FRESH START MEDICINE

PATIENT INTAKE FORMS

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Secondary Phone #: _____

Email: _____ SSN: _____Gender: _____

Emergency Contact: _____ Relationship: _____

Address (if different): _____

Phone #: _____ Secondary Phone #: _____

Referred By/How'd You Hear About Us? _____

CURRENT/PAST MEDICAL CONDITIONS (check all that apply)

*If there is any family history of the illness listed, place an "F" next to that illness.

General:

- ☐ Night Fever/Chills
- ☐ Change in appetite
- ☐ General Fatigue
- ☐ Frequent Nausea
- ☐ General Weakness
- ☐ Fibromyalgia

Integumentary:

- ☐ Skin Rash
- ☐ Change in skin appearance
- ☐ Skin Cancer
- ☐ Easy bruising
- ☐ Hair Changes
- ☐ Abscess

Head/Ears/Eyes/Nose/Throat:

- ☐ Bad Teeth
- ☐ Sinusitis
- ☐ Hearing Loss
- ☐ Vision Changes
- ☐ Gum Disease
- ☐ Sore Throat
- ☐ Ear Drainage
- ☐ Blindness
- ☐ Mouth Sores
- ☐ Nasal Discharge
- ☐ Eye Discharge
- ☐ Glaucoma

Cardiovascular:

- ☐ Endocarditis
- ☐ Cardiac Arrest
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Heart Murmur/ Palpitations
- ☐ Chest Pain
- ☐ Arrythmia
- ☐ Rheumatic Fever

Respiratory:

- ☐ Bronchitis
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Wheezing/Shortness of Breath
- ☐ Chronic Cough
- ☐ Lung Cancer

Nervous System:

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Bad Nerves
- ☐ Chronic Headaches
- ☐ Migraines
- ☐ Tension Headaches
- ☐ Brain Disease
- ☐ Fainting
- ☐ Blackout Spells
- ☐ Numbness
- ☐ Weakness
- ☐ Paralysis
- ☐ Alzheimer's
- ☐ Meningitis
- ☐ Spinal Cord Disease
- ☐ Epilepsy
- ☐ Seizures

Gastrointestinal:

- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Ulcers
- ☐ Hernia
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Irritable Bowel
- ☐ Chrohn's Disease
- ☐ Ulcerative Colitis
- ☐ Gallbladder Disease
- ☐ Loss of Bowel Control

Endocrine:

- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Pancreatitis
- ☐ Thyroid Disease, high
- ☐ Thyroid Disease, low
- ☐

Musculoskeletal:

- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Infection in the Bones
- ☐ Bursitis
- ☐ Artificial Joints
- ☐ Low Bone Density

Genito-Urinary:

- ☐ Kidney Stones
- ☐ Kidney Infection
- ☐ Bladder Infection
- ☐ Loss of Urine Control
- ☐ Dialysis
- ☐ Kidney Failure/Low Kidney Function

Hematology:

- ☐ Taking Blood Thinners
- ☐ Sickle Cell Trait
- ☐ Sickle Cell Disease
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Hemophilia
- ☐ Anemia
- ☐ Blood Clots/Abnormal Clotting
- ☐ Swollen Glands/ Lymph Nodes

Any other medical history not listed (Personal or Family)?

SURGICAL HISTORY

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

PSYCHIATRY

Have you ever been diagnosed with a psychiatric or mental illness? Yes ( ) or No ( )

If yes, please select all that apply:

- ☐ Depression ☐ Bipolar Disorder ☐ Anxiety Disorder
- ☐ PTSD ☐ Antisocial ☐ Schizophrenia

*Do you have a Declaration for Mental Health Treatment Plan (legal document that lists your wishes in case of a mental health crisis)? Yes ( ) or No ( )

If not, would you like information about a DHMT? Yes ( ) or No ( )

Patient Signature: _____

MEDICATION ALLERGIES

Please indicate the medications you are allergic to and the reactions you experience.

Medication	Reaction/Side Effects
1.	
2.	
3.	
4.	

Please indicate if you have any of the below allergies:

☐ Bees ☐ Pollen ☐ Grass ☐ Dogs ☐ Cats ☐ Hay Fever

☐ Please check this box if you do not have any known allergies.

CURRENT MEDICATIONS

Please list all medications that you are prescribed (including dosage and how often you take it).

MEDICATION	DOSAGE	HOW OFTEN YOU TAKE IT
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

SOCIAL HISTORY

Cigarettes/Tobacco:
Current Smoker? Yes ( ) or No ( )
If so, how many per day? _____
History of Tobacco Use? Yes ( ) or No ( )
If so, how many years? _____

Alcohol:
Current Drinker? Yes ( ) or No ( )
If so, how much per day? _____
History of Alcohol Use? Yes ( ) or No ( )
If so, how many years? _____

PREVIOUS SUBSTANCE ABUSE TREATMENT

Have you ever been to a treatment clinic or facility where medication (Methadone, Suboxone, Subutex, etc.) was used? Yes ❑ or No ❑

If yes, please answer the following questions:

Name of Facility: _____

Do you authorize us to request your records from the above facility? Yes ❑ or No ❑

Were you successful (clean/stable) in treatment? Yes ❑ or No ❑

Which of the following medications were prescribed during your treatment?

❑ Suboxone	❑ Bunavail	❑ Subutex	❑ Methadone
❑ Vivitrol	❑ Neurontin	❑ Benzodiazepines	❑ Sublocade

OTHER PROVIDERS

Please list any other healthcare providers you see regularly (such as your Primary Care Provider, Mental Health Provider, OB/GYN, etc.) and indicate whether you authorize us to request and obtain your medical records from them.

