Thank You For Choosing

MAGNOLIA MEDICAL

1850 Race Street
Denver, CO 80206
P: 303-209-5115

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Welcome to Magnolia Medical!

In order to serve you better, we would like to provide you with important information regarding your treatment. Please read each of the below statements carefully and thoroughly and sign where indicated to acknowledge you understand and agree to the terms outlined in this agreement. If you have any questions or concerns, please discuss these with your provider and/or counselor.

General Information

Magnolia Medical complies with all federal and state laws in regards to patient consent where applicable. Services provided by Magnolia Medical are for the intended purpose of opioid and alcohol dependency only. Administrative hours are Monday through Friday 8:00 am to 5:00 pm. (Subject to change) Our website https://magnoliamed.com contains more detailed information about our philosophy.

Emergency Information

Should an emergency arise, please call 9-1-1. For non-emergency service after hours a message can be left at 303-209-5115. Please note all calls are recorded and logged for quality purposes.

Program Information

Attending our outpatient Suboxone program requires your commitment. Your adherence to schedule, rules, and instructions from Magnolia Medical; as well as, being present and participating in the program is very important for your recovery process. It is also an opportunity for you to give yourself permission to receive help and experience a healthy community with others. Patients should expect to participate in this program for a minimum of 1 year.

Patients who enroll in Magnolia Medical's treatment program will meet with a physician to provide medication therapy and are required to attend 6 individual therapy sessions. This treatment program is individualized and scheduled according to your physician's analysis of your needs as well as compliance with therapy, drug screening, and absence of any behavioral issues. Patients may be chosen at random for an "observed" drug screen and/or random pill/strip count at any given time. Magnolia Medical's program is based on an underlying principle of deep respect for each client who seeks treatment, with the expectation that our clients will behave in a respectful manner to clinical and administrative staff. **No form of verbal and/or physical abuse will be tolerated!**

Patient Signature_______________________________________

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Privacy Pledge

Magnolia Medical will not disclose any client information without a HIPAA authorization form. (Upon request Only) Except in circumstances pertaining to Colorado legal statutes that allow healthcare professionals to break confidentiality without consent. Circumstances such as a client may be in serious danger in which they may cause harm to themselves and/or others, any suspicion of child or elder abuse and rare cases of a court subpoena. You may request to review your records by submitting a written request to our medical staff. All medical records requests to outside agencies the client must provide a signed HIPAA release and allow up to 30 days to process. Patient's requesting their medical records to be released to them directly may be subjected to a fee. (Please see the medical staff for pricing information)

Attendance Information

Participation in the program requires a commitment to being on time and present for every appointment. Patients who miss appointments may be discharged from the program or may require more medical and therapeutic supervision. If you are unable to consistently attend the program and have multiple unexcused absences, this may be an indication of your needing a higher level of care.

If you are unable to attend your scheduled appointment, please call 303-209-5115 at least 24 hours in advance to reschedule. Patients more than 15 minutes late to an appointment may have to be rescheduled for a different time/day. More than three no-shows in a 60-day period will result in a 60-day temporary termination from the program.

If an emergency occurs outside of program hours, such as you are feeling suicidal and you are not able to follow your safety plan, go to the nearest emergency room for a psychiatric evaluation and/or dial 911. If we do not hear from you, a Magnolia staff member will call to assess how you are. If we are not able to get in contact with you, a staff member may speak with the individual designated under your emergency contact.

Patients are responsible for self-administration of their medication. If you have questions and/or concerns with your medication, please inform your physician.

Patient Signature______________________________________

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Patient Financial Responsibility

Patients at Magnolia Medical must adhere to our strict cash payment policies. At this time we are currently contracted with the following insurance carriers: Colorado Medicaid (not including Denver Health, Rocky Mountain Health Plans, or Kaiser Medicaid), Medicare, United Healthcare, and Cigna. If you do not have one of these insurances, you may be considered self-pay. The self-pay rates are as follows:

1) First month = $450 or two payments of $225.
2) Second month = $350 or two payments of $175
3) Third month and all months thereafter= $275

This covers all doctor visits, counselor visits and in house drug screens **ONLY**. Patients may receive bills or invoices from outside laboratories in the event your insurance does not cover the total billed charges for services. This includes patients without insurance who are considered 'self pay' due to lack of insurance and/or choosing to not utilize your insurance benefits for your treatment with Magnolia Medical. Patient will be responsible for payment to those outside agencies in this instance. All fees and copays are due at the time of service and can be paid by cash or credit card. The fees listed are a global fee and will not be discounted regardless of missed appointments, outside counselor treatment and client non-compliance. If the client discharges from the program for any reason all fees paid will **NOT** be refunded. Should this account be turned over to collections and/or an attorney the client will be responsible for all fees and expenses.

