OFFICE POLICIES ACKNOWLEDGEMENT

PATIENT NAME: _____

I acknowledge receipt or signing of the following from Deland Medical Wellness.

- HIPAA notice
- Payment Agreement and Release
- Controlled Substances Agreement
- Consent and Authorization
- COMM Questionnaire

I further acknowledge and reiterate acceptance of the following protocols at Deland Medical Wellness.

1. Appointment for Suboxone Therapy.
2. Cancellation of appointment incurs no fee if 24 hours notice is provided.
    - The morning of your appointment is not 24 hours notice.
3. Missed Visits will incur a $50 fee.
4. Patients who fail to maintain the appointment schedule may be discharged.
5. We do not prescribe medication by calling into a pharmacy unless authorized by the physician and only under certain circumstances.
6. Prescriptions are only prescribed during the appointment.
7. No physician coverage or authorizations after hours or on the weekend.
8. Deland Medical Wellness can report any criminal activity to law enforcement officials.
9. Operating Hours Monday - Friday 10 to 4.

_____	_____	_____
Patient Signature	Date	Deland Medical Wellness

AGREEMENT TO STAY AWAY FROM OPIOID PRODUCTS

I agree to refrain from using any opioid products including any food products containing poppy seeds while I am attending the Deland Wellness Center addiction program. I understand that doing so may result in failed drug screenings which may cause me to be discharged from the program.

Patient Signature: _____ Date: _____

PATIENT RISK QUESTIONNAIRE

Patient Name: _____

As you know, opined analgesic medications can be abused, and they are sometimes diverted from legitimate medical use to illegal users. Your answers to these questions will allow us to determine the level of risk to which you and we are exposed to when we prescribe opioid analgesics to you. Your answers to these questions will not result in your being denied medication. Depending on your answers, we may provide an additional level of care to you, so the risk to us and to you is reduced.

If we discover that you have not answered these questions truthfully, that may result in us no longer being able to provide medical services to you. Once completed, this document contains confidential Protected Health Information. It may be disseminated only if specifically permitted under federal and state laws.

IN THE LAST 30 DAYS	Never	Seldom	Sometimes	Often	A lot
Have you had trouble thinking clearly or memory issues?	O	O	O	O	O
Have others complained that you did not complete tasks?	O	O	O	O	O
Have you received pain or any other medicine from more than 1 doctor?	O	O	O	O	O
Have you taken your medication differently than prescribed?	O	O	O	O	O
How often have you seriously thought about hurting yourself?	O	O	O	O	O
How often did you think about opioid medications or heroin?	O	O	O	O	O
How often have you been in an argument?	O	O	O	O	O
How often have you had trouble controlling your anger?	O	O	O	O	O
How often have you taken another person's pain medicine?	O	O	O	O	O
How often have you worried about how you are controlling your meds?	O	O	O	O	O
How often have	O	O	O	O	O

How often have you made emergency call or come to Healthy Life Medical, Inc. without appt?	O	O	O	O	O
How often have you gotten angry with people?	O	O	O	O	O
How often have you taken more medication than prescribed?	O	O	O	O	O
How often have you borrowed pain or other medication from others?	O	O	O	O	O
How often have you used pain medication to treat other illnesses (stress)?	O	O	O	O	O
How often have you visited the Emergency Room?	O	O	O	O	O

Patient Signature: _____ Date: _____

Payment Agreement and Release

PATIENT NAME: _____

Assignment of Benefits:

I hereby irrevocably assign payment to Deland Medical Wellness Center of all medical benefits applicable and otherwise payable to me. Where Medicare benefits are applicable, I certify that the information given by me in applying for payment, under Title XVIII or XIX of the Social Security Act is correct, and request said payment of authorized benefits are made on my behalf. I understand that I am financially responsible to Deland Medical Wellness Center for charges which the carrier declines to pay. It is further agreed that any credit balance resulting from payment by my insurance or other sources may be applied to any other accounts owed to Deland Medical Wellness Center to me or my immediate family.

Release of Information for Payment Purposes:

I hereby authorize and consent Deland Medical Wellness Center LLC release of medical information to obtain payment as noted in the HIPAA notice.

