BAP Wellness
5553 Hwy 90
Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

Intake Packet To Include:

1. Fee Schedule (1 page)
2. Explanation of First Visit (2 pages)
3. Explanation of Treatment (2 pages)
4. Urine Drug Screen and Pill Count Agreement (1 page)
5. Patient Handout - Evolving Treatment Empowering Patients (24 pages)
6. Medication Guide (4 pages)
7. Patient Treatment Contract (3 pages)
8. Patient Intake Medical History Form (4 pages)
9. Patient Intake Social/Family History (1 page)
10. Consent to release/Receive Confidential Information Form (2 pages)
11. Methadone Transfer Consent Form (2 pages)
12. Appointed Pharmacy Consent Form (2 pages)
13. Counseling Resource Sheet (1 page)
14. After Hours Contact (1page)
15. Telephone Appointment Reminder Consent Form (1page)

BAP Wellness
5553 Hwy 90
Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

Fee Schedule For Suboxone Clinic

Intake Packet: $10.00 (There $10.00 will be taken off of there initial visit price if excepted, $5.00 refunded if they return the packet and decide not to register as a patient in the program or if we decide not to accept you as a patient.)

Initial Visit:
Male: 250.00
Female: 275.00

Follow up Visits:
$175.00

$6.00/day

Family conferences $200.00/hr (minimum charge $200.00)

BAP Wellness
5553 Hwy 90 Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

EXPLANATION OF FIRST VISIT

Your first visit is generally the longest, and may last anywhere from 1 to 4 hours.

When preparing for your first office visit, there are a couple of logistical issues you may want to consider:

- You may not want to return to work on the day of your visit—this is very normal, so just plan accordingly
- Because the medication can cause drowsiness and slow reaction times, particularly during the first few weeks of treatment, driving yourself home after the first visit is generally not recommended, so you may want to make arrangements for a ride home

It is very important to arrive for your first visit already experiencing moderate opioid withdrawal symptoms. If you are in withdrawal, the medicine is supposed to help lessen the symptoms. However, if you are *not* in withdrawal, the medicine will "override" the opioids already in your system, which will *cause* severe withdrawal symptoms.

The following guidelines are provided to **ensure you are in withdrawal for the visit.** (If this concerns you, it may help to schedule your first visit in the morning; some patients find it easiest to skip what would normally be their first dose of the day.)

- No methadone or long-acting painkillers for at least 24 hours
- No heroin or short-acting painkillers for at least 4 to 6 hours

Bring ALL medication bottles with you to your first appointment.

Before you can be seen by the doctor, all of the paperwork your doctor provided must be completed. If your doctor provided the paperwork to you prior to this visit, bring it completed or arrive about 30 minutes early to fill it out.

Urine drug screening is a regular procedure of treatment, because it provides physicians with important insights into your health and your treatment. Your first visit will include urine drug screening, and may also entail a Breathalyzer®* test and blood work. If you haven't had a recent physical exam, your doctor may require one. To help ensure that this medicine is the best treatment option for you, your doctor will perform a substance dependence assessment and mental status evaluation. Lastly, you and your doctor will discuss the medicine and your expectations of treatment.

After this portion of your visit is completed, your doctor will administer your first dose. Your doctor may have you fill the prescription at the pharmacy and return to the doctor's office so you can take the medication in a safe place where the medical staff can monitor your response.

Once you take your first dose, you should begin to feel better within 30 minutes. Your doctor may choose to give you additional doses while you are in the office. It's important that you are honest about how you are feeling during induction so your doctor can find the appropriate dose for you.

When you leave the office, the doctor will likely give you a prescription that will last until your next appointment. The doctor may also want to discuss counseling with you, since medication plus counseling has been shown to

produce better results. At the same time, your doctor may suggest enrolling in the Here to Help® Program, which can provide you with an added support system.

Your doctor may ask you to keep a record of any medications you take at home to control withdrawal symptoms. You will also receive instructions on how to contact your doctor in an emergency, as well as additional information about treatment.