Patient Signature______________________________________

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In addition to phone calls, give Magnolia Medical permission to contact me in the following ways regarding reminders for my future appointments:

____Text

____Email

I understand that I must provide up-to-date information (i.e., phone number/email address) in order to receive these reminders.
I also understand that I have the right to revoke this permission at any time (see below).

______________________________________ __________________

(Print Name) (Date)

____
(Signature)

I revoke the above permission(s):

____ Text

____ Phone Call

____ Email

______________________________________ __________________

(Print Name) (Date)

______________________________________(Signature)

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Accessing the CO PDMP

The Colorado prescription drug monitoring program (CO PDMP) is an electronic service providing patient information in regards to their controlled substance prescriptions that have been filled in the past 2 years. It is required by law that before a physician writes a prescription for a controlled substance that they review the patient's CO PDMP. Suboxone is a controlled substance and therefore accessing your CO PDMP record is essential to ensure patient safety and compliance with rules of Magnolia Medical's treatment program.

Counseling Services

Magnolia Medical offers individual counseling services conducted by our licensed addiction counselors. This service requires participation from the patient in order to maintain a stable treatment plan. Counseling appointments may contain private medical and psychological information that can be distressing and difficult

Patient Signature______________________________________

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Authorization and Informed Consent for Treatment and Conditions of Admission

1. **Consent:** I voluntarily consent to this admission to the Facility and do hereby voluntarily consent to such care-encompassing procedures and treatment by the Facility that its Director, employees, and designees deem necessary in their judgment. These services may be terminated by me at any time I so desire by informing the Facility verbally or in writing. I understand that any evaluation, testing, counseling/therapy or other treatment procedure is confidential and will not be released by the Facility without my written consent.
2. **Emergency Treatment and/or Hospital Transfer:** I understand while at the Facility, the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. Should the need for such treatment and/or transfer be deemed necessary and appropriate due to an emergency, by attending physician, their assistants and designees, I consent to such emergency treatment and/or transfer to a hospital and indemnify the Facility and its staff, or any physician who may be in attendance, from any loss resulting from such emergency treatment and/or transfer.
3. **Medical Consent:** The Patient is under the care of their attending physician, or the physician assigned by the Facility and the undersigned consents to examination and laboratory procedures. Medical treatment is rendered under the order of the physician or his/her designee.
4. **Drug Screen Consent:** I further understand that part of the treatment offered by the Facility may require my submitting to urinalysis for drug/alcohol content, psychological testing and other such similar procedures and that the consent that I have given in this document shall include, but not limited to, the same. The results of urinalysis will be released without Patient consent. Federal regulations prohibit making any further disclosure of this information unless expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by CFR 42, part 2.
5. **Conditions of Treatment:** I acknowledge and understand that no promises or guarantees have been made to me regarding the final outcome of my treatment by the Facility and I do hereby absolve the Facility from any liability in the event its treatment of my person is unsuccessful either in the short or long term.
6. **Rules and Regulations:** I hereby agree to comply with and abide by the policies, rules and regulations of the Facility during my treatment stay.
7. **Releases of Information:** The Facility may disclose all or any part of the Patient's record to any person or corporation which is or may be liable under a contract to the facility, or the Patient, or to a family member of the Patient, all or part of the facility charges. The Facility may further disclose all or said part of the Patient's record to the referring doctor, hospital, clinic, and in case of minors, may disclose aftercare forms to the Patient's school system. A Release of Information form may be required for third parties.

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8. **Personal Valuables:** The Facility shall not be liable for the loss or damage to any money, jewelry, eyeglasses/contact lenses, dentures, documents or other articles of value.
9. **Drugs:** The Patient shall neither use, nor keep, any drugs or drug paraphernalia as not permitted by or on behalf of the attending physician. All medications should be taken as prescribed by the physician during the Patient's stay at the Facility. Any such contraband found in the Patient's possession will be removed and destroyed.
10. **Injury:** In consideration of the acceptance of the undersigned for voluntary care by the Facility, I do hereby waive, release and indemnify the facility, its officers, agents, employees and professional associates of all any kind of liability (legal, financial, medical, and otherwise) for any claim of loss or damages because of any injuries, direct or indirect which may occur to me or to my family or friends, or for loss, damage or theft of any of my personal property during my enrollment, whether or not the professional associates, and whether or not such injury, loss or damage occurs on or off the premises or in or out of a vehicle, surveillance or supervision of the facility or its officers, agents, employees or professional associates.