Obligation of Payment: I hereby agree to pay all charges for all services provided by Deland Medical Wellness Center except those covered by insurance. Deland Medical Wellness Center will assist in insurance matters, but I understand that it is my responsibility to comply with all requirements for insurance coverage. I agree to pay all charges not paid by insurance. In the event that I fail to fulfill any obligation in this section, I agree to pay all collection costs incurred by Deland Medical Wellness Center in the enforcement of this section.

Patient Name: _____

Patient Signature: _____ Date: _____

Payment Agreement

I understand that at this time Deland Medical Wellness Center does not accept insurance and collects cash only in the form of payment for services rendered.

Payments for Services:

I hereby agree to pay all charges for all services provided by Deland Medical Wellness Center. Deland Medical Wellness Center will assist in insurance matters regarding prescriptions, but I understand that it is my responsibility to comply with all requirements for insurance coverage for the cost of the medications.

Patient Name: _____ Date: _____

Patient Signature: _____

DRUG ABUSE SCREENING TEST

1. Y N Have you used drugs other than those required for medical reasons?
2. Y N Have you ever misused prescription drugs?
3. Y N Do you misuse more than one drug at a time?
4. Y N Can you get through the week w/o drugs that are nor prescribed?
5. Y N Are you always able to stop using drugs when you want to?
6. Y N Do you misuse drugs on a continuous basis?
7. Y N Do you try to limit your drug use to certain situations?
8. Y N Have you had “blackouts” or “flashbacks” as a result of drug use?
9. Y N Do you ever feel bad about drug misuse?
10. Y N Do your friends or family ever complain about your involvement with drugs?
11. Y N Do your friends or family know or suspect you misuse drugs?
12. Y N Has drug misuse ever caused issues between you and your friends/family?

Have you ever:

13. Y N Lost friends because of your use of drugs?
14. Y N Neglected your family or missed work because of your use of drugs?
15. Y N Been in trouble at work because of drug misuse?
16. Y N Lost a job because of drug misuse?
17. Y N Gotten into fights while under the influence of drugs?
18. Y N Been arrested for being under the influence of drugs?
19. Y N Been arrested for driving while under the influence of drugs?
20. Y N Engaged in illegal activities to obtain drugs?
21. Y N Been arrested for possession of illegal drugs?
22. Y N Experienced withdrawal symptoms as a result of heavy drug intake?
23. Y N Had medical problems due to your drug use?
24. Y N Gone to anyone for help for a drug problem?
25. Y N Been in a hospital for medical problems related to your drug use?
26. Y N Been involved in a treatment program specifically related to drug use?
27. Y N Been treated as an outpatient for problems related to drug dependence?

Name: _____ Date: _____

Signature: _____

PATIENT REGISTRATION FORM

Patient Name: _____ Birthdate: _____

Address: _____Apartment: _____

City, State Zip Code _____ SSN _____-_____-_____

Best Contact Number: _____ Alternate Number: _____

Email Address: _____

Alternate Names used for PDMP: _____

Emergency Contact: _____Phone Number: _____

Please list any doctors who have prescribed controlled substances for you. Failure to disclose this information may lead to your dismissal as a patient of DMWC.

Doctor	Phone Number	Date Last Seen
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

With my signature, I affirm that all the information provided is true and I have omitted nothing. I waive any applicable privilege and give permission to Deland Medical Wellness to obtain my medical records and discuss my medical history with any physicians, hospitals, clinics, diagnostic centers, pharmacies, insurance companies, family, and law enforcement without violating HIPPA. I hold Deland Medical Wellness, its officers, directors, employees, and contractors harmless for any information that may be discussed with any physician, hospital, clinic, diagnostic center, pharmacy, insurance company, family, and law enforcement.

