



Suboxone Procedure Policy

The handling of Boyett Health Services suboxone patients will follow the following guidelines. It is the goal of this practice to avoid or eliminate confusion and upset in relation to the treatment of drug addiction.

The following will take place with patients desiring treatment for drug addiction:

1. The concierge will speak to the patient about;
 - An appointment
 - Ask them to fill out patient intake medical history form; by printing it off the website or coming by the office and picking up the forms. They should be filled out completely prior to their first appointment.
 - Give them the explanation of first visit handout, via the same method as the form distribution.
 - Instruct the patient to call when the forms are complete and they have considered and agree that treatment is desired
2. The concierge will make the first appointment, allowing at least 30 minute slot for this initial appointment, prior to going back they will be given a “Here to Help” card.
3. The receptionist will collect \$170.00 and enter all the usual patient information, if the patient does not want to file addiction therapy to their insurance, the patient must sign the form stating this fact and it will be scanned into the patient chart. If the patient is filing to insurance, we will file and if covered, the \$170.00 will be credited to the patient account.
4. The nurse will:
 - Assess the patient

- go over the medical intake form
- collect the urine for drug screen
- go over the contract and have the patient ready to sign it when the doctor comes in

Urine drug screens will be done on each new patient, after that, they will be randomized by the screening lab or when there is suspicion among the staff of miss-use of the suboxone. If patient has dirty urine, there will always be random urine to follow. Dirty urine is defined as: urine that is negative for suboxone or positive for illegal substances.

All randomized urine screening will follow the same procedure, whether it is for dirty urine or just a random screen.

1. The patient is responsible for a fee of \$80.00, if filing to insurance, this will be filed and if covered the \$80.00 will be credited to the patient account.
2. The patient will be notified the morning of the random screen and will be appointed an appointment the same day at 4:15pm.

No further prescriptions will be written until the random urine is collected. Two dirty urines will result in automatic dismissal.

It is imperative that this clinic has functioning contact phone numbers; it is the responsibility of the patient to notify the clinic in any changes to their contact phone numbers. The clinic will make 2 attempts to contact the patient for the collection of random urine screens and NO message will be left on the recorder. The patient will need to make sure they can be reached. Failure to respond to the call for random urine screening will be considered dirty urine. The patient will not be allowed to arrange a time to come to the office for the random urine screens.

The subsequence appointments will be slotted as a 1 complaint visit, only addition treatment will be discussed on that visit.

No medical problems will be addressed at the suboxone appointment. If the addition therapy patient is an established medical patient, they will need another appointment scheduled for other complaints. If they are not an established medical patient, they must satisfy all the requirements and be taken under consideration, before they are accepted by this practice as a medical patient.

Please read the patient contract and it will shed light on what is acceptable behavior and what is not tolerated.



EXPLANATION OF 1ST VISIT—No Drugs are kept at this office!! **SUBOXONE® WILL BE PRESCRIPTION ONLY**

Your 1st visit is generally the longest, and may last anywhere from 1 to 2 hours.

When preparing for your 1st office visit, there are a couple of logistical issues you may want to consider.

- You may not want to return to work after your visit—this is very normal, so just plan accordingly
- Because SUBOXONE can cause drowsiness and slow reaction times, particularly during the 1st few weeks of treatment, driving yourself home after the 1st visit is generally not recommended, so you may want to make arrangements for a ride home

It is very important to arrive for your 1st visit on time and prepared to answer a battery of questions.

Bring ALL medication bottles with you to your 1st appointment.

Before you can be seen by the doctor, all of your paperwork must be completed, so bring all your completed forms with you or arrive about 30 minutes early. In addition, you will need to pay the \$170.00 prior to being seen.

Urine drug screening is a regular feature of SUBOXONE therapy, because it provides physicians with important insights into your health and your treatment. Your 1st visit may include urine drug screening and blood work. If you haven't had a recent physical exam, your doctor may require one. To help ensure that SUBOXONE is the best treatment option for you, your doctor will perform a substance dependence assessment and mental status evaluation. Lastly, you and your doctor will discuss SUBOXONE and your expectations of treatment.

After this portion of your visit is completed, your doctor will give you a SUBOXONE prescription and may add another prescription to be taken for a few days to help prevent or lessen withdrawals.

CHECKLIST FOR 1ST VISIT:

- Arrive 30 minutes prior to appointment time
- Arrive with a **full bladder**
- Complete **forms**
- Bring **ALL medication bottles**
- Fees due** at time of visit (cash or check)



CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

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

MD check all that apply

- Receive my medical history information from the following physicians:
(name, address) _____
(name, address) _____
- Receive my treatment records from the following therapist
Therapist (name, address) _____
- Release my treatment information/records to the following healthcare professional
(name, address) _____
- Release my treatment information to the health insurance company listed below for billing purposes
Insurance Provider (name, address) _____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it.