CHECKLIST FOR FIRST VISIT:

- ☐ Arrive experiencing moderate **opioid withdrawal** symptoms
- ☐ Arrive prepared to give a urine sample for screening
- ☐ Bring completed **forms** (or come 30 minutes early)
- ☐ Bring **ALL medication bottles**
- ☐ **Fees due** at time of visit (cash or check)

Please see your doctor or pharmacist for full Product Information for your medicine

BAP Wellness
5553 Hwy 90 Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

EXPLANATION OF TREATMENT

Intake

You will be given a comprehensive substance dependence assessment, as well as an evaluation of mental status and physical exam. The pros and cons of the medication, will be presented. Treatment expectations, as well as issues involved with maintenance and medically supervised tapering off the medication will be discussed.

Induction

Treatment begins here. You will be switched from your current opioid of misuse (heroin, methadone, or prescription painkillers) to your treatment medication. You are asked to arrive at the doctor's office in a moderate state of withdrawal. Being in a state of moderate withdrawal is vital to having the medication work well. If you are not in moderate withdrawal, the medication might actually make you feel worse rather than better (intensifying withdrawal symptoms). This is called **precipitated withdrawal.**

It is really important to be truthful with your doctor about the last time you used an opioid, which opioid it was, how much you took, and which other drugs or medications you used. Your doctor needs this information to determine the timing of your first dose.

Once you take your first dose, you should begin to feel better within 30 minutes. Your doctor may choose to give you additional doses while you are in the office. Be sure to tell your doctor about how you are feeling during induction so your doctor can find the appropriate dose for you.

When you leave the office, the doctor will likely give you a prescription that will last until your next appointment. The doctor may also want to discuss counseling with you, since medication plus counseling has been shown to produce better results. At the same time, your doctor may suggest enrolling in the Here to Help® Program, which can provide you with an added support system.

Since an individual's tolerance and reactions to the medicine vary, daily appointments may be scheduled and medications will be adjusted until you no longer experience withdrawal symptoms or cravings. Urine drug screening is typically required for all patients at every visit during this phase.

Intake and Induction may both occur at the first visit, depending on your needs and your doctor's evaluation. Call your doctor if you have any questions or concerns.

Stabilization & Maintenance

This is the second phase of treatment. During this phase, your doctor may continue to adjust your dose until you find, and continue on, the dose that works for you. It is important to take your medication as directed. To evaluate the effectiveness of your dose, your doctor may request urine samples from time to time.

During this phase is when you may also begin working on your treatment goals with your doctor and counselor. At times when you feel stressed, or experience triggers or cravings, your doctor may suggest a dose adjustment, or there may be a need to change the frequency of counseling and/or behavioral therapy.

Occasionally, as you achieve your treatment goals and feel confident about your progress, your physician may suggest a dose decrease. During these times, you are "restabilized." This is why stabilization and maintenance go together.

Tapering Off

There are no time limits for treatment with this medicine. Length of therapy is up to your doctor, you, and sometimes your therapist or counselor. If you and your doctor agree that the time is right for a medical taper, he or she will slowly lower your dose (also known as a taper), taking care to minimize withdrawal symptoms. If you feel at risk for relapse during a taper, let your doctor know. You can be restabilized and continue maintenance if needed.

Please note: This medicine is a narcotic medication indicated for the maintenance treatment of opioid dependence, available only by prescription, and must be taken under a doctor's care as prescribed. It is illegal to sell or give away your medicine.

Please see your doctor or pharmacist for full Product Information and Medication Guide

BAP Wellness
5553 Hwy 90
Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

Patient Consent To Urine Drug Screen and Pill Counts

I understand that by the current Florida Laws for controlled medications, that my physician (Dr Garg) will request that I be tested to determine the level of drug or metabolite in my body. The Urine Drug Screen will be performed initially, every visit and then randomly or if deemed necessary by my physician as long as I am receiving suboxone from this clinic. We will also do pill counts randomly.