Provider Name: _____ Authorization to request records? Yes ❑ or No ❑

Provider Name: _____ Authorization to request records? Yes ❑ or No ❑

Provider Name: _____ Authorization to request records? Yes ❑ or No ❑

Provider Name: _____ Authorization to request records? Yes ❑ or No ❑

Provider Name: _____ Authorization to request records? Yes ❑ or No ❑

Provider Name: _____ Authorization to request records? Yes ❑ or No ❑

SUBSTANCE	Do you have a history?	If yes, past or present?	Date of last use?
Alcohol			
Cocaine			
Methamphetamine			
Heroin			
Inhalants			
LSD, Ecstasy, or Hallucinogens			
Marijuana			
Pain Killers			
PCP			
Stimulants			
Benzodiazepines/ Tranquilizers/Sleeping Pills			

FRESH START MEDICINE

ASSIGNMENT OF BENEFITS/RELEASE OF MEDICAL INFORMATION

I hereby authorize and request that payment of benefits by my Insurance Company(s) be made directly to Fresh Start Medicine herein referred to as "Facility", for services furnished to me or my dependent. I understand that my Insurance Company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize the facility to disclose all written information from the above named to my Insurance Company(s) or its designated representatives, or other financially responsible party, at the determination of facility. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release the facility, its officers, agents, employees, and any clinician associated with my case, from all liability that may arise because of disclosure of information to my Insurance Company(s) or their designated representatives.

By signing this Assignment of Benefits and Release of Information, I acknowledge:

- I am aware and understand that this authorization will not be used unless my Insurance Company(s) or their designated representatives request records of information for reimbursement purpose; or seek to act on reference payment for treatment services.
- I agree to participate in and assist the Facility and its designated representatives with the appeal process necessary to collect payment for the services rendered.
- I am aware and have been advised of the provisions of Federal and State Statutes rules and regulations that provide for my right to confidentiality to these records.
- I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
- The facility is acting in filing insurance benefits assigned to Fresh Start Medicine and it can assume no responsibility for guaranteeing payments of any charges from the Insurance Company(s).
- Billing may be done by a firm contracted by Facility for billing and collection purposes.
- Facility has been appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment for my insurance carrier.
- Should an overpayment take place, a refund check will be mailed to the authorized party that is owed the overpayment.
- The facility shall be entitled to the full amount of its charges without offset.
- I agree to endorse and forward to Facility any monies from the Insurance Company(s) paid to me and/or the primary insurance. I understand that I am otherwise responsible for the cost of all charges accrued.

Signature: _____ Date: _____

FRESH START MEDICINE

BENZODIAZEPINE TREATMENT AGREEMENT

Benzodiazepines (such as Klonopin, Xanax, etc.) are dangerous when taking Buprenorphine products (such as Suboxone, Subutex, and Bunavail). It has been proven to have side effects including respiratory distress, coma, or even death.

As a patient at Fresh Start Medicine, I agree to be tapered off Benzodiazepines completely to continue my Buprenorphine treatment. This means I will be tapered until I am completely off Benzodiazepines.

As a patient at Fresh Start Medicine, I acknowledge that I will not be initiated on Benzodiazepines.

If I do not comply with the above, I understand that I will be dismissed from Fresh Start Medicine.

Signature: _____ Date: _____

FRESH START MEDICINE

OBOT SERVICE CLIENT RIGHTS, CONFIDENTIALITY, RESPONSIBILITIES, & GRIEVANCE PROCEDURES

Rights and Confidentiality:

- To be fully informed/presented before the initiation of services about your rights and responsibilities in a manner/format that promotes understanding – including any limitation imposed by the rules of the licensee.
- To be treated with consideration, respect and full recognition of their dignity and individuality, and have courteous, compassionate care.
- To be protected by the licensee from neglect, physical, verbal, and emotional abuse (including corporal punishment), and from all forms of misappropriation and/or exploitation
- To have reasonable personal privacy when you receive care.
- To receive a list of available advocacy services upon admission
- To have your records kept confidential and private – to ask the facility to correct information in the records.
- To be informed about your care and involved in your care planning in a language of your understanding.
- To submit complaints without fear of retaliation and have them addressed timely.
- To refuse services and be informed of the impact on your care.
- To be informed of any changes in your care, including the type, amount, and frequency
- To participate fully, or to refuse to participate, in community activities.
- Not to be required to make public statements which acknowledge gratitude to the agency.
- Not required to perform in public gatherings.
- Identifiable photographs will not be used without written and signed consent by the patient or guardian.
- To voice grievances to the licensee and to outside representatives of their choice with freedom from restraint, interference, coercion, discrimination, or reprisal.
- To be assisted in the exercise of their civil rights.
- To have all applications, certificates, records, reports, and all legal documents, petitions, and records made or information received pursuant to treatment in a Facility directly or indirectly identifying a patient to be kept confidential in accordance with T.C.A 33-3-103; Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations at 45 Code of Regulations (CFR) Parts 160 and 164, Subparts A and E; and Confidentiality of Alcohol and Drug Abuse Patient Records regulations at CFR Part 2.
- You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a “Release of Information Form” from the front office personnel. You will not be charged for your personal protected health information.
- You are to not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including

conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

Responsibilities – The Patient Agrees...

- To keep and be on time for scheduled appointments or make reasonable notifications; not arrive intoxicated.
- That the medication is my responsibility and to keep it in a safe place; not to sell or share my medication; and to take my medication as instructed.
- To notify staff of any additions/changes in medications from other providers or any conditions which may affect my care.
- That medication is not sufficient treatment; the patient agrees to participate in Relapse Prevention, Group, and Individual Counseling Sessions.

Grievance Procedures:

You have the right to voice grievances to the staff of the agency, to the owner of the agency, and to outside representatives of your choice with freedom from restraint, interference, coercion, discrimination, or reprisal. Any question or specific concerns regarding patient's rights or to report a complaint may be directed to any of the following:

Facility's Contact Person: Jill Corvin	Phone #: 423-251-6670
TN Department of Mental Health & Substance Abuse Services	Phone #: 1-866 797-9470
Disability Law and Advocacy Center of TN	Phone #: 1-800-342-1660
TN Department of Human Services – Adult Protection Services	Phone #: 1-888-277-8366

I have been explained and received a copy of Service Recipient Rights, Confidentiality, Responsibilities, and Grievance Procedures.

_____ _____

Patient Signature Date

_____ _____

Agency Witness Signature Date

FRESH START MEDICINE

CLIENT FEE SCHEDULE & FINANCIAL RESPONSIBILITY

Fresh Start Medicine believes that a key component of quality healthcare is the clear establishment and communication of our financial policy to patients. We are committed to delivering the highest quality care and ensuring that you have a clear and complete understanding of our financial policy.