_____ _____

Patient Signature Date

SUBOXONE CONSENT FORM

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 to keep, and be on time to all of 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 manor while in the doctor's office.
4. I agree to not sell, share, or give any of my medication to another person. I understand that such is mishandling of my medication and is a serious violation of this agreement that would results in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities while in the doctor's office.
6. I understand that if dealing, stealing, disruptive or illegal activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior reported to my doctor's office could result in my termination 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 will result in me not being able to have my medication/prescription until my next scheduled visit.
8. I agree to make another appointment in case of a lost or stolen medication and to alert the pharmacy of such incidents.
9. I agree to store medication properly. Medication may be harmful to children, household members, guests and pets. The Suboxone film should be stored in a safe place, out of the reach of children. If anyone besides the patient ingests the medication, I agree to call the Poison Control Center or 911 immediately.
10. I agree not to obtain medications from any other doctors, pharmacies, or other sources without telling my treating physician. I understand that mixing this medicine with other medications, especially benzodiazepines. (Deaths have occurred among persons mixing buprenorphine and benzodiazepines, especially if taken outside the care of a physician).
11. I agree to take my medication as my doctor has instructed and not to alter it in any way without first consulting my doctor.
12. I agree to read the Medication Guide and consult my doctor or pharmacy should I have any questions or concerns about side effects.
13. I understand that medication alone is not a sufficient treatment for my condition, and I agree to participate in counseling as well as attending the chemical dependency rehab program and other support groups as discussed and agreed upon with my doctor and specified in my treatment plan.
14. I agree to notify the clinic in case of a relapse to drug abuse. Relapse to opiate drug abuse can result in being removed from the Suboxone program. An appropriate treatment plan must be developed as soon as possible. The physician should be informed of a relapse before monthly urine testing reveals it.

15. I agree to the guidelines of office operations. I understand the procedure for making appointments and paying for missed appointments and late cancellation fees. I have the phone number to this clinic and I understand the office hours. I understand that no medications will be prescribed by phone or on weekends. I understand that I am required to abide by these restraints in order to remain on the Suboxone treatment plan in this office.
16. I agree to comply with the required film counts and monthly urine tests. Urine testing is a mandatory part of office maintenance. The patient must be prepared to give a urine sample for testing each visit and to show Suboxone film for a film count including reserve medication.
17. I agree to abstain from alcohol, opioids, cocaine, and other addictive substances.
18. I agree to allow my doctor to test my blood alcohol level.
19. I understand that violations of the above may be grounds for termination of my treatment.
20. I understand that the phone numbers I give will be used to contact me to remind me of appointments. I give my permission for the office staff to leave messages on these phone numbers.

FOLLOW UP APPOINTMENT PROTOCOL

Follow up appointments will be at least monthly.
The visits are focused on evaluating compliance and the possibility of relapse. They include: • Film counts

- Urine testing for drug abuse at every visit
- An interim history of any new medical problems or social stressors • Prescription of medication
- No refills of Suboxone will be made for any reason except during a clinic visit.
- Appointments do not include evaluation or care for other problems outside of Suboxone management. Should you have other medical conditions that you wish to address, you will need to schedule a separate appointment.

Dangerous behavior, relapse and relapse prevention.

The following behavior "red flags" will be addressed with the patient as soon as they are noticed:
• Missing appointments

- Running out of medication too soon & Taking medication off schedule
- Refusing urine testing
- Neglecting to mention new medication or outside treatment
- Agitated behavior
- Frequent or urgent inappropriate phone calls
- Outbursts of anger
- Lost or stolen medication
- Non-payment of visit bills as agreed, missed appointments or cancellations within 24 hours of your appointment
- Treatment may be discontinued if these behaviors occur

INFORMED CONSENT

Please read this information carefully. Suboxone (buprenorphine + naloxone) is an FDA approved medication for treatment of people with opiate (narcotic) dependence.

Suboxone is a weak opiate and reverses actions of other opiates. It can cause a withdrawal reaction from standard narcotics or Methadone while at the same time having a mild narcotic pain-relieving effect from the Suboxone. The use of Suboxone can result in physical dependence of the buprenorphine, but withdrawal is much milder and slower than with heroin or Methadone. If Suboxone is suddenly discontinued, patients will have only mild symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opiate withdrawal, Suboxone may be discontinued gradually, usually over several weeks or more.