I understand that I might be called to come into the clinic at any given time and agree to come into the clinic with in 24 – 48 hrs.

I understand that any discrepancies between the results of the drug screening and the medication list I have provided and/or my physician will consider pill count discrepancy a violation of my agreement and result in actions.

I understand that the results and interpretation will become part of my medical record.

I understand that if I fail a urine drug screen and/or pill count that I will be asked to come every (2) two weeks for monitoring and will pay $175.00 each time, until deemed otherwise by Dr. Garg.

All of the above have been discussed with and I have had the opportunity to have any answered that I have regarding the drug testing or my rights to privacy.

_____ _____
Patient Printed Name Date

_____ _____
Patient Signature Date

Witness Signature: _____ _____
Date

BAP Wellness
5553 Hwy 90
Pace, FL 32503
Phone: (850) 995-8811
Fax: (850) 512-1405

PATIENT TREATMENT CONTRACT

Patient Name: _____ **Date:** _____

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

1. I agree and will be advised of the initial cost of my first visit will be $275.00 for female and $250.00 for male. The follow up visits will be $175.00 per month.

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. Initial Visit: You will be seen and evaluated; at that time you will be given a script for (2) two Suboxone filmstrips and asked to go to the Pharmacy and have it filled and you are to return to the office for further evaluation. At that time the Doctor will instruct you on how to use the medication and you will remain at the office for (1) one hour and be reevaluated again to make sure you are giving the correct dosage.

5. Follow up Visits: You will be asked to return on the following Thursday for further evaluation. When you become an established patient you will be seen on the 2nd or 4th Thursday of every month. Thursday at 9:00am for the Davis Hwy Clinic and 2:00pm for the Pace location. If you see you are going to miss your appointment you must call as soon as possible, no less than 24 hours. When you call the office make a note of the date, time, person you spoke to and the code they will give you. You will need this information when you come in and if you do not have the right code, the call never happened.

   If for some reason you are going to be going out of town at the time of your scheduled appointment you will need to make an appointment to see Dr. on the appropriate date and time before you go, so you will not be with out your medicine for that time period, i.e. I am going to be leaving town for work the Sunday before I am due to come in on Thursday for my regular appointment and will be gone out of town for 3 weeks. So I call Dr Garg's office and schedule an appointment for the Thursday before I am to leave even though I still have medicine left When I go to Dr Garg's office I will inform him I am going to be gone out of town for 3 weeks and will only have enough medicine for about a week. He will determine when you will need to come back after you return to town. He might only give you enough medicine to cover the time you will be gone which in this case is 19 days worth of your medicine - so you would have to pay for 19 days at $6.00/day - 6 x 19 = $114.00 or he might give you the hole months worth and charge you for the month.

6. I agree if I see I am going to miss my appointment I must call as soon as possible, no less than 24 hours. If I fail to come for my scheduled appointment I will be charged $6.00 for every day that I am late.

7. I agree after 10 days of not coming that I will be treated as a new patient, (i.e.) and must pay the initial induction fee), Period no excuses, and we may or may not have a slot for you.

Example of 6 and 7 above: I call and inform the office that I will not be able to make my scheduled Thursday appointment but will come in the following Thursday. When I come in I have all the right information and code. I will have to pay 6.00 for 7 days then pay the $175.00 for the next month. Another scenario is this: I call and inform the office that I will not be able to make my scheduled appointment on Thursday but will call back and schedule when I can make I - at this point we will hold you slot for 9 days and the 10th day you will be discharged and be treated as a new patient. If you need to make arrangements to come after 10 days you need to let us know when you first call canceling appointment so that arranges can be made - understanding that you are still responsible to pay the $6.00 a day till you come back in.

8. 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.

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

10. 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.

11. 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.

12. 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.**

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

14. I understand that mixing this medicine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡etc.), can be dangerous. I also recognize that several deaths have occurred among persons 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).

15. I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events.

16. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication or dosage without first consulting my doctor.

17. I understand that the drug addition is not only a physical but also a mental state, and with 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 plan.