Fee information for those without insurance coverage:

OBOT Services (includes physician and counseling services, assessments, and case management):

- **Weekly Patients: $50**
- **Bi-Weekly Patients: $100**
- **Monthly Patients: $200**

Additional Services:

- **Primary Care & MAT Services Provided Same-Day: OBOT Fee + $25 PCP Visit Fee**
- **Primary Care (Non-OBOT Patients): $150 Initial Visit; $50 Follow-Up**
- **Individual Counseling (Non-OBOT Patients): $100 per visit**
- **Department of Transportation (DOT) Physical: $95**

**DOT Physicals are non-billable to medical insurance*

FSM offers a sliding scale based on the patient's income. Please speak to the front staff if you are interested in applying for the sliding scale.

Payment Policy: Payment is expected at the time of your visit, at check-in, before services are rendered. We will accept cash (**ONLY** for co-payments) or credit card (with fee). Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company including maximum out of pocket benefit limits. **If you do not carry insurance, or if your coverage is currently pended due to your non-payment of premium, payment in full is expected at the time of your visit**. If you are unable to pay at the time of your visit, your appointment will be rescheduled for the next available date. If you have any questions regarding charges or billing, please contact our office. Fresh Start Medicine does not receive governmental or other funding or donations applicable to the fee or fees for services.

Insurance: We will file the appropriate insurance claims on your behalf. Please remember that insurance is a contract between the client/patient and the insurance company and ultimately the client/patient is responsible for payment in full. If your insurance company does not render payment to the practice within a reasonable period (60 days), you may be billed for services provided. If we later receive payment from your insurer, we will refund any overpayment to you. Refunds are given on a case-by-case basis. If we are out-of-network providers, you may be responsible for partial or full payment depending upon your insurance policy. Due to the many different insurance products, our staff cannot guarantee your eligibility and coverage at the time you are seen. Be sure to verify your coverage details with your insurer's member benefits department before your appointment. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you may be responsible for payment in full for all services provided.

FRESH START MEDICINE

Your insurance may be billed for ancillary services which include but are not limited to laboratory testing, urine drug screens, group meetings, individual counseling sessions, case management sessions, chronic care management, etc. You will be required to pay all patient-responsible cost-shares associated with these services according to your insurance plan.

General Consent for Treatment and Financial Responsibility:
I hereby authorize Fresh Start Medicine and its healthcare providers to provide medical care and treatment as deemed necessary. I understand that I am financially responsible for all charges for services rendered, including those not covered or paid by my insurance plan. This includes, but is not limited to, co-payments, deductibles, co-insurance, and services deemed non-covered or not medically necessary by my insurance.

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits to Fresh Start Medicine for services rendered. I understand it is my responsibility to notify the clinic of any changes to my insurance coverage or contact information.

By signing below, I acknowledge that I have read, understand, and agree to the terms of this financial policy and give general consent for treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

CONSENT FOR LABORATORY DRUG SCREENING

It is the policy of Fresh Start Medicine to provide each client with an alcohol and illicit drug free environment. Urine and/or oral drug screens and breathalyzer tests will help us in achieving our goal.

As a client of Fresh Start Medicine, I understand that I will be expected to submit urine and/or oral samples for drug and/or alcohol screenings under the supervision of staff.

I understand that I may be requested to provide a urine or oral sample upon admission, for scheduled and/or randomly, or upon suspicion of drug or alcohol abuse.

My signature below indicates that I have acknowledged Fresh Start Medicine's drug free protocols and consent to the administration of urine and/or oral drug screening by staff of Fresh Start Medicine.

I understand that my refusal to provide a urine or oral specimen upon request could result in my being asked to leave Fresh Start Medicine and to forfeit all my rights and privileges as a client.

Signature: _____ Date: _____

FRESH START MEDICINE

NOTICE OF PRIVACY PRACTICES

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

Effective Date: January 1, 2023
Revised Date: January 5, 2026

We understand that your health information is personal, and we are committed to protecting its privacy. We are required by law to:

- Maintain the privacy of your health information.
- Give you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of our Notice of Privacy Practices that are currently in effect; and
- Notify you following a breach of your unsecured health information

Your rights regarding health information about you

Right to inspect and copy: You have the right to request to inspect and obtain a paper or electronic copy of the health information that may be used to make decisions about your care or payment, and to request that an electronic copy of your electronic health record be forwarded to a third party of your choice. However, under certain circumstances and, if permitted by law, we may deny your request. To inspect and obtain a copy of your health information, you must submit your request in writing. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request, or less as required by state law. There may be reasonable, cost-based fees for the costs of copying, mailing or other supplies associated with your request.

Right to amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information as long as it is kept by Fresh Start Medicine. To request an amendment, your request must be made in writing and provide a reason that supports your request. Ask us how to submit this request. We may deny your request under certain circumstances. You will be informed of the decision regarding any request for amendment of your health information within 60 days and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

Right to an accounting of disclosures: You have the right to request a list of certain disclosures we make of your health information. We will include all disclosures except those for treatment, payment, health care operations, and certain other disclosures (such as those you asked us to make). To request this list of disclosures, you must submit your request in writing to us. Your request must state a time period for which the accounting of disclosures is sought, which cannot be longer than six years prior to the date on which your request for accounting is made. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list but will notify you of the cost involved and offer you the chance to withdraw or modify your request before any costs are incurred.

Right to request restrictions: You have the right to request a restriction on the health information we use or disclose about you for treatment, payment, health care operations, to persons involved in your care or payment, or disclosures for disaster relief purposes. We are not required to agree to a request for restrictions, other than a request that we not disclose information to a health plan for payment or health care operations where the request relates only to a health care item or service for which we have been paid in full. We will notify you if we don't agree to your request for restriction. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to us. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your health plan.

Confidential communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Your request must be in

writing and specify how or where you wish to be contacted and to what address we may send bills for payment for services provided to you. We will accommodate reasonable requests.