The undersigned certifies to understand and agree to the above, receiving a copy thereof, and is the Patient, or is duly authorized by and on behalf of the Patient to execute the above and accept its terms personally and upon the Patient's behalf.

Patient Signature_______________________________________

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Confidentiality, HIPAA, and Privacy Practice Notice

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

General Information:

Information regarding your health care, including payment for health care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 42 USC 1320d et seq., 45 CFR parts 160 & 164 and the Confidentiality Law, 42 USC 290dd-2, 42CFR Part 2.

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal laws and regulations. Generally, the program and patient may not say to a person outside the program that a patient attends the program nor disclose any information identifying a patient as an alcohol or drug abuser and/or identifying a patient's health status unless:

- A patient consents in writing.
- The disclosure is allowed by a court order.
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Treatment, payment and health care operations:

The Facility uses and discloses your protected health information for treatment, payment, and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

- Sharing test results with other health care providers for confirmation of a diagnosis;
- Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide;
- **Reviewing information as part of our quality improvement program.**

Other uses and disclosures:

The Facility may also use or disclose your protected health information, in compliance with the guidelines outlined by law, for the following purposes:

- Providing you with information related to your health;

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- Contacting you regarding appointments, information about treatment alternatives, or other health related services;
- Incidental uses or disclosures (e.g., listing your name on a sign-in sheet, etc.);
- Compliance with all laws (including reports of suspected abuse, neglect or violence);
- Providing certain specified information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director or organ procurement organization;
- Public health activities when requested by a public health authority or the FDA. Responding to health oversight agencies;
- Responding to court or administrative tribunal orders, subpoenas, discovery requests or other lawful process;
- Research activities;
- When necessary to avert a serious threat to health, safety, or when Patient is a danger to themselves;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information to public or private disaster relief agencies; or Information to a family member, other relative, or close personal friend when: notification of your location, general condition or death; to assist in your health care (e.g. pick-up prescriptions or other documents, note follow-up care instructions, etc.)

Authorization for other uses:

The Facility will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time, by notifying us in writing that you wish to revoke your authorization.

Your rights regarding the privacy of your health information:

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses and disclosures. However, the facility is not obligated to agree to requested restrictions;
- Receive confidential communications or protected health information;
- Inspect and copy your protected health information with some limited exceptions;
- Amend your health information;
- Receive an accounting of disclosures of your health information;

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- Obtain a copy of this notice.

The Facility's duties regarding the privacy of your health information:

Subject to limitations outlined by law, the Facility has certain duties related to your protected health information, including:

- The Facility is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- The Facility is required to abide by the terms of the privacy notice that is currently in effect.
- The Facility reserves the right to change the privacy practices described in this notice and to make such changes effective for all protected health information. A Revised notice will be posted in our office and available upon request.

Concerns:

No individual will be retaliated against for filing a complaint.

Printed Name: ____________________________
Signature (Patient, Parent/Guardian, Representative): ________________________________
Relationship (if not client): ____________________ **Date**: ________________________________

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Release of Information Form

I authorize the Facility to release & receive information contained in my medical record and/or financial statement to: (please provide name/address/phone number where information is to be released)

Patient Name: ______________________________ Date of Birth: ___________________

Phone Number: ______________ Address: ____

I hereby authorize Magnolia Medical Group to release & receive copies of the following confidential information which may include alcohol and substance abuse information which may be protected under Federal Regulations in Code 42, part 2, and/or abstract information, which includes medical, psychiatric and/or psychological, HIV Antibody testing information to:

Name:_____________________________________

Address:__________________________________

____

____

- The Facility and/or its representative or entity, solely for the purpose of obtaining information from referring agency. (Under the Mental Health Code, release of mental health records must be germane to the purpose and need for disclosure.) I further understand that Magnolia Medical Group may not require this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. (Under the Mental Health code, release of mental health records must be relevant to the purpose and need for disclosure.)

