MAGNOLIA MEDICAL GROUP

New Patient Welcome Packet

2925 E. Colfax Avenue, Denver, CO 80206
P: 303-209-5115

Welcome to Magnolia Medical Group: 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 Group complies with all federal and state laws in regards to patient consent where applicable. Services provided by Magnolia Medical Group are for the intended purpose of opioid and alcohol dependency only. Administrative hours are Monday through Friday 8:00AM to 5:00PM. (Subject to change) Our website www.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 Group; 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 one year.

Patients who enroll in Magnolia Medical's treatment program will meet with a physician to provide medication therapy and are **REQUIRED** to attend a minimum of 12 counseling sessions within a year of entering the program. 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 exception 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_____ **Date**_____

MAGNOLIA MEDICAL GROUP

Patient Demographic Form:

Today's Date:_____

Name (Last, First, Middle Initial):_____

Address/Apartment #:_____

City/State/Zip Code:_____

Phone Number/Area Code:_____

Date of Birth (Month/Day/Year):_____/_____/_____

Social Security #:_____

Sex: ( ) Female ( ) Male
Race: ( ) Black-Non Hispanic ( ) American Indian/Alaskan Native ( ) Hispanic
( ) Asian/Pacific Islander ( ) White-Non Hispanic ( ) Other

Email:_____

Do you currently have Medicaid? ( ) YES ( ) NO
Are you a Veteran? ( ) YES ( ) NO
Do you have a 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:_____

MAGNOLIA MEDICAL GROUP

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 ( ) Other ( )

Social Preference/Living Arrangements

Number of people in your household: _____

Do you: ( ) Live Alone ( ) Live w/Others ( ) Live w/Spouse & Children ( ) Live w/Children ( ) Other

Employment

( ) Employed Full Time; Length of Employment____ ( ) 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 administration: ( ) Oral ( ) Smoking ( ) Inhalation ( ) Injection

Patient Intake Form Continued…

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 transferring from a methadone program? ( ) YES ( ) NO

Medical History

Please list all past and current medical conditions:

_____

_____

_____

Please list all past and current surgical procedures:

_____

_____

_____

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 all medications you are currently taking:

_____

_____

EMERGENCY CONTACT:

Name:_____

Relationship:_____Phone Number:_____

MAGNOLIA MEDICAL GROUP

Accessing the Colorado PDMP

The Colorado Prescription Drug Monitoring Program (PDMP) is a powerful tool for prescribers and dispensers to help reduce prescription drug misuse, abuse, and diversion: helping them to make more informed decisions when considering prescribing or dispensing a controlled substance to a patient. 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.

Patient Signature:_____**Date:**_____

Counseling Services

Magnolia Medical Group offers individual counseling services conducted by our licensed addiction counselors. Patients who enroll in Magnolia Medical's treatment program are **REQUIRED** to attend a minimum of 12 counseling sessions within a year of entering the program. I acknowledge that counseling sessions may contain private medical and psychological information that can be distressing and difficult.

Patient Signature:_____**Date:**_____

Privacy Pledge

Magnolia Medical Group 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. For all medical record requests to outside agencies that client must provide a signed HIPAA release and allow up to 30 days to process. A fee may be assessed to anyone requesting medical records.

Patient Signature:_____**Date:**_____

MAGNOLIA MEDICAL GROUP

Patient Financial Responsibility

Patients with Health Insurance:

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical services or visits, counseling, lab charges or any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the service I receive.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care provider and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

Magnolia Medical Group can NOT waive copays, deductibles, co-insurance, or non-covered service amounts defined as patient responsibility under the terms of our contract with the health insurance entity.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

Patients with no insurance (self-pay):
The below fees cover all doctor visits, counselor visits and drug screens. All fees are due at the time of service and can be paid by cash, check or credit card.

Not covered under the fees below are medications, psychiatric visits, flu shots, immunizations, oral swabs and DNA swabs.

1) Phase 1 = $908.00
2) Phase 2 = $804.00
3) Phase 3 = $500.00

Patient Signature:_____**Date:**_____

MAGNOLIA MEDICAL GROUP

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 your scheduled appointments and have multiple late cancellations, late reschedules or no-shows, this may be an indication that you are needing a higher level of care.