Right to a paper copy of this notice: You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may also obtain a copy of this notice at our website www.freshstartmedicine.com.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make reasonable efforts to ensure the person has this authority and can act for you before we take any action.

How your health information may be used and disclosed without your authorization: The following describes different ways that we are permitted to use and disclose health information that identifies you. If you receive services at any of our facilities, then information that identifies that you have or had a substance use disorder (Substance Use Disorder Records) are subject to additional restrictions that are addressed below. Note that the federal medical privacy law commonly known as HIPAA only applies to certain entities (certain health care providers, health plans, and entities acting on their behalf). Accordingly, health information that is disclosed as described below in accordance with HIPAA may be subject to redisclosure by the recipient and no longer protected by HIPAA. For example, if we disclose your health information as required by a court order, the information may no longer be protected by HIPAA.

Treatment: We may use health information to treat you or provide you with healthcare services. For example, we may tell your primary care physician about the care we provided you or give health information to a specialist to provide you with additional services. We generally will not disclose Substance Use Disorder Records for treatment purposes without your consent, except in a bona fide medical emergency in which your consent cannot be obtained.

Payment: We may use and disclose health information so that we may bill or receive payment from you, an insurance company, or a third party for the treatment and services provided to you. For example, we may disclose your health information to your insurance company in order to receive payment for service rendered. We generally will not disclose Substance Use Disorder Records for payment purposes without your consent.

Healthcare operations: We may use and disclose health information for healthcare operations and administrative purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may share information with doctors, nurses, medical students, and other personnel for learning purposes. We generally will not disclose Substance Use Disorder Records for health care operations purposes without your consent.

Individuals involved in your care or payment for your care: If you do not object, or we reasonably infer, based on professional judgment, that you do not object to the disclosure, we may disclose relevant health information to a family member, friend, or other person involved in your medical care or who helps pay for your care. We may also disclose health information to a personal representative, who is a person who has legal authority to make healthcare decisions on your behalf. We generally will not disclose Substance Use Disorder Records to a family member, friend, or other person involved in your medical care or payment without your consent.

Business associates: We may disclose health information to our business associates who perform functions on our behalf or provide us with services, if the information is necessary for such functions or services.

Research: Under certain circumstances, we may use and disclose health information for research purposes provided that we comply with applicable federal and state legal requirements.

Other purposes: We may use or disclose health information about you for other reasons:

- In a disaster relief situation (except for Substance Use Disorder Records).

- When required by international, federal, state or local law, including a request by the Secretary of the Department of Health and Human Services to see that we are complying with federal privacy law (additional restrictions may apply to disclosures of Substance Use Disorder Records).
- To avert or reduce a serious threat to health or safety of the public or another person (except for Substance Use Disorder Records).
- For special government functions such as national security and intelligence activities, including presidential protective services (except for Substance Use Disorder Records).
- For a member of the Armed Forces (domestic or foreign), we may disclose your medical information as required by military command authorities (except for Substance Use Disorder Records).
- In response to a court or administrative order, subpoena or other lawful process (except that a specialized type of court order generally is required before we will disclose Substance Use Disorder Records).
- To a law enforcement official for law enforcement purposes provided we comply with applicable legal restrictions (except for Substance Use Disorder Records).
- To report suspected abuse, neglect, or domestic violence.
- If you are an inmate, to the correctional institution or law enforcement official (except for Substance Use Disorder Records).
- To an organ donation bank or to facilitate organ or tissue donation and transplantation (except for Substance Use Disorder Records).
- To workers' compensation or similar programs for work-related injuries or illness to the extent necessary to comply with laws related to these programs (except for Substance Use Disorder Records).
- For public health activities such as to prevent or control disease, injury or disability; to report births and deaths; to notify a person who may have been exposed or who may be at risk of spreading a disease; or reporting information to the Food and Drug Administration (FDA) if you experience an adverse reaction from any drugs, supplies or equipment (except for Substance Use Disorder Records).
- To health oversight agencies for activities authorized by law (except for Substance Use Disorder Records).
- To a coroner/medical examiner as authorized by law to identify a deceased person or determine cause of death (except for Substance Use Disorder Records).
- To funeral directors to carry out their duties (except for Substance Use Disorder Records).

Uses and disclosures of medical information which require your authorization: Uses and disclosures of health information that are not discussed by this notice or required by law will only be made with your written permission. Your written authorization will typically be required for most uses and disclosures of psychotherapy notes, most uses and disclosures for marketing and most arrangements involving the sale of health information.

Further restrictions on substance use disorder records: We generally will not use or disclose substance use disorder treatment records received from programs that hold themselves out as providing substance use disorder services (including programs outside of Fresh Start Medicine) in civil, criminal, administrative, or legislative proceedings against you without your consent or a special type of court order that is specific to substance use disorder records and is accompanied by a subpoena or other legal requirement compelling disclosure.

How you may revoke your authorization: If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. Your request to revoke your authorization must be sent to our Compliance Officer.

Changes to this notice: We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our facilities and on our website. You may request a copy of the new notice be sent to you in the mail or electronically.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Compliance Officer at 423-251-6670. There will be no retaliation against you for filing a complaint.

Contact: If you have questions or would like additional information, you may contact the Compliance Officer via phone at 423-251-6670 or in writing to 1700 Pinebrook Dr Ste 4, Kingsport, TN 37660.

Confidentiality of substance use disorder patient records: Fresh Start Medicine specializes in providing substance use disorder treatment. Federal law and regulations provide additional privacy protection to information about substance use disorder treatment generated by these programs. Accordingly, in addition to the privacy protections described in the Fresh Start Medicine Notice of Privacy Practices, these additional restrictions apply to substance use disorder treatment records generated by programs. These restrictions do not apply to substance use disorder information that is not generated by a program, such as substance use disorder information generated by a primary care physician.