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Reason for Request:

____

____

____

<u>**Information to be Released**</u>: **Dates of Service From:__________ To:___________**

___Biopsychosocial Assessment ___Intake Evaluations ___Motivation ___Progress Notes

___Treatment Dates ___Coordination of Care ___Laboratory Reports ___Presence in Treatment

___Return to Work ___Discharge Summary ___Letters ___Prognosis

___Staff Conference/Treatment Plans & Reviews ___Emergency Contact ___Medical History

___Progress ___Telephone Calls (Specify Information to be Released) ___Other

I understand that I may revoke this authorization at any time upon written notice to the Facility. I acknowledge that such revocation will not be effective if the Facility has already acted in reliance upon this authorization. I understand that if this information is faxed that confidentiality cannot be guaranteed.

This authorization is valid until this consent will terminate, up to 2 years from the date of signature of this form or the following event/condition: revocation, or the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later.
- I revoke the above consent as of this date:____________________

PROHIBITION ON REDISCLOSURE: "This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse Patient."

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Printed Name: ___________________________
Signature (Patient, Parent/Guardian, Representative): _______________________________
Relationship (if not client): ____________________ **Date**: _____________________________

1850 Race St, Denver, CO 80206
Phone: 303-209-5115
Fax: 720-638-5562
Email: office@magnoliamed.com

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Medical Information Release Form

Family and/or Friends

Name: ________________________ Date of Birth: _____/____/_____ EMR#:_____

Release of Information

[ ] I authorize the release of all information involving my care including the diagnosis, records; examination rendered to me and claims information.

[ ] I authorize the release of specific information involving my care. This is to include (please select below):

[ ] Visit Times/Dates
[ ] Lab Reports/Results
[ ] Visit Notes/Details
[ ]

This information may be released to:

[ ] Spouse____

[ ] Child(ren)_____________________________________

[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: ______________________________________ Date: ____/____/______

Witness:______________________________________ Date: ___/____/_______

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Acknowledgement of Mental Health, Alcohol and Drug Abuse Patient Records

The confidentiality of mental health, alcohol abuse and drug abuse shall be adhered to by the Facility. Patient records maintained by this program are protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a Patient attends the program, or disclose any information identifying a Patient as an alcohol abuser or drug abuser 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 program evaluation.

Violation of the Federal laws and regulations by a program is a crime. Suspected violations may be reported to the appropriate authorities in accordance with Federal regulations.

Federal laws and regulations do not protect any information about a crime committed by a Patient either at the program or against any person who works for the 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.

I understand that my records are protected under Federal Confidentiality regulations (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations) published August 10, 1987, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.

Printed Name: ___________________________
Signature (Patient, Parent/Guardian, Representative): _______________________________
Relationship (if not client): ____________________ **Date**: ______________________________

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OUT-OF-STATE OFFENDER CLIENT QUESTIONNAIRE

The following questions must be answered by all clients seeking admission to this program for any education or treatment; as required by Colorado law. Refusal to cooperate, or failure to provide complete or accurate information, including failure to sign a release of information to the referring criminal justice agency, will result in a denial to attend the treatment program and notification of authorities, in accord with the requirements in C.R.S. 17-27.1-101.

1) Are you required to report your treatment progress or completion to any Court, Department of Corrections, Parole, Probation, Adult Diversion Program, or the DMV? Yes No
2) Do you have any pending cases in another state? Yes No

If yes to 1 or 2, please answer the following questions:
3) What state are you completing treatment for?___________________
4) Who are you to report the treatment to? (Example: Court, Judge, Probation Parole, etc.)________________________________
5) Are you, or will you be under the supervision of a Probation or Parole Officer in Colorado? Yes No
6) For DUI Offenders only: Are you seeking education or treatment for the sole purpose of restoring you driving privileges as the result of an alcohol or drug related driving Offense in another state, but are not under court order to do so? Yes No

Your Name:_____________________________ Date of Birth:________________

Social Security Number:__________________ Place of Birth:________________________

Signature:______________________________ Today’s Date:____________________

If you answered “Yes” to 1 or 2 above, please provide the following:

Name, address and phone number of your probation officer, parole officer, judge or diversion officer:
Name:____
Address:____
____
____
Phone:____

A copy of your probation, parole, court or diversion order, including treatment requirements must be included.