Some patients find that it takes several days to get used to the transition to Suboxone from the opiate they had been using. After stabilized on Suboxone, other opiates will have virtually no effect. Attempts to override the Suboxone by taking more opiates could result in an opiate overdose. Do not take any other medication without discussing it with you physician first. Combining Suboxone with alcohol or some other medications may also be hazardous. The combination of Suboxone with mediation such as Valium, Librium, Ativan, or Xanax has resulted in deaths.

The form of Suboxone given in this program is a combination of buprenorphine with a short-acting opiate blocker, naloxone. If the Suboxone Film was dissolved and injected by someone taking heroin or another strong opiate it would cause severe opiate withdrawal. Suboxone Film must be held under the tongue until completely dissolved. It is then absorbed from the tissue under the tongue. If swallowed, Suboxone is not well absorbed from the stomach and the desired benefit will not be experienced.

We do not prescribe, under any circumstances, narcotics, Methadone, or sedatives for patients desiring maintenance or detoxification from narcotics. All Suboxone must be purchased at private pharmacies. We will not supply any Suboxone.

SUBOXONE TREATMENT MAINTENANCE

Suboxone treatment may be discontinued for several reasons:

- Suboxone controls withdrawal symptoms and is an excellent maintenance treatment for many patients. If you are unable to stop your heroin abuse or if you continue to feel like using narcotics, even at the top doses of Suboxone, the doctor will discontinue treatment with Suboxone and you will be required to seek help elsewhere.
- There are certain rules and patient agreements that are part of Suboxone treatment. All patients are required to read and acknowledge these agreements by signature upon admission to the treatment panel. If you do not abide by these agreements, you may be discharged from the Suboxone treatment program.

- Prompt payment of clinic fees is part of this program. If your account does not remain current as agreed, appointments cannot be scheduled. If appointments cannot be kept as agreed, your status as an active patient will be cancelled - no exceptions.
- In the rare case of an allergic reaction to medication, Suboxone must be discontinued.
- Dangerous or inappropriate behavior that is disruptive to our clinic or to other patients will result in your discharge from the Suboxone treatment. This includes patients who come to the clinic intoxicated or on other narcotics, Valium, barbiturates or Xanax like medications.
- In the case of dangerous behavior there will be no two-week taper. You will be discharged and asked not to return to the clinic.

By signing this treatment information and consent form, I the undersigned client, acknowledge that l have read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

CONTROLLED SUBSTANCES AGREEMENT

Patient Name: _____

The purpose of this agreement is to protect the patient's access to controlled substances and to protect Deland Medical Wellness Center's ability to prescribe appropriate treatment.

Because controlled substances have potential for substance abuse or diversion, strict accountability is necessary. Addiction is a medical condition. Any and all medication prescribed shall be used only for this purpose. As a condition of the Deland Medical Wellness Center's physician treating me, I agree to the following policies.

1. I will obtain all my suboxone, buprenorphine or Subutex medication from Deland Medical Wellness Center.
2. I will not sell, share or trade medicine. I will only use medication prescribed to me.
3. I will not use any illegal controlled substances.
4. I will safeguard my medication from loss or theft. Medication will not be replaced.
5. I will keep my medication out of the reach of children or others who may not tolerate the medication's effects.
6. I will submit monthly urine tests and medication counts as deemed necessary by Deland Medical Wellness Center. Failure to submit to such tests will result in me being discharged.
7. I give permission to Deland Medical Wellness Center to discuss my diagnosis and treatment with doctors, pharmacies, family, law enforcement, state agencies and others deemed necessary to receive proper care. I agree to waive any applicable privilege or right of privacy or confidentiality in the event of an investigation or any possible misuse, abuse or violations regarding my treatment.
8. I agree to attend my scheduled appointments. Continuation of therapy is based on following the protocol of Deland Medical Wellness Center and the demonstrated benefit of the medication. Refills will only be made at the time of my appointment.
9. I agree to use the medication only as prescribed.
10. I will inform Deland Medical Wellness Center of any adverse reactions from the medication.
11. I will not stop taking prescribed medication abruptly. This could cause withdrawal. If Deland Medical Wellness Center chooses to stop prescribing medication, the doctor will taper the medication, prescribe detoxification services or provide ample time to find a new physician.
12. I will communicate fully with the doctors of Deland Medical Wellness Center about the severity of my addiction, the effect it has on my daily life and how the medicine is helping with that.
13. I agree to bring pharmacy receipts and any unused medication to each office visit.