18. I agree to allow Dr. Garg to receive my evaluation and any ongoing progress reports, and speak with the Counselor at any time concerning my disease and progress while under his treatment.

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

20. I agree to provide random urine samples and have my Doctor test my blood alcohol level, and do random pill count.

21. I agree that if called to come into the office other than my regular appointment that I will come in within 24 - 48 hrs. and to bring my medication with me, unless I have notified the office before hand that I will be out of town. If I do not come in, it could result in my treatment being terminated without any recourse for appeal.

22. I agree if I fail a urine drug screen and / or pill count that I will be asked to come in every (1-2) one two weeks for monitoring as determined by Dr. Garg, and will have to pay $175.00 for each visit, until deemed by Dr. Garg that I can go longer between visits.

23. I understand that violations of the above may be grounds for termination of treatment without any recourse for appeal.

_____ _____

Patient Printed Name Date

_____ _____

Patient Signature Date

BAP Wellness
5553 Hwy 90 Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

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

Name: _____

Address: _____

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

DOB: _____ Age: _____ SS no.: _____

Emergency contact: _____

Relationship to patient: _____ Phone: _____

Primary care physician: _____ Phone: _____

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

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

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

Other (Please describe) : _____

_____

_____

If there a family history of any of the illnesses listed above, **please put an "F" next to that illness.**

MD NOTES: _____

_____

_____

Is there a family history of anything NOT listed here? ( ) N ( ) Y (Please explain) _____

_____

_____

MD NOTES: _____

_____

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

_____

_____

MD NOTES: _____

_____

Childhood Illnesses

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

Have you or a family member ever been diagnosed with a **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 current **herbal medicines, vitamin supplements**, etc, and how often you take them: _____

_____

MD NOTES: _____

_____

_____

Please list any **allergies** you have (eg, penicillin, bees, or peanuts): _____

_____

MD NOTES: _____

Tobacco History

Cigarettes: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day, on average? _____ For how many years? _____

Pipe: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How often per day, on average? _____ For how many years? _____

Have you ever been **treated for substance misuse**? ( ) N ( ) Y (Please describe when, where and for how long)

_____

How long have you been **misusing substances?** _____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
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? ( ) N ( ) Y (Please list) _____

What was your longest period of abstinence? _____

Are you receiving, or have you ever received counseling support? ( ) N ( ) Y (Please describe when and for how long) _____

MD NOTES: _____

BAP Wellness
5553 Hwy 90 Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name: _____

(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 _____

Are you currently employed? ( ) N ( ) Y Where (if no, where were you last employed)? _____

What type of work do/did you do? _____ How long have/did you work(ed) there? _____

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

Have you ever attended:

AA: ( ) Current ( ) Past **NA:** ( ) Current ( ) Past **CA:** ( ) Current ( ) Past

ACOA: ( ) Current ( ) Past **OA:** ( ) Current ( ) Past

If you are not currently attending meetings, what factors led you to stop? _____

Have you ever been in counseling or therapy? ( ) N ( ) Y (Please describe) _____

BAP Wellness
5553 Hwy 90 Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I, _____, authorize _____ at the above address to:
Patient Name (Print) Physician Name (Print)

MD check all that apply

☐ Receive my medical history information from the following physicians:
(name, address)_____

(name, address)_____

☐ Receive my treatment records from the following therapist:
Therapist (name, address)_____

☐ Release my treatment information/records to the following healthcare professional:
(name, address)_____

☐ Release my treatment information to the health insurance company listed below, for billing purposes:
Insurance Provider (name, address) _____

_____

This information is for the following purposes (any other use is prohibited): _____

_____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____	_____	_____
Patient Signature	Patient Name (Print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Name (Print)	Date
_____	_____	_____
Witness Signature	Witness Name (Print)	Date

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol- and drug-dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol- or drug-dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

BAP Wellness
5553 Hwy 90
Pace, Fl 32571
Phone: (850) 995-8811
Fax; (850) 512-1405