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NOTICE OF PRIVACY PRACTICES & BILL OF RIGHTS ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

THE PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

The goal of Magnolia Medical is to provide all patients with high quality health care in a manner that clearly recognizes individuals' needs and rights. To accomplish this goal effectively, the patient and the health care provider must work together to develop and maintain optimum health. To promote this goal, the following rights and responsibilities have been identified:

AS A PATIENT, YOU HAVE THE RIGHT

1. To receive considerate care that is respectful of your personal beliefs, your cultural, and your spiritual values;
2. To have all things explained to you in terms that you can understand and to have any questions answered concerning your diagnosis, prognosis, and treatment;
3. To know what the diagnosis is; what your prognosis is; what treatment options are available to you; how risky the treatments are; and whether they will hurt, and for how long;
4. To have all the common side effects of a drug explained;
5. To know the contents of your medical records through interpretation by the provider;
6. To know who it is that is interviewing and examining you;
7. To have explained to you ways that you can prevent your medical problem from recurring;
8. To refuse to be examined or treated by a health practitioner and to be informed of the consequences of such a decision;
9. To be assured of the confidential treatment of disclosures in your record and to have the opportunity to approve or refuse the release of such information, except when the release of specific information is required by law or is necessary to safeguard you or the university community;

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10. To be informed and asked whether you wish to participate in medical research that is being conducted at Health Services;
11. To participate in the consideration of ethical issues that arise in the provision of your care;
12. To receive care in a secure and private environment so that the treatment experience is positive and supportive;
13. To receive care in a timely and professional manner within available resources from a provider with whom you are comfortable;
14. To be heard when you have a concern regarding quality of care or patient safety with resolution by empowered staff or through submission of a formal Patient Care Survey or a more formal Incident Report to the Director;
15. To designate a Partner in Care (surrogate) decision-maker to participate with you and the provider in care decisions and delivery;
16. To have information provided regarding the health service fee, insurance requirements, cost of treatment, and payment options;
17. To have appropriate assessment and management of pain.

AS A PATIENT, YOU HAVE THE RESPONSIBILITY

1. To provide Health Services with information about past illnesses, hospitalizations, and medications;
2. To follow the plan of care or to express concern regarding your ability to comply;
3. To ask questions if you do not understand the directions or treatment being given to you by a provider;
4. To take responsibility for the outcome of your care if you have refused treatment;
5. To keep your appointment or to telephone Health Services, with reasonable notice, if you need to cancel;
6. To be respectful of others and others' property while in a Magnolia Medical facility;
7. To provide current and accurate insurance information to Magnolia Medical;
8. To be an active partner in arranging transition of care when no longer eligible for care. This includes arranging for recommended follow-up care and requesting copies of appropriate records be forwarded to a provider of your choice.

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I have received, read and understand your Notice of Privacy Practices and Patient Rights containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change this Notice of Privacy Practices and Patient Rights from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices and Patient Rights..

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Printed Name: ___________________________
Signature (Patient, Parent/Guardian, Representative): _______________________________
Relationship (if not client): ___________________ **Date**: ______________________________

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For clinician use only: At risk for HIV If so is at:
___Medium risk ___High risk
Score: ________________ (ADAD ID Screening Instruments . Rev. 8/02)

INFECTIOUS DISEASE SCREENING

In response to increasing rates of hepatitis B and C, sexually transmitted diseases, TB and HIV, all clients/patients receiving services from substance abuse treatment providers licensed by the Alcohol and Drug Abuse Division (ADAD) shall be screened for past and present risk factors, including those associated with substance abuse, for disease acquisition and transmission. In a joint effort, ADAD, the Colorado Department of Public Health and Environment, substance abuse treatment providers and HIV and hepatitis advocacy groups and coalitions have developed two Screens and a guided interview for determining client/patient risk. In introducing the Screens to clients/patients the following points should be made (not in preferential order):

- Administering a screen is required by state regulation;

- Privacy of responses to screen questions is protected by federal regulation and state law;

- The screen provides important information to clients/patients about their levels of risk;

In order to get the best information, honest, accurate responses to questions are vital.

1. Infectious Disease Medical Screen

The Infectious Disease Medical Screen is intended to be self-administered at time of intake or shortly thereafter. A counselor or other person knowledgeable about the Screen should be available to assist with any client/patient questions or concerns. Questions 1 through 8 screens for risk of hepatitis B and/or C exposure. Questions 9 through 14 screens for risk of tuberculosis exposure/infection.

Appropriate Clinical Responses Guide

-A “Yes” response to any of questions 1 through 7 and no record of being tested for hepatitis B and C should prompt a referral for testing and appropriate follow-up.

-A “yes” response to question 8 should prompt making information available about the possible (though low-level) risks involved.