Generally, the programs may not identify that you receive services at a program, or disclose any information from a program identifying you as receiving substance use disorder treatment (collectively, "Substance Use Disorder Records") unless:

1. You consent in writing;
2. The disclosure is allowed by a court order specific to Substance Use Disorder Records; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

The programs must obtain your consent for most uses and disclosures of your Substance Use Disorder Records for treatment, payment, or health care operations. For example, the programs must obtain your consent to disclose your Substance Use Disorder Records to your primary care physician. You may provide a single consent for all future uses or disclosures of your Substance Use Disorder Records for treatment, payment, and health care operations purposes (TPO Consent Form). The programs may only make uses and disclosures of your Substance Use Disorder Records that are not listed in this notice with your written consent. You may revoke a consent in writing at any time, except to the extent that the program or a recipient of your substance use disorder has already acted in reliance on your consent. Your request to revoke your consent must be sent to our Compliance Officer.

Substance Use Disorder Records, or testimony relaying the content of such records, may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record, as provided in the federal law governing confidentiality of substance use disorder records at 42 C.F.R. part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Substance Use Disorder Records that are disclosed to another program governed by 42 C.F.R. part 2 or to a HIPAA covered entity or business associate pursuant to your written consent for treatment, payment, and health care operations may be further disclosed by the recipient (including Fresh Start Medicine), without your written consent, to the extent HIPAA regulations permit such a disclosure.

Federal law and regulations governing Substance Use Disorder Records do not protect:

- Any information about a crime committed by a patient either at the treatment program or against any person who works for the program, or about any threat to commit such a crime.
- Any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Your rights regarding your substance use disorder treatment records: You have the following rights with respect to your substance use disorder treatment records:

- The right to request restrictions on disclosures made with your prior consent for purposes of treatment, payment, and health care operations.

- The right to request and obtain restrictions of disclosures of Substance Use Disorder Records to your health plan for those services for which you have paid in full.
- To the extent that your Substance Use Disorder Records are disclosed to an intermediary, such as a Health Information Exchange network, for further disclosure, you have a right to a list of disclosures by the intermediary for the past three years.
- You have a right to obtain a paper or electronic copy of this notice upon request.
- You have a right to discuss this notice with the Compliance Officer.

For information about the programs' duties with respect to privacy, how to file a complaint regarding a program, and contact information for further information about this notice, please see the sections of the Fresh Start Medicine Notice of Privacy Practices titled "Complaints," and "Contact."

Changes to This Notice: We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our facilities and on our website. You may request a copy of the new notice be sent to you in the mail or electronically.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Compliance Officer at 423-251-6670. There will be no retaliation against you for filing a complaint.

Contact: If you have questions or would like additional information, you may contact the Compliance Officer via phone at 423-251-6670 or in writing to 1700 Pinebrook Dr Ste 4, Kingsport, TN 37660.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Fresh Start Medicine's **Notice of Privacy Practices**, which explains how my health information may be used and disclosed and how I can access my information. I understand that I may request a copy of this Notice at any time.

I understand that this Notice applies to my protected health information, including any records that may be subject to additional protections under **42 CFR Part 2**, when applicable.

Signature: _____ Date: _____

FRESH START MEDICINE

Consent to Disclose Substance Use Disorder (SUD) Records Covered by 42 CFR Part 2

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____

Information about this Consent

By completing and signing this form, you consent to all future uses and disclosures of your health information, including Substance Use Disorder Records, for purposes of treatment, payment, and health care operations (TPO).

Examples include, but may not be limited to, your primary care provider, specialty care providers, hospital and emergency providers, case managers or care coordinators, employees of Fresh Start Medicine, your insurance company or payer, laboratories performing your diagnostic testing, business associates of ours, and other individuals who are involved in coordination or payment of your care.

Entities receiving your information must follow all state and federal laws to keep your information private; however, there is the potential for the records used or disclosed pursuant to the consent to be redisclosed by the entities receiving the information and as a result, the information may no longer be protected by 42 CFR Part 2 (the federal regulation which protects the privacy of SUD information). Once your SUD information is shared with members of your health care team for purposes of treatment, payment, or operations, they may incorporate it into their records and further share it with other health care providers, payers, or organizations that provide services for them. Your information may be redisclosed or shared in accordance with HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you, the patient.

Consent to Disclose My Substance Use Disorder Treatment Information
I authorize Fresh Start Medicine to disclose any of my past, present, and future 42 CFR Part 2 – Substance Use Disorder information and/or records for the purposes of treatment, payment, and healthcare operations, including my health plan, third-party payers, and staff and employees of Fresh Start Medicine coordinating my care.

Type and Amount of Data
The information shared will be used for the purposes of treatment, payment, and health care operations as defined by HIPAA. The information to be shared could include but may not be limited to encounter notes, clinical documents, lab results, drug test results, medication information, and claims data relating to my 42 CFR Part 2 – Substance Use Disorder treatment.

Consent Options

- ☐ Disclose All Substance Use Disorder Data for Treatment, Payment, and Operations Purposes
  This includes, but may not be limited to, my treatment plan, medications, laboratory results, drug screen results, counseling notes, encounter notes, claims information, and other data about my 42 CFR Part 2 – Substance Use Disorder treatment.

FRESH START MEDICINE

REVOKING MY PERMISSION

I understand that I may revoke this consent at any time by submitting a request in writing. I understand that my information will be shared during the time the consent is active and my health care team may use this information for treatment, payment, and health care operations in accordance with state and federal law. I understand that the revocation will not affect any reliance, action, or disclosure of information by the organization that was authorized to release my information before it received notice of my revocation of my consent. I understand that Fresh Start Medicine cannot retrieve information once it is released; if I revoke my consent, whatever has been shared before that consent may continue to be in the files of the entities with whom it was shared before I revoked my consent and may be further shared in accordance with HIPAA and state law.

EXPIRATION DATE

This Consent and Authorization to share my 42 CFR Part 2 – Substance Use Disorder treatment information will remain in effect until the date indicated, unless revoked prior to that time. **If no date is indicated, the consent will not expire and will remain in effect until revoked.**

Expiration Date: _____

Signature/Attestation

By signing below, I acknowledge that I have read this consent form and understand that, as indicated on this form, my 42 CFR Part 2 – Substance Use Disorder information may be shared for purposes of treatment, payment, and healthcare operations.