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

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

Patient Signature Date

Parent/Guardian Signature Parent/Guardian Name (Print) Date

Witness Signature Witness Name (Print) Date

Confidentiality of Alcohol and Drug Dependence Patient Records

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

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

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

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

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



PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

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

Name _____

Address _____

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

DOB _____ Age _____ SS# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

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

Current or past medical conditions (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma/respiratory | <input type="checkbox"/> Cardiovascular (heart attack, high cholesterol, angina) | |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Epilepsy or seizure disorder | <input type="checkbox"/> GI disease |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Pancreatic problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> STDs | <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> Nutritional deficiency |

Other (Please describe) _____

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

MD NOTES _____

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

MD NOTES _____

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

MD NOTES _____

Childhood Illnesses

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

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? (Please describe)

Have you ever taken or been prescribed **antidepressants**? ()N For what reason _____
Medication(s) and dates of use _____ Why stopped _____

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).
DO NOT include medications you may be currently misusing (that information is needed later) _____

Please list all current **herbal medicines, vitamin supplements**, etc. and how often you take them

MD NOTES _____

Please list any **allergies** you have (penicillin, bees, peanuts)

MD NOTES _____

Tobacco History

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

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

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

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

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

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

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth- Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? (Please list) _____

What was your longest period of abstinence? _____

What are your expectations of Suboxone therapy? _____

Do you think Suboxone is a miracle drug? Yes____No____

Do you understand that this treatment requires dedication and effort from you? Yes____No____

What are your major concerns about taking Suboxone and being successful? _____

MD NOTES _____



PATIENT TREATMENT CONTRACT

Patient Name _____ Date _____

There are 4 phases in this treatment program:

Phase I; Induction and maintenance

Phase II; 10 sessions of spiritual counseling.

You will enter into contract with Pastor Crews and the number of contractual sessions is 10, this is without appeal, 3 sessions are required during the first month and no appointment will be given until Pastor Crews has confirmed kept appointments. The counseling sessions must be scheduled directly with Pastor Crews, the fee of \$40.00/session and must be paid prior to the session; the fee is non-refundable. The counseling sessions are held at a location of Pastor Crew's choice and satisfactory progress reports from Pastor Crews are required before you will be given your next appointment with this office.

Phase III; In-patient treatment

Phase IV; Dismissal, without any recourse or appeal

As a participant in buprenorphine 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 my scheduled appointments.
If you need to be seen on the weekend:
 - You will first need to be seen and established as a patient on a Tuesday
 - You will need to notify the office in advance of this need, so that the doctor can review the case and make arrangements for the prescription
 - There are no exceptions to this rule and no appeal
2. I agree to adhere to the payment policy outlined by this office.
 - Cash payment of \$170.00 due at each appointment.
 - You cannot be seen without payment.
 - If insured, we will file and reimburse you
 - If not covered by your insurance, no reimbursement
 - If you do not want to file to your insurance, you must sign a form stating this fact

3. I agree to conduct myself in a courteous manner in the doctor's office and not cause any upsets.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious illegal violation and results in **Phase IV**.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office, this is automatic **Phase IV**.
6. I understand that if dealing, stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in **Phase IV**, if confirmed.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit will result in my not being able to get my medication/prescription until the next scheduled visit. You will be allowed to reschedule an appointment one time and the rescheduled appointment must be scheduled within the next 7 days.
8. I agree that if I miss 1 appointment, it will result in movement to **Phase II**.
9. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication or lost prescriptions will not be replaced until I have begun **Phase II**.
10. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician, this would result in **Phase II**.
11. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium^{®*}, Klonopin^{®†}, or Xanax^{®‡}), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines.
12. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
13. I agree to randomize urine testing. The randomized testing can be initiated by this clinic or by the lab conducting the urine testing. There will be a 6 hour window of time that you will have to report to the office for collection of urine. I also agree that **one "dirty urine" will result in Phase II**.

"Dirty urine" is defined as:

- Urine test positive for any illegal or controlled substances.
- Urine test negative for buprenorphine.

On your first dirty urine, a repeat random urine will be required, you will be given the same 6 hour window of time to report to the office for collection of the urine, this urine test will be an additional \$80.00 cost for you to pay, and no further prescription will be written until this repeat urine is collected and evaluated. This fee will also be filed to your insurance and reimbursement will follow the same guidelines as regular visits.

14. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
15. I agree if I have **one "dirty urine"**, I will be required to enter **Phase II**. If I refuse, this will result in **Phase III**.
16. I agree that continued "dirty urines" while in **Phase II**, could result in **Phase III**.
17. I agree that I am only seen at this clinic for addiction therapy and if I wish to become a medical or dental patient, I will have to meet all the requirements for a new patient. There is no guarantee that I will be accepted.

18. I agree that at any time the patient/doctor relationship can be dissolved and I would need to find another provider.
19. I agree that Pastor Eric Crews will supply a written confirmation of counseling attendance to Dr. Boyett and this will become part of my permanent chart. An alert will be placed in your chart reflecting your status for future appointments. You will be in good standing for attendance or hold for missed attendance. No appointment will be made if your status is hold until written confirmation from Pastor Crews is received in this office of good standing, this is without appeal.
20. I agree that without written confirmation of counseling attendance for violations of agreement, missed appointments, lost medication, lost prescription or dirty urine, I will not receive an appointment for further prescriptions of buprenorphine.

Date _____

Patient Signature

* Valium® is a registered trademark of Roche Products Inc.

† Klonopin® is a registered trademark of Roche Laboratories Inc.

‡ Xanax® is a registered trademark of Pharmacia & Upjohn Company



Insurance Filing Refusal Form

I _____ am requesting that my treatment for addiction not be filed to my insurance. I do, however want my visits for medical conditions to be filed.

Signature _____ date __/__/__

Witness _____ date __/__/__



Forms Received

I have received the following forms:

1. Suboxone Procedure Policy
2. Patient Treatment Contract
3. Explanation of First Visit
4. Consent to Release/Receive Confidential Information
5. Patient Intake Medical History
6. Support Group Information

Signed _____ date ___/___/___

Witnessed _____ date ___/___/___