Revised 05/13/2025

FRESH START MEDICINE
Where Your Recovery Begins

PATIENT INTAKE FORMS

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Alternate #: _____

SSN: _____ Gender: _____

Emergency Contact: _____ Relationship: _____

Address (if different): _____

Phone #: _____ Alternate #: _____

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. _____

CHILDHOOD ILLNESSES

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: _____

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 providers you see on a regular basis (PCP, Mental Health, OBGYN, etc.)

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

May we request records from the above providers? Yes ( ) or No ( )

SUBSTANCE USE HISTORY

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			

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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: _____

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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: _____

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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 #: 423-434-6677
TN Department of Mental Health & Substance Abuse Services	Phone #: 1-866-777-1250
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

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CLIENT FEE SCHEDULE & FINANCIAL RESPONSIBILITY

Fresh Start Medicine believes that part of a good healthcare practice is to establish and communicate a financial policy to our clients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

Fee schedule for those without insurance coverage: (All OBOT patient visit fees include physician and counseling services, drug screens, and basic labs (CBC, CMP, HIV, & Hepatitis C):

Weekly Patients: $75
Bi-Weekly Patients: $150
Monthly Patients: $300
Yearly Bloodwork (CMP, CBC, HIV, Hepatitis C): $40
Individual Counseling (Non-OBOT Patients): $100

- 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 is expected at the time of your visit during the check-in process before you are seen by any physicians or counselors. We will accept cash (**ONLY** for co-pay 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 under a pre-existing condition clause, 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.

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.

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 check with your insurer's member benefits department about service and clinicians before your appointment. Many websites have wrong/incomplete information and are not guaranteed coverage. 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.

General consent:

I agree to pay Fresh Start Medicine for Outpatient Treatment Program & Intensive Outpatient Treatment Program services as listed above.

Payment for co-pays and co-insurance will be made through cash or credit card (applicable fees apply). Co-pay is due at the time of visit. This must be paid before you are seen by the physician or any of the treatment team. 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, etc. You will be required to pay all co-insurances associated with these services according to your insurance plan.

Signature: _____ Date: _____

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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 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 samples for drug and/or alcohol screenings under the supervision of staff.

I understand that I may be requested to provide a urine 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 drug screening by staff of Fresh Start Medicine.

I understand that my refusal to provide a urine 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: _____

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NOTICES OF PRIVACY PRACTICES/HIPAA

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

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. This notice will also describe your rights and certain obligations we have regarding the use and disclosure of your health information.

Your health information is personal. We are committed to protecting your health information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and comply with certain legal requirements. This Notice applies to all the records of your care generated by this office whether made by your therapist or one of the office's employees.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The following describes the different ways that your protected health information (PHI) may be used or disclosed by this office. PHI refers to information in your health record that could identify you. For clarification, we have included some examples. Not every possible use of disclosure is specifically mentioned. However, all the ways we are committed to use and disclose your PHI will fit within one of these general categories:

Child Abuse: If we have a reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.

Adult and Domestic Abuse: If we have reasonable cause to suspect you have been criminally abused, we must report this suspicion to the appropriate authorities as required by law.

Health Oversight Activities: If we receive a subpoena or other lawful request from the Department of Health or other regulatory body, we must disclose the relevant PHI pursuant to that subpoena or lawful request.

Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records, thereof, such information is privileged under state law, and we will not release any information without your written authorization or court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may use your PHI to defend the office or to respond to a court order.

Law Enforcement: We may release PHI about you if required by law when asked to do so by a law enforcement official.

Serious Threat to Health or Safety: If you communicate to use a threat or physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious physical harm on yourself, we may disclose information to protect you.

Worker's Compensation: We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

II. EFFECTIVE DATE, RESTRICTIONS, AND CHANGES TO PRIVATE POLICY

This notice will go into effect January 1, 2017. We reserve the right to change the terms of this notice and to make the notice provisions effective for all PHI that we maintain. If we revise the policies and procedures, we will post a copy of any revised Notice in this office.

Other uses and disclosures of your PHI not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us with such an authorization in writing to use and disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. Be aware that we are unable to take back any disclosures we have already made with your permission, and we are required to retain the records of care that we provide for you.

Print Name: _____ Date: _____

Signature: _____

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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: _____

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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: _____

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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: _____

FRESH START MEDICINE
Where Your Recovery Begins

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
Where Your Recovery Begins

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: _____

FRESH START MEDICINE
Where Your Recovery Begins

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: _____

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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/HIPAA
- 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: _____