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-If any of the categories in question 9 are marked, a TB skin test should be encouraged.
-A "yes" response to any of questions 10 through 14 indicates high risk for active TB or TB infection and a referral to a healthcare practitioner or health department for testing/treatment should be made immediately.

2.Infectious Disease Behavioral Screen

The Infectious Disease Behavioral Screen can be self-administered or used in a face-to-face interview. The questions identify behaviors that may place clients/patients at risk for HIV and hepatitis B and C exposure. A scoring instrument for the screen tallies numeric values of client/patient responses and indicates appropriate clinical responses.
Because of the sensitive nature of the information being collected and the possibility of clients/patients perceptions of personal intrusion, it is recommended that the Screen be administered after some rapport and trust has been established, preferably following HIV and hepatitis education. If self-administered, a counselor or other person knowledgeable about the Screen should be available to assist with any client/patient questions or concerns.

3.Infectious Disease Behavioral Interview

The Infectious Disease Behavioral Interview is used when scores from the Infectious Disease Behavioral Screen Scoring Instrument place clients/patients in the medium risk and high-risk categories for acquiring/transmitting HIV and hepatitis. It is based on responses to questions asked by the Behavioral Screen and provides more detail in the behavioral risk aspects of substance abuse and disease acquisition/transmission. This instrument is designed for use as an evaluative interview; it should not be self-administered.

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INFECTIOUS DISEASE MEDICAL SCREEN

Name:________________________________ Date: ______________________

I understand that my responses to this screen are protected under the federal regulations governing Confidentiality Of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV, STD and TB related information about me is protected by state law and cannot be disclosed unless state law authorizes the disclosure.

I have read and understand the above.

Signature:____

Please mark the one most accurate response to each question.

1. Have you been a recipient of a blood transfusion or organ transplant prior to 1992 (includes receiving blood during birth or other surgical procedures)? Yes No
2. Have you ever been or are you now on long-term hemodialysis (blood cleansing)? Yes No
3. Are you a recipient of clotting factor made prior to 1987? Yes No
4. Have you ever been stuck by a needle or anything sharp that was likely to have been contaminated with hepatitis C-infected blood? Yes No
5. Were you born to a mother who had hepatitis? Yes No
6. Have you ever had symptoms of liver disease or abnormal liver function/enzyme tests? Yes No
7. Have any of your sexual partners been infected with hepatitis B or C? Yes No
8. Have you been the recipient of tattooing or body piercing in unsanitary conditions (e.g. unsterile needles)? Yes No
9. Mark all of the following that currently apply to you or that applied to you in the past.

___Close contact with active TB
___Medical condition that increases the risk of TB disease (e.g., HIV, other immune disorders, diabetes, silicosis, [black lung or coal miners disease], bleeding/clotting disorders, specific malignancies, kidney failure, etc.)
___Abnormal chest x-ray showing fibrotic lesions
___Resident or employee of a high risk group setting (e.g., correctional facilities, nursing homes, mental institutions, homeless shelters, residential treatment, etc.)
___Health care worker or volunteer who serves high-risk clients
___Foreign-born person who has arrived within the last five years from countries that have a high TB incidence or prevalence (e.g., most countries in Africa, Asia, Latin America, Eastern Europe, and Russia)

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___Person from a medically underserved, low-income population
___Member of a high-risk racial, ethnic, or other minority population with an increased prevalence of TB (e.g., Asian and Pacific Islanders, Hispanics, African-Americans, Native Americans, migrant farm workers, homeless persons)
___History of inadequately treated TB

10. Have you had a cough for more than three weeks? Yes No
11. Have you coughed up blood/colored mucous? Yes No
12. Do you have swollen, non-tender lymph nodes? Yes No
13. Have you had a prolonged loss of appetite or unexplained weight loss of ten pounds or more? Yes No
14. Have you had recurrent fevers or heavy night sweats for more than three weeks? Yes No

Response Guide:
-If you answered "yes" to any question # 1-7, please see your counselor for a referral to be screened for hepatitis B and C.
-If you answered "yes" to question # 8, please see your counselor for a referral for infectious disease screening and testing.
-If you answered "yes" to any of the categories in question # 9, please see your counselor for a referral to be screened for tuberculosis.
-If you answered "yes" to any question # 10-14, please see your counselor immediately for a referral for tuberculosis screening and treatment.