14. I agree not to take alcohol or benzodiazepines during my treatment.
15. I understand that trust and confidence is necessary for proper treatment.
16. I understand that failure to follow these policies will result in being discharged from Deland Medical Wellness Center.

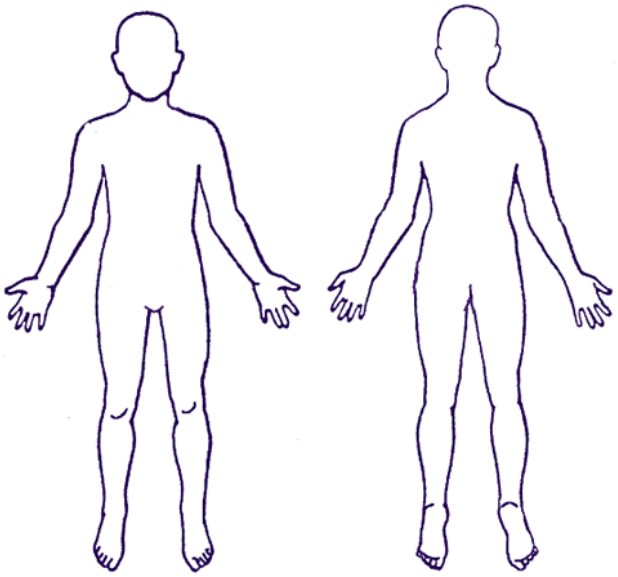
_____ _____

Patient Signature Date

Health History

_____
Patient Name

1. Please mark anywhere you may have pain and if it travels or radiates:



XXXXX-Pain
OOOOO-Numbness

/////////-Aching

*******-Pins & Needles

If you have pain, is it CONTINUOUS?
_____

2. Please mark any applications you have tried in the past.
   Injections, joint _____ Injections, epidural _____Acupuncture_____
   Yoga _____ Chiropractor _____ Ultrasound _____ Massage_____ Electrical
   Stimulation _____ Hot Pack_____ Pain Psychologist _____

3. Please check any positions that aggravate your pain.
   Standing _____ Sitting_____ Lying down _____
   Bending waist _____ Bending, knees_____ Sleep w pillow_____
   Walking_____ Bowel Movement _____

4. Do you have control of your bowels and bladder? YES NO

5. Please check any symptoms you have now or have had in the past.

GENERAL	**GENITO-URINARY**	**CARDIOVASCULAR**
_____ Chills	_____ Blood in urine	_____ Chest Pain
_____ Depression	_____ Frequent Urination	_____ High Blood Pressure
_____ Dizziness	_____ Painful urination	_____ Irregular heart beat
_____ Fainting		_____ Poor circulation
_____ Fever	**MUSCLE/BONE/JOINT**	_____ Rapid Heart Beat Low

_____ Forgetfulness
_____ Headache
_____ Loss of sleep
_____ Loss of weight
_____ Nervousness

Pain, weakness numbness in:
_____ Arms
_____ Back
_____ Feet
_____ Hands
_____ Hips
_____ Legs
_____ Neck
_____ Shoulders

_____ Low Blood Pressure
_____ Ankles swelling
_____ Varicose veins

7. Please check any symptoms you have had within the past 12 months.

GASTROINTESTINAL
____Appetite poor
____Bloating
____Bowl changes
____Constipation
____Diarrhea
____Excessive hunger
____Excessive thirst
____Gas
____Hemorrhoids
____Indigestion
____Nausea
____Rectal bleeding
____Stomach Pain
____Vomiting
____Vomiting blood

EAR, EYE, NOSE, THROAT
____Bleeding gums
____Blurred vision
____Crossed eyes
____Difficulty swallowing
____Double vision
____Earache
____Ear discharge
____Hay fever
____Hoarseness
____Loss of hearing
____Nosebleeds
____Persistent Cough
____Ringing in ears
____Sinus problems
____Vision – flashes or halos