_____
Printed Name

_____ _____
Signature of Patient Date

Legal Guardian Signature

By signing below, I acknowledge that I have the legal authority to consent to share the named individual's 42 CFR Part 2 – Substance Use Disorder treatment information. I acknowledge that I have read this consent form and understand that as indicated on this form, the 42 CFR Part 2 – Substance Use Disorder information of the person on whose behalf I am signing, may be shared for purposes of treatment, payment, and healthcare operations.

_____
Printed Name of Legal Guardian

_____ _____
Signature of Legal Guardian Date

OUTPATIENT THERAPY SERVICES CONTRACT

Welcome to Fresh Start Medicine. This document contains important information about our professional therapy services. Please read this carefully and feel free to ask any questions that you might have.

Therapy Services

Therapy is not easily described in general statements. It varies depending on the personalities of the therapist and the patient, and on the goals that we identify and agree to work on. There are many different methods that we may use to deal with problems, and this calls for active effort on your part.

Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to improve relationships, identify solutions to specific problems, and significantly reduce feelings of distress.

Confidentiality

In general, the privacy of all communications between a patient and a therapist is protected by law, and information about our work together can only be released to others with your written permission. However, there are some situations in which we are legally obligated to act to protect our patients and/or others from harm.

If a patient threatens to harm himself/herself, we are obligated to call Crisis Services for an assessment, to seek hospitalization for the patient, and/or to contact family members or others who can help provide protection. If this situation occurs during our work together, we will attempt to fully discuss it with you before taking any action.

If we believe that a patient is threatening serious bodily harm to another, we are required to take protective actions. These actions include notifying the potential victim and contacting the police.

If we have reason to believe that a child, an elderly person, or a disabled person is being abused or has been abused, we must report to the appropriate state agency.

In some legal proceedings, a judge may order testimony if he/she determines that the issues demand it, and we must comply with that court order.

We may occasionally find it helpful to consult other professionals with our agency about a case. During a consultation, we make every effort to avoid revealing the identity of a patient. The consultant is also legally bound to keep the information confidential. Ordinarily, we will not tell you about these consultations unless we believe that it is important for our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions that you may have.

Signature: _____ Date: _____

PATIENT TREATMENT AGREEMENT

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this contract as follows:

1. I agree to be evaluated for acute detox, medically managed withdraw from medications, or be placed on a continued maintenance program. I agree that the goal of treatment is stabilization of functioning.
2. I agree to keep and be on time for all my scheduled appointments. I understand that if I fail to call the office prior to being late, my appointment may be rescheduled for the next available appointment date. I understand that if I miss/reschedule 3 consecutive appointments, I will be discharged from FSM for 90 days.
3. All new patients will be seen weekly for the first 12 weeks. After the induction/initial phase, if I comply with the program and I remain clean from opioids, alcohol, marijuana, etc. I will be allowed to schedule my appointments bi-monthly (every 2 weeks). If I happen to test positive for ANY substance (opioids, marijuana, alcohol, benzodiazepines, etc.) that are not prescribed to me, my appointments will go back to weekly until I am clean from non-prescribed medications. If I continue to fail urine drug screens each week, my physician may require me to come to the clinic more than once per week.
4. All females of childbearing age shall use contraception while taking ANY buprenorphine products (Suboxone, Subutex, Bunavail, Zubsolv, etc.)
5. I understand that I will be tested for Hepatitis-C and HIV. If I test positive, I will be referred to the case management team. I understand that I can prevent Hepatitis-C and HIV by avoiding direct exposure to blood or blood products, never sharing needles, practicing safe sex, and never sharing personal care items (razors, toothbrushes, manicure tools, etc.)
6. I understand there are risks associated with taking Buprenorphine such as respiratory problems, sleepiness, dizziness, dependency or abuse, liver problems, allergic reactions (hives, swelling, wheezing, and possible death), opioid withdraw, decreased blood pressure, etc.
7. I agree to notify the front office of any changes in my contact information as soon as possible. The office is not responsible for being unable to reach me due to outdated phone number/address or inability to leave a voicemail.
8. I agree to conduct myself in a courteous manner in the doctor's office.
9. 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 violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
10. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
11. 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 will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
12. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
13. I agree that the staff will discuss my present level of functioning, course of treatment, and future goals with me at regular intervals.

14. I agree that the medication I receive is my responsibility, and I agree to keep it in a safe, secure place in a lockbox to prevent tampering or accidental indigestion by an infant or child. I agree that lost/stolen medication will not be replaced regardless of reasoning.
15. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
16. 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 (especially if taken outside the care of a physician, using routes of administration other than sublingual, or in higher than recommended therapeutic doses).
17. Overdose Prevention: 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.
18. I understand that Narcan is FDA-approved for the emergency treatment of a known or suspected overdose.
19. 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.
20. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances.
21. I agree to provide random urine samples and have my doctor test my blood alcohol level. I also agree that at any time I may be observed during my urine drug screenings by a staff member.
22. I agree to purchase all prescriptions related to my treatment here at the same pharmacy each visit, unless discussed with my physician beforehand.
23. Failure to follow any of the above rules may also result in family members being discharged from or not being accepted here for treatment as well.
24. I have the right to choose to withdraw from or be maintained on the medication unless medically contraindicated.
25. I have the right to present complaints, either orally or in writing. Complaints will be addressed by the facility director.