METHADONE TRANSFER CONSENT

I, _____, authorize _____
Patient Name (Print) Physician Name (Print)

practicing at the above address to disclose my treatment for opioid dependence to the outpatient treatment program specified below in order to obtain my medical history, methadone treatment, and any other of my patient information pertinent to the office-based treatment with buprenorphine. I understand that the physician mentioned above may need to discuss my medical and treatment history with the physicians and other staff at the outpatient treatment program specified below.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____	_____	_____
Patient Signature	Patient Name (Print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Name (Print)	Date
_____	_____	_____
Witness Signature	Witness Name (Print)	Date

Outpatient Treatment Program: Name: _____

Phone: _____

Address: _____

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol- and drug-dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol- or drug-dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

BAP Wellness
5553 Hwy 90 Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

APPOINTED PHARMACY CONSENT

I, _____, do hereby: **(MD check all that apply)**
Patient Name (Print)

☐ Authorize _____ at the above address to disclose my treatment for opioid
Physician Name (Print)
dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy.

☐ Agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary so that my buprenorphine prescriptions can be filled and either delivered to the office addressed given above or picked-up by employees of the same.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____	_____	_____
Patient Signature	Patient Name (Print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Name (Print)	Date
_____	_____	_____
Witness Signature	Witness Name (Print)	Date

Appointed Pharmacy: Name: _____ Phone: _____

Address: _____

Confidentiality of Alcohol- and Drug-Dependence Patient Records

The confidentiality of alcohol- and drug-dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol- or drug-dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Local Area Counseling Centers

Cordova Counseling Center
www.cordovacounselingcenter.com/
4400 Bayou Blvd #8D
Pensacola
(850) 474-9882

Counseling & Coaching Associates
www.mytherapistcoach.com/
1720 W Fairfield Dr #302
Pensacola
(850) 912-4492

Pennewill Counseling
www.counselingpensacola.com/
6706 N 9th Ave #4
Pensacola
(850) 462-8870

The Anchor Clinic
www.anchorclinic.com
890 S Palafox St #300
Pensacola
(850) 433-1656

Bay Counseling & Forensic Services
1150 N 12th Ave
Pensacola
(850) 449-1821

Hope Counseling Services
14 W Jordan St
Pensacola
(850) 791-6952

Pensacola Bay Baptist Association
www.pbbassocisation.com
9999 Chemstrand Rd
Pensacola
(850) 471-3430

Lakeview
http://www.bhcpns.org/BehavioralHealth/
1221 Lakeview Ave
Pensacola
(850) 432.1222

Stone Ridge Counseling Center, Inc.
9013 University Parkway, Suite C
Pensacola
(850) 478-7800

Psychological Associates
1120 north Palafox St
Pensacola, FL 32501
(850) 434-5003

BAP Wellness
5553 Hwy 90 Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

AFTER-HOURS CONTACT INFORMATION

Normal office hours are between 8:30 AM and 5:00 PM, Monday thru Friday. For non-urgent requests, please leave a message at the phone number indicated above.

If you need to contact me at any other time, call 1-850 270-2161 and leave your name and phone number with the service. The service will contact me and I will call you back. Note that my phone number is blocked, so if your phone service does not accept calls from blocked telephone numbers, I will not be able to get through to you.

If this is a true emergency, please call 911 first, and contact me second.

BAP Wellness
5553 Hwy 90 Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 512-1405

TELEPHONE APPOINTMENT REMINDER CONSENT

I, _____ give _____,
Patient Name (Print) Physician Name (Print)

and members of his/her staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

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

( ) Work _____

( ) Cell _____

Yes, this office may leave (check all that apply):

( ) Voice mail at my Home ( ) Voice mail at my Work ( ) Voice mail on my Cell

( ) Messages with people at my Home ( ) Messages with people at my Work

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

_____	_____	_____
Patient Signature	Patient Name (Print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Name (Print)	Date
_____	_____	_____
Witness Signature	Witness Name (Print)	Date