

13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).

14. I agree to provide random urine samples and have my doctor test my blood alcohol level.

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

_____ _____

Patient Signature Date

AUTHORIZATION TO RELEASE INFORMATION, TREATMENT OF A MINOR, AND ASSIGNMENT OF BENEFITS

I understand that as part of my health care, this organization originated and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I authorize Clinton County Medical Center to bill and release to private insurance carriers such information from my patient records as is required in order to receive reimbursement for any billings for services. This includes alcohol and drug abuse and mental health treatment information protected under the regulations in title 42 or code of Federal Regulations Part II. Information about human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC) as defined by the Department of Public Health rules Act 174 1989 and Act 368 Public Act 1978.

We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other healthcare provides who may be involved in your care and treatment. We may also call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding you care. Also, we may contact you to provide information about health related benefits and services offered by our office.

I request that payment of authorized benefits (if billed by the office) be paid directly to Clinton County Medical Center on my behalf. This is an authorization agreement, until such time as revoked by me and a yearly update is required. I understand that I am responsible for/hereby accept responsibility for the payment to Clinton County Medical Center for whatsoever sums of money shall become due and payable for services received. I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. I certify that all statement made on this application are true.

I authorize Clinton County Medical Center staff to discuss my medical and billing information with the following person(s): (This may include family members, friends, neighbors, or anyone else you designate):

Name & Phone number (if possible)	Relationship to patient	Info to be released (Please circle)
		Medical, Financial, Mental Health, or all
		Medical, Financial, Mental Health, or all
		Medical, Financial, Mental Health, or all

★ ____ __________________ ___________________

Signature of Patient or Legal Representative Date Initials of Witness

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REQUEST AND CONSENT FOR TREATMENT OF MINOR CHILDREN (IN THE ABSENCE OF PARENT OR GUARDIAN)

As a parent or guardian, I, _________________________________, hereby request and give my full consent for medical care, treatment and/or surgery, and authorize hospital admission, as the treating physician may deem medically necessary, for my child during my absence. This is a lifetime authorization agreement, until such time as revoked by me. However, a yearly update is required. Listed below are the individual(s) that are authorized to make medical decisions and bring my child in for medical treatment in my absence. (You may use the back of this form as well)

Name	Phone	Relationship

★ ____ _______________ ______________________

Signature of Patient or Legal Representative Date Initials of Witness