Signature: _____ Date: _____

IMPORTANT INFORMATION REGARDING YOUR TREATMENT

1. Alternatives to medication assisted treatment (MAT) include medical withdrawal and drug-free treatment; inpatient and intensive outpatient treatment facilities; and programs utilizing alternative medications such as methadone and naltrexone. Benefits associated with more intensive treatment plans include a highly secure environment and more intense monitoring and accountability. Risks include the difficulties that may arise while trying to coordinate a normal daily schedule with the intense demands of your treatment program. It is important to understand that the goal of opioid treatment is stabilization of functioning.
2. Due to the risk of neonatal abstinence syndrome in pregnant females taking opioid medications, including buprenorphine products, it is highly advisable that women of child-bearing age consider using voluntary long-acting reversible contraception to reduce the possibility of an unplanned pregnancy while receiving MAT.
3. Chronic viral illnesses are common among individuals who suffer from the disease of addiction. It is very important that you do not inject any medication or substance into your body. Even doing so in a seemingly "clean" manner can result in contracting viruses such as Hepatitis C or HIV. If you are found to already have these viruses in your body, it is important to seek care with an appropriate specialist to further evaluate and treat your infection.
4. Buprenorphine is an effective tool when used as part of a comprehensive treatment plan to facilitate recovery in an individual suffering from the disease of addiction. It helps lessen cravings and eases the withdrawal symptoms associated with the discontinuation of opioids. For some individuals, this medication can cause uncomfortable side effects, such as headache, nausea, and constipation. It is important to talk with your doctor about strategies for minimizing these effects.
5. Overdose can occur when buprenorphine is taken together with other medications such as alcohol, benzodiazepines, or other respiratory depressants. It is very important to only take the medications prescribed to you and follow the dosing instructions provided by your doctor. It is also important to recognize the risk of overdose following relapse after periods of abstinence from opioids.
6. It is advisable that overdose reversal kits be kept with you and in your home. These products, such as Narcan/Naloxone, can be lifesaving for you as well as for others. Please ask your doctor for more information on obtaining these agents.
7. Be advised that the goal of opioid treatment is stabilization of functioning.
8. Be advised that at regular intervals the following elements of your treatment will be discussed with you: present level of functioning, course of treatment, and future goals.
9. Be advised that you may choose to withdraw from or be maintained on the medication as you desire unless medically contraindicated.

By my signature below, I acknowledge that I have read and understand the items listed above and consent to treatment.

Signature: _____ Date: _____

CLIENT ADVOCACY SERVICES

(After you have signed this document, it will be scanned into your chart. If you ever need a copy of this list, we will be happy to print it for you. If you need any other resources, our counseling staff will be happy to help you in any way they can.)

THIS IS NOT A COMPLETE LIST OF RESOURCES. PLEASE SPEAK TO COUNSELING IF YOU NEED FURTHER ASSISTANCE

TDMHSAS – 866-797-9470
Adult Protective Service – 888-277-8366
Ombudsman – 877-236-0013
Department of Children's Services – 877-237-0004
Disability Law & Advocacy Center – 888-395-9297
TN Protection & Advocacy, Inc – 615-298-1080

Council on Aging – 615-353-4235
*Can help with transportation as well as advocacy

Community Mental Health Centers
Holston Counseling Center (Kingsport) – 423-224-1300
Charlotte Taylor Center (Elizabethton) - 423-547-5950
Cherokee Health Systems – Knoxville – (865) 544-0406
Helen Ross McNabb Center – (865) 637-9711

Local Free Health Clinics
Sullivan County Health Department – 423-279-2777 or 423-224-1600
Friends in Need – 423-246-0010
Greater Kingsport Alliance for Development (G.K.A.D.) – (423) 392-2578
InterFaith Health Clinic -- (865) 546-7330
Knoxville Area Project Access (KAPA) -- (865) 531-2766

Mental Health Hospitals
Woodridge – 423-431-7111
Turning Point – 423-926-0940
Peninsula Behavioral Health (Covenant Health) -- (865) 970-9800
East Tennessee Behavioral Health – (865) 693-4301

Mobile Crisis – 877-928-9062

Local Food Pantries
Salvation Army (Kingsport) – 423-246-6671
1st Broad Street Methodist (Kingsport) - 423-224-1531
Second Harvest Food Bank of Northeast Tennessee (Main Distribution Hub) – (423) 279-0430
FISH Hospitality Pantries – (865) 523-7900
Knoxville Dream Center – The Care Cuts Mobile Pantry – (865) 200-4524
Salvation Army – Knoxville – (865) 525-9401

Local Transportation

Kingsport Area Transit Service (KATS) – (423) 224-2613
First Tennessee Human Resource Agency (FTHRA) – NET Trans -- (423) 461-8233 or 1-800-528-7776
Kingsport City Bus System – 423-224-2611
Knoxville Area Transit (KAT) – (865) 637-3000
ETHRA Public Transit (East Tennessee Human Resource Agency) – (865) 691-2551
You may also contact your insurance company for insurance covered transportation services

Local Shelters
Hope House - (for women) - (423) 247-7994
Salvation Army (Kingsport) - 423-246-6671 - (Bristol) - 423-764-6156
Family Promise of Greater Kingsport – (423) 246-6500
Refuge – (865) 673-0235
YWCA Knoxville & the Tennessee Valley (for women) – (865) 523-6126
Family Promise of Knoxville – (865) 584-2822

Local Housing Agencies
Kingsport Housing & Redevelopment Authority (KHRA) – (423) 392-2545
Appalachian Regional Coalition on Homelessness (ARCH) – (423) 928-2724
Johnson City Housing Authority – 423-232-4784
Knoxville's Community Development Corporation (KCDC) – (865) 403-1100
Tennessee Valley Coalition for the Homeless (Regional Office) – (865) 859-0360

Veterans Affairs
Department of Veterans Affairs – (800) 698-2411
James H. Quillen VA Medical Center - (423) 926-1171
VA Community-Based Outpatient Clinic – Johnson City -- (423) 979-3400
Knoxville VA Outpatient Clinic – (865) 545-4592

Local Law Enforcement (in case of emergency, please call 911 immediately)
Kingsport Police Department – (423) 229-9300
Sullivan County – (423) 279-7500
Knox County Sheriff's Office – (865) 215-2444

By signing below, I acknowledge that I have received this list of advocacy services and that I understand that the counseling staff at Fresh Start Medicine will be able to help me with any other resources that I may need.

Signature: _____ Date: _____

FRESH START MEDICINE

PATIENT COMMUNICATION CONSENT

Fresh Start Medicine
1700 Pinebrook Dr Ste 4
Kingsport, TN 37660
P: (423) 251-6670
F: (423) 251-1899

We may need to contact you regarding your medical care. This is to acknowledge that you authorize Fresh Start Medicine to:

- Leave a detailed message on cell phone or home phone voicemail/machine.
- Call my workplace phone number and leave a message.
- None of the above

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Cancel or change an appointment.
- Reminder calls about annual preventive care due.
- Medication reminders

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message.

I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act 15 U.S.