Your counselor is referring you to the following program/agency for follow-up:

Program/Agency:____

Address:____

Contact: ________________________ Phone:________________________

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For clinician use only: At risk for HIV If so is at:
___Medium risk ___ High risk
Score: ________________ (ADAD ID Screening Instruments . Rev. 8/02)

INFECTIOUS DISEASE BEHAVIORAL SCREEN

Name: ____ Date: ________________________

I understand that my responses to this Screen are protected under the federal regulations governing Confidentiality Of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV, STD and TB related information about me is protected by state law and cannot be disclosed unless state law authorizes the disclosure.

I have read and understand the above.

Signature:____

Please mark the one most accurate response to each question.

1. Have you had 2 or more sexual partners in the past 10 years?
Yes No

2. Have you had anal sex (penis in anus) with any of your sexual partners during the past 10 years?
Yes No

3. How often have you used a condom when having anal sex in the past 10 years?
Never Sometimes Always Have not had anal sex

4. Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts (HPV), genital herpes, or hepatitis?
Yes No

5. At any time in the past 10 years, have you ever given money or drugs to anyone to have sex with you?
Yes No

6. Have you ever had sex with someone so that they would give you money or drugs?
Yes No

7. Have you ever injected street drugs, steroids, or vitamins with a needle?

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Yes No

8. Have any of your sexual partners in the past 10 years ever injected street drugs, steroids, or vitamins with a needle?
Yes No Don't know

9. Have any of your sexual partners in the past 10 years been men who have had sex with other men?
Yes No Don't know

10. Have any of your sexual partners in the past 10 years ever had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts (HPV), genital herpes, or hepatitis
Yes No Don't know

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INFECTIOUS DISEASE BEHAVIORAL SCREEN SCORING

Client/Patient Name/ID ______________________________ Date ________________

Transfer responses from the Infectious Disease Behavioral Screen onto this form and total the corresponding numeric values.

1. Yes (5) No (0)

2. Yes (10) No (0)

3. Never (20) Sometimes (15) Always (10) No Anal Sex (0)

4. Yes (15) No (0)

5. Yes (10) No (0)

6. Yes (20) No (0)

7. Yes (30) No (0)

8. Yes (30) No (0)

9. Yes (30) No (0)

10. Yes (30) No (0)

My score: ____

Scoring Guide:

☐ 0 to 29 indicates low risk for acquiring/transmitting HIV. You do not need to be evaluated further, unless it is believed to be necessary based on other information you have provided.

☐ 30 to 119 indicates medium risk for acquiring/transmitting HIV and hepatitis. You should receive further evaluation and appropriate referrals should be provided.

☐ 120 or higher indicates high risk for acquiring/transmitting HIV and hepatitis. You should contact the Colorado Department of Public Health and Environment, 303-692-2759, or your local county health department for further evaluation and follow-up.

Note: Answering “yes” to question 7 indicates past or present injection drug use and testing for HIV and hepatitis B and C is strongly encouraged as behaviors associated with injection drug use place you at an increased risk for acquiring and/or transmitting these infections.

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INFECTIOUS DISEASE BEHAVIORAL SCREEN SCORING

Score is over 120	**HIGH RISK** A score over 120 indicates that you are at high risk for acquiring/transmitting HIV and/or hepatitis. See your counselor right away for referral to your local county health department or the Colorado Department of Public Health and Environment for further evaluation and follow-up.
Score is 30 - 119	**MEDIUM RISK** A score of 30-119 indicates that you are at medium risk for acquiring/transmitting HIV and/or hepatitis. See your counselor for more information about ways that you can reduce your risk and other programs that can help you.
Score is 0 – 29	**LOW RISK** A score of 0-29 indicates that you are at low risk for acquiring/transmitting HIV and/or hepatitis. Low risk doesn't necessarily mean no risk. See your counselor if you have questions or concerns about behaviors that may place a person at risk.

