

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

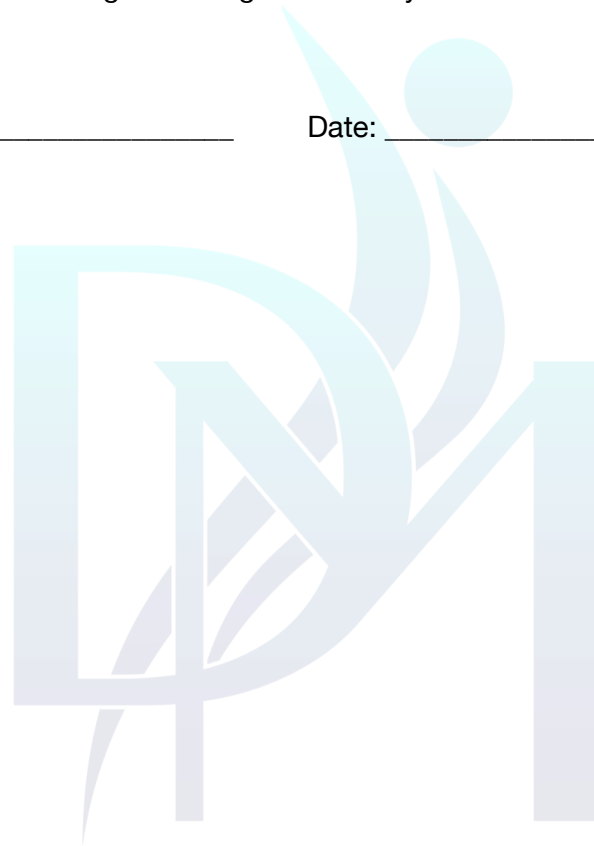
Date

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: _____



DELAND MEDICAL
WELLNESS CENTER

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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have others complained that you did not complete tasks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you received pain or any other medicine from more than 1 doctor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you taken your medication differently than prescribed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often have you seriously thought about hurting yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often did you think about opioid medications or heroin?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often have you been in an argument?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often have you had trouble controlling your anger?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often have you taken another person's pain medicine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often have you worried about how you are controlling your meds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often have	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Patient Signature: _____ Date: _____

DELAND MEDICAL
WELLNESS CENTER

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: _____



DELAND MEDICAL
WELLNESS CENTER

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 HIPAA. 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

PATIENT REGISTRATION FORM

Patient Name: _____ Birthdate: _____

Address: _____ Apartment: _____

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

Best Contact Number: _____ Alternate Number: _____

Email Address: _____

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_____	_____	_____
_____	_____	_____

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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 result 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 your physician first. Combining Suboxone with alcohol or some other medications may also be hazardous. The combination of Suboxone with medication 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 I 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: _____



DELAND MEDICAL
WELLNESS CENTER

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

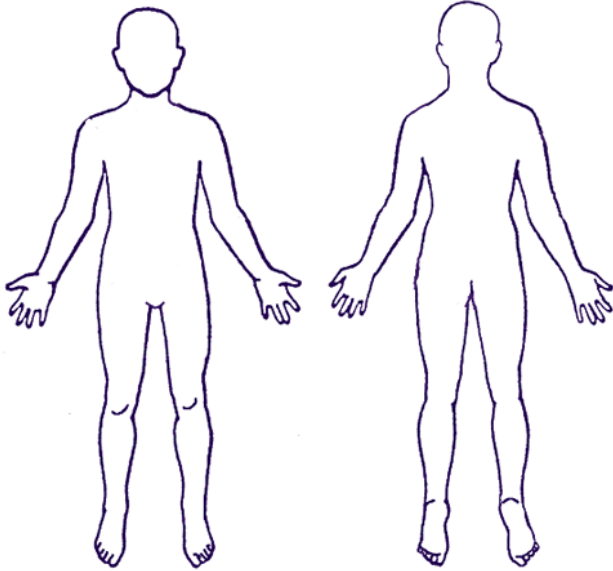


DELAND MEDICAL
WELLNESS CENTER

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

_____ Chills
 _____ Depression
 _____ Dizziness
 _____ Fainting
 _____ Fever

GENITO-URINARY

_____ Blood in urine
 _____ Frequent Urination
 _____ Painful urination

MUSCLE/BONE/JOINT

CARDIOVASCULAR

_____ Chest Pain
 _____ High Blood Pressure
 _____ Irregular heart beat
 _____ Poor circulation
 _____ Rapid Heart Beat Low

- | | | |
|---|---|---|
| <input type="checkbox"/> Forgetfulness | Pain, weakness numbness in: | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Arms <input type="checkbox"/> Hips | <input type="checkbox"/> Ankles swelling |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Back <input type="checkbox"/> Legs | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Feet <input type="checkbox"/> Neck | |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders | |

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.

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> kidney disease | <input type="checkbox"/> Psych care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Mono | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Bleeding D/O | <input type="checkbox"/> Gout | <input type="checkbox"/> MRSA | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> heart disease | <input type="checkbox"/> MS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> 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.

<u>Medication</u>	<u>Strength</u>	<u>Quantity per day</u>
_____	_____	_____
_____	_____	_____

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.

	<u>Living/Deceased</u>	<u>Age</u>	<u>Cause of Death</u>
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



DELAND MEDICAL
WELLNESS CENTER

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: _____



DELAND MEDICAL
WELLNESS CENTER

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.)

******MISSED APPOINTMENT FEE NOTICE******

I understand that Deland Medical Wellness Center LLC charges a \$50 missed appointment fee that will be charged on my next appointment for any primary care or opioid addiction therapy appointments that were confirmed and not rescheduled or cancelled within a 24 hours prior to my appointment time.

Patient Signature: _____

Date: _____

Pharmacy Information

Patient Name: _____

Date: _____

Pharmacy Name: _____

Address: _____

Phone: _____

Fax: _____

Patient Signature: _____

*** If you have insurance please let the front office make a copy of the front and back of your insurance card**