Code § 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting the Provider or utilizing the opt-out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described.

Signature: _____ Date: _____

PILL COUNT POLICY

Fresh Start Medicine's pill count policy is in place to ensure that our patients are taking their medications as directed and to demonstrate accountability on their part. It is very important that this medication be taken as directed and to be sure that the medication can be accounted for by the staff and administration to attempt to prevent diversion.

Diversion, misuse, or abuse of this medication is a serious matter. Therefore, our pill count policy exists to minimize and halt such activities and as such, the procedures for this policy will be firm and inviolate.

ALL PILL COUNTS ARE REQUESTED BY THE PROVIDER ON A RANDOM BASIS!

PILL COUNT PROCEDURES/PENALTIES:

It is the patient's responsibility to make sure that we always have a working phone number on file. Failure to return our phone call and/or show up for your pill count is grounds for dismissal.

When called in for a pill count, you must bring ALL medications that are prescribed to you by your provider. All pill counts will be done by staff/administration/provider and witnessed by the patient. All medication will be counted twice to ensure accuracy.

FAILURE TO SHOW FOR A PILL COUNT AND/OR ANY DISCREPENCIES IN THE PILL COUNT ARE GROUNDS FOR DISMISSAL!

By signing below, you acknowledge the following:

The phone number you provided below is the best phone number to reach you at

If we are unable to reach you directly, we can leave you a detailed voicemail regarding your random pill count.

You understand that failure to show up for the pill count is grounds for dismissal.

Phone Number: _____

Alternate Phone Number: _____

Signature: _____ Date: _____

I have been fully oriented to the information below and understand that I may ask questions about any of this information at any time during my treatment at Fresh Start Medicine.

I acknowledge that I have read and signed the following consent forms:

- Assignment of Benefits/Release of Medical Information
- Benzodiazepine Treatment Agreement
- Client's Rights, Confidentiality, Responsibilities, and Grievance Procedures
- Client Fee Schedule & Financial Responsibility
- Consent for Laboratory Drug Screening
- Notice of Privacy Practices
- Consent to Disclose Substance Use Disorder (SUD) Records Covered by 42 CFR Part 2
- Outpatient Therapy Services Contract
- Patient Treatment Agreement
- Important Information Regarding Your Treatment
- Client Advocacy Services
- Communication Consent
- Pill Count Policy

I acknowledge that I have received a copy of the following consent forms:

- Client Cell Phone Policy
- Client Infection Prevention & Control Procedures
- Information About HIV/AIDS, Hepatitis C, and Cigarette Smoking
- Non-Smoking/Loitering
- List of Communicable Diseases and Reporting

For pregnant women only:

- Pregnancy Agreement & Consent for Buprenorphine Treatment

Patient Name: _____

Signature: _____

Date: _____

Sexually Transmitted Infection (STI) Questionnaire

Patient Name: _____ Date: _____

Date of Last STI Screening: _____

Please answer the following questions as best as you can:

Have you…	**YES**	**NO**	**DON'T KNOW**
Received the Hepatitis B Vaccine (3 shots)?			
Received the HPV Vaccine (Gardasil or Cervarix, 2 shots)?			
Received the Hepatitis A Vaccine (2 shots)?			
Had intercourse with men?			
Had intercourse with women?			
Had intercourse with a sex worker?			
Had > 5 lifetime sexual partners?			
Received a blood transfusion?			
Accidentally been exposed to a needle or blood?			
Shared needles?			
Used condoms on a regular basis?			
Have you ever been diagnosed with an STI (including HPV, genital warts or herpes/cold sores)? If yes, please indicate which one(s) below:			
STIs:			

If you have questions about this form, please discuss them with your clinician.

Department of Mental Health & Substance Abuse Services

Tuberculosis (TB) Symptom Screening Tool

Name (Last, First, MI): _____ **DOB:** _____/_____/_____

Facility: _____ **Contact Person:** _____

Address: _____ **Phone#:** _____ **Fax#:** _____

Program type: ☐ Residential ☐ Non-residential ☐ Personnel

INTERVIEWER INSTRUCTIONS: Check **YES** or **NO** for each item below.

Section I: Signs and Symptoms of TB Disease
Does the individual now have?

☐Yes	☐No	Cough lasting 3 weeks or longer?	☐Yes	☐No	Coughing up blood?
☐Yes	☐No	Chest pain?	☐Yes	☐No	Night sweats (drenching)?
☐Yes	☐No	Difficulty breathing?	☐Yes	☐No	Hoarseness and/or trouble swallowing?
☐Yes	☐No	Persistent fever and/or chills?	☐Yes	☐No	Persistent fatigue?
☐Yes	☐No	Persistent loss of appetite?	☐Yes	☐No	Other _____
☐Yes	☐No	Weight loss (without dieting)?			

Section II: Evaluation for TB Infection (TBI)
Has the individual had?

☐Yes ☐No Documented history of a previous **POSITIVE** TB test?
If **YES**, attach a copy of test results

☐Yes ☐No Documented history of previous **NEGATIVE** TB test in the past 12 months
If **YES**, attach copy of test results
If **NO**, refer for TB test

Section III: Disposition

Step 1 *Cough lasting 3 or more weeks plus any other symptom*	**Step 2** Evaluation for TB Infection (TBI)		**Step 3** **Action Needed:**	**Step 4** **Action Taken:** *(Check only one)*
	Documented previous *positive* test?	Documented *negative* test within last 12 months?		
YES	NA	NA	▪ **Notify physician immediately**	☐
NO	**YES**	NA	▪ Educate about TB ▪ If no Chest X-Ray (CXR) report, refer for CXR ▪ Recommend treatment for TBI if not previously completed	☐
NO	NO	**YES**	▪ Educate about TB	☐
NO	NO	NO	▪ Educate about TB ▪ Refer for TB test	☐

Action Taken: ☐No Action Required ☐Documentation Required ☐Refer to Health Dept for Testing
☐Referred to Healthcare Provider, if applicable: _____

Agency name: _____
Agency address: _____ Zip code: _____
Phone #: _____ Fax #: _____

_____ Date: _____/_____/_____
Interviewer Signature/Title