If you are unable to attend your scheduled appointment, please call 303-209-5115, at least 4 hours in advance to reschedule. Patients more that 10 minutes late to an appointment may be cancelled and need to be rescheduled. Patients arriving late may also be asked to wait to be seen until the provider has an opening in their schedule. More than four no-shows in a 60-day period may result in a 30-day dismissal 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 team 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 provider.

Patient Signature:_____**Date:**_____

MAGNOLIA MEDICAL GROUP

Patient Agreements

By signing this form, I understand the following:

( ) _____ I agree that in order for the physician to prescribe Suboxone/Buprenorphine, they must access the Colorado PDMP (Prescription Drug Monitoring Program) report. I give consent for the physician to access my CO PDMP report as often as appropriate.

( ) _____ I agree that treatment with an addiction counselor is **REQUIRED** for the Suboxone program. Not complying with the counseling requirement may lead to dismissal from the program.

( ) _____ I agree that should I attend group counseling that group member names, comments and discussions that occur within the group are confidential.

( ) _____ I agree I must sign a HIPAA release of information before anything pertaining to my treatments and/or care will be disclosed.

( ) _____ I understand my HIPAA rights and I authorize Magnolia Medical to leave a message, including those containing my PHI (personal health information) for me at the number and/or email provided.

( ) _____ I agree to Magnolia Medical's Appointment Cancellation, No-Show, Late Arrival policy and understand the commitment and dedication to the program is my responsibility. My negligence and non-compliance may result in dismissal from the program.

( ) _____ I agree 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 to the patient responsibility for controlled substance form. I acknowledge that my non-compliance may result in dismissal from the program.

( ) _____ I agree to cooperate with the urine drug testing and random pill/strip counts.

I have read and understand all the information provided by Magnolia Medical Group. I wish to be treated with Buprenorphine/Suboxone. Vivitrol, Naltrexone, Zubsolv and/or other medications recommended by my Provider.

Patient Printed Name: _____

Patient Signature:_____Date:_____

MAGNOLIA MEDICAL GROUP

Appointment Reminder - Permission to Contact

In addition to phone calls, I give Magnolia Medical Group 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 (phone number and email address) in order to receive these reminders. I also understand that I have the right to revoke this permission at any time.

Patient Printed Name: _____

Patient Signature:_____Date:_____

I revoke the above permission(s):

_____TEXT

_____PHONE CALL

_____EMAIL

Patient Printed Name: _____

Patient Signature:_____Date:_____

MAGNOLIA MEDICAL GROUP

Medical Information Release Form Family and/or Friends

Name:_____

Date of Birth: _____/_____/_____ **Account#:**_____

( ) I authorize the release of all information involving my care including the diagnosis, records, examinations and claims information.

( ) I authorize the release of specific information involving my care. This is to include (select all that apply):

( ) Visit Times/Dates

( ) Lab Reports/Results

( ) Visit Notes/Details

( ) Counseling Notes/Details

( ) Other _____

This information may be released to:

( ) Spouse: Name_____DOB_____/_____/_____

( ) Children:

Name_____DOB_____/_____/_____

Name_____DOB_____/_____/_____

( ) Other: Name_____DOB_____/_____/_____

( ) Information is NOT to be released to anyone

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

Patient Printed Name: _____

Patient Signature:_____Date:_____

MAGNOLIA MEDICAL GROUP

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 Magnolia Medical Group. 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 an 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 Sate 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 regulation) 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):_____

Date:_____

MAGNOLIA MEDICAL GROUP

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 above, 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, Parole Officer, 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 your 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

Name, Address and Phone Number of your Probation Officer, Parole Officer, Judge or Diversion Officer:

Name:_____

Address:_____

_____

_____

Phone: _____

Your Name:_____ Date of Birth:_____/_____/_____

Social Security Number:_____ Place of Birth:_____

Signature:_____ Today's Date:_____

MAGNOLIA MEDICAL GROUP

Informed Consent for Treatment and Conditions of Admissions

1. **Consent:** I voluntarily consent to this admission to Magnolia Medical Group (facility) and do hereby voluntarily consent to such care-encompassing procedures and treatment by facility. 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 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.

Informed Consent Continued……

7. **Release 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.
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.
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 statements, 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 patients behalf.

Printed Name:_____

Signature (Patient, Parent/Guardian, Representative):_____

Date:_____

MAGNOLIA MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES AND BILL OF RIGHTS ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 Group 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;
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;
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.

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):_____

Date:_____