SKIN
____Bruise easily
____Hives
____Itching
____Change in moles
____Rash
____Scars
____non-healing sores

8. Please check any symptoms you have had within the past 12 months.

MEN
____Breast lump
____Erection difficulties
____Lump in testicles
____Penis discharge
____sore on penis

WOMEN
____Abnormal pap smear
____Bleeding between period
____Breast lump
____Extreme menstrual pain
____Hot flashes
____ Nipple discharge
____ Painful intercourse
____ Vaginal discharge
_____Last GYN exam

9. Please check any conditions you have had within the past 12 months.

____AIDS
____Alcoholism
____Anemia
____Anorexia
____Appendicitis
____Arthritis
____Asthma
____Bleeding D/O
____Breast lump
____Bronchitis
____Cancer
____Cataracts
____Chicken Pox
____Diabetes
____Emphysema
____Epilepsy
____Glaucoma
____Goiter
____Gonorrhea
____Gout
____heart disease
____Hepatitis
____Hernia
____Herpes
____HIV Positive
____kidney disease
____Liver Disease
____Measles
____Migraines
____Miscarriage
____Mono
____MRSA
____MS
____Mumps
____Pacemaker
____Pneumonia
____Prostate problem
____Psych care
____Rheumatic fever
____Scarlet fever
____Stroke
____Suicide attempt
____Thyroid problem
____Tonsillitis
____Tuberculosis
____Typhoid fever
____Ulcers
____Vaginal infect

____Chemical Dep ____Hi Cholesterol ____Polio ____Venereal Disease

10. Please list any medications or substances to which you have had allergic reactions.

11. List all medications you are currently taking.

Medication	Strength	Quantity per day

12. Do you have a history of substance abuse? YES NO When

13. Please check if you use any of the substances listed and how often.

Heroin_____ How often_____ How much_____
Opioid Pain Pills_____ How often_____ How much_____
Benzos_____ How often_____ How Much_____
Alcohol _____ How often _____ How much _____
Caffeine _____ How often _____ How much _____
Cocaine _____ How often _____ How much _____
THC _____ How often _____ How much _____
Tobacco _____ How often _____ How much _____

14. Why are you seeking care from Deland Medical Wellness Center LLC?

_____

15. Please list your immediate blood relatives and, if deceased, please note cause of death.

	Living/Deceased	Age	Cause of Death
Father	_____	___	_____
Mother	_____	___	_____
Brothers	_____	___	_____
Sisters	_____	___	_____

16. Have you been to any detox treatment centers or addiction/drug counseling for your addiction? If so, please explain when and where and for what exactly.

_____
_____
_____

I certify that the information I have provided on this health history questionnaire is correct to the best of my knowledge. I will not hold my doctor, Deland Medical Wellness Center, its affiliates, officers, directors, employees and contractors responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

HIPAA Disclosure

Due to HIPAA patient privacy regulations I agree to not discuss my treatment with other patients at any time while I am a patient of Deland Medical Wellness Center.

Patient Signature: _____

Date: _____

MEDICAL LIABILITY RELEASE FORM

Deland Medical Wellness Center policy for malpractice is as follows: As per Florida law we post on the wall in the reception area a notice that advises our patients that our physicians do not carry malpractice insurance. By signing this form, you agree not hold liable Deland Medical Wellness Center its partnering physicians, or staff legally responsible for injuring, harm or medical negligence resulting from treatment provided by Deland Medical Wellness Center. Patient's must complete this form to be eligible for any services with Deland Medical Wellness Center.

PLEASE PRINT ALL INFORMATION:

Patients Name: _____
Home Address: _____
Date Of Birth: _____
Telephone: _____
Patients Primary Care Physician: _____

LIABILITY RELEASE: I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her emergency care. I hereby release Deland Medical Wellness Center and its Partner Physicians or Staff from any legal, medical or financial responsibility.

PATIENT /PARENT/GUARDIAN: Please check one of the following and sign your name.
_____ I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.
_____ I do not give permission for medical treatment until I have been contacted.

Parent/Guardian's Signature: _____
Date: _____
(The above line is applicable for delegates under the age of 18 and must be signed by the parent or legal guardian.)