Your counselor is referring you to the following program/agency for follow-up:

Program/Agency:____

Address:____

Contact: ______________________ **Phone:**______________________

Appointment: ____

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Patient Demographic Form

Today's Date: ____

Name (Last, First, Middle Initial) ____

Address/Apartment Number:

____

City/State/Zip Code :

____

Phone Number/Area Code:

____

Date of Birth (Month/Day/Year): __________/_________/________

Social Security #: ______________

Sex : ( ) Male ( ) Female Race: _______________

Email: ______________________________

Do you currently have Medicaid? ( ) Yes ( ) No Are you a Veteran? ( ) Yes ( ) No

Do you have a valid driver's License? ( ) Yes ( ) No Mode of Transportation?_________

Insurance Information

Name of Insurance Company: ____

Policy and Group Number: ____

Subscriber Name: ______________________ Date of Birth: _________________________

Relationship: ____

Subscriber Address: ____

Subscriber phone number: ____

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Patient Intake Form

Psychological

Marital Status: ( ) Married ( ) Never Married ( ) Single ( ) Separated ( ) Divorced ( ) Other

Religious Preference : ( ) Catholic ( ) Christian ( ) Baptist ( ) Jewish ( ) Jehovah's Witness ( ) Other

Sexual Orientation:( ) Heterosexual ( ) Bisexual ( ) Gay ( ) Lesbian ( ) Transsexual ( ) Do not wish to disclose

Social Preference/Living Arrangements

Number of people in your household: ___ Do you: ( ) Live alone ( ) Live w/others ( ) Live w/spouse/kids

( ) Live w/children ( ) Other:

____

Employment

( ) Employed Full Time ( ) Employed Part Time ( )

Length of employment: _____________________________________

( ) Unemployed ( ) Disabled ( ) Retired

( ) Other: _____________________________________

Education

Highest Grade in School Completed: ______________

Degree Earned: ____________________

Legal Status

( ) No legal problems ( ) Under Parole Supervision ( ) On probation ( ) Case Pending

Have you ever been arrested for a drug related charge? ( ) Yes ( ) No

Do you have any court dates pending? ( ) Yes ( ) No If yes, when is your court date?

____

Current Drug Use

( ) Heroin ( ) Alcohol ( ) Barbiturates ( ) Other Sedatives or Hypnotics ( ) Methamphetamine

( ) Amphetamines ( ) Cocaine/Crack ( ) Marijuana/Hashish ( ) PCP ( ) Vicodin ( ) OxyContin

( ) Percocet ( ) Other-please specify:

____

Opiate Drug Use

Date of last use: __________ Average daily amount: ____________ Length of use:

____

Usual routine of admission: ( ) Oral   ( ) Smoking   ( ) Inhalation   ( ) Injection

Drug Treatment History

Date of last admission: ___________ Date of last discharge: _________ Number of admissions:

____

What was the type of treatment during your last admission? ( ) Detox   ( ) MMTP ( )

Outpatient

Outcome of last admission treatment was: ( ) Completed ( ) Not Completed

Are you currently transferring from another methadone program? ( ) Yes ( ) No

Medical History

Please list all past and current medical conditions:

____

____

Please list all past and current surgical history:

____

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Any Family History of Drug Addiction? ( ) Yes ( ) No If yes, please specify:

____

Any Family History of Alcohol Addiction? ( ) Yes ( ) No If yes, please specify:

____

Any Drug Allergies? ( ) Yes ( ) No If yes, please specify:

____

Please list current medications you are taking:

____

____

Emergency Contact

Name:____

Relationship:____________________________ Phone Number:___________________________

I have read this document and completed to the best of my ability!

Patient Signature: ____

Witness Signature: ____

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By signing and initialing this form, I understand the following:

- ❑ _______ I agree that in order for the physician to prescribe Suboxone/ Buprenorphine, they must access the Colorado PDMP report. I give consent for the physician to access my CO. PDMP report as often as appropriate.
- ❑ ______ I agree that I am financially responsible for the payment of the services rendered and all payments, copays, and no show fees are due at the time of service.
- ❑ ______I agree that treatment with an addiction counselor is required for the Suboxone program. Not complying with the counseling services can lead to dismissal from the program.
- ❑ ______I agree that group members names, comments, and discussions that occur within the group are confidential.
- ❑ ______I agree to Magnolia Medical's attendance policy and understand the commitment and dedication to the program is my responsibility. My negligence and non-compliance may result in termination from the program.
- ❑ _______I agree to the patient responsibility for controlled substance form. I acknowledge that my non-compliance may result in termination from the program.
- ❑ ______I agree to cooperate with the urine drug testing and random pill/strip counts.
- ❑ ______ I agree I must sign a HIPAA release of information before anything pertaining to my treatment and/or care will be disclosed.
- ❑ ______I understand my HIPAA rights and I authorize Magnolia Medical to leave a message, including those containing to PHI, for me at the number and/or email provided.

I have read and understand all the information provided by Magnolia Medical. I wish to be treated with buprenorphine/Suboxone.

Patient Signature: ____ Date: ____