

PATIENT INFORMATION Name______(First Name) (Last Name) (M.I.) Male_____ Female____ Marital Status_____ Address City State Zip Home Phone _____ Cell Ph_____ Work Ph_____ Date of Birth____/_____Social Security #_____ Emergency Contact Name______Phone #_____ ______Phone#_____ Primary Care Physician_____ Employer______Phone #_____ Employer Address______Phone #_____ RESPONSIBLE PARTY Responsible Party Name______ Address _____ Date of Birth____/_____Social Security #_____ Relationship to Patient______Phone #_____ PRIMARY INSURANCE Patient Relationship to Insured: Self_____Spouse____Child___Other____ Insured's Name Insured's Address Insured's Date of Birth____/____Insured's Social Security #_____ Insured's ID#_____ Group #_____ SECONDARY INSURANCE Patient Relationship to Insured: Self_____Spouse____Child___Other____ Insured's Name_____ Insured's Address Insured's Date of Birth____/___Insured's Social Security #____ Insured's ID#______ Group#_____ Date Printed Name Patient's Signature

I hereby authorize direct payment of medical benefits to MEDSAVE CLINIC URGENT CARE for services rendered by the staff. I understand that I am financially responsible for any balances not covered by insurance. I certify that all information is correct and authorize MEDSAVE CLINIC to release any information for either medical care or in processing applications for financial benefits.

Medical/Surgical History Patient Name: DOB: MEDICAL HISTORY: check boxes that apply and circle items as needed ☐ Asthma: Seasonal or allergy-induced Exercise-induced Chronic ☐ Arthritis: Rheumatoid Osteoarthritis ☐ Other Joint Disease □ Lupus ☐ TBI (Traumatic Brian Injury) ☐ Blood Clots Legs Lung Brain ☐ Stroke ☐ Arrhythmia ☐ Hypertension ☐ Heart Failure ☐ Cardiac Disease: ☐ Coronary Artery Disease _____. 🗆 In Remission since____ ☐ Cancer: TYPE: □ COPD: □ w Emphysema □ TB Other lung disease ☐ Type 2 ☐ Gestational ☐ Diabetes: □ Type I ☐ Schizophrenia □ ADD/HD □ Depression: Seasonal Chronic ☐ Bipolar Disorder ☐ Psychiatric Illness (other): ☐ Celiac Disease ☐ Gastrointestinal Disease ☐ Hepatitis C ☐ HIV ☐ Other Infectious Disease ☐ Hepatitis B ☐ Traumatic ☐ Other ☐ Migraine ☐ Muscle-tension ☐ Headaches TYPE: ☐ Kidney Disease □ Seizures □ MS _____ ☐ Neurologic Illnesses: ☐ Peripheral Neuropathy ☐ Hidradenitis Suppurativa ☐ Other Skin Disease: ☐ Insomnia ☐ Apnea ☐ Other: ______ ☐ Psoriasis ☐ Sleep Disorders ☐ Insomnia ☐ Vision or Hearing Disorder(s): □ Addiction: □ Heroin/Opioids □ Cocaine □ Marijuana □ Stimulants □ Benzos □ Alcohol ☐ Other(s): SURGICAL HISTORY: List Only MAJOR Procedures Month/Year Procedure If none, check box MEDICATIONS: Allergies will be asked of you and listed on another sheet Dose (mg or mcg) Frequency For Name Physician Notes:





CONSENT TO MEDICAL CARE AND TREATMENT

While at MEDSAVE CLINIC, I consent to all medical and surgical care, examinations, and tests determined to be necessary for me. Though I accepted the care given to meet industry standards, I understand that there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me or if I leave the urgent care facility against medical advice, I will not hold Medsave Clinic or any Individual responsible for any of the consequences.

RELEASE OF INFORMATION

Lunderstand that Medsave Clinic may use health information for a range of purposes including: insurance/payment eligibility verification, billing and collecting moneys due from me, private and public payers, or their agents including insurance companies, managed care entities, my employer, state and federal government programs, and the Bureau of Worker's Compensation, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance or qualifications of physicians and healthcare workers, conducting medical and nursing training and education programs, conducting or arranging for medical review and audit services, ensuring compliance with legal, regulatory, and accreditation requirements, performance of autopsies, and public health activities. I authorize Medsave Clinic to utilize or release my health information, whether written, verbal, electronic including secured internet websites or by facsimile to such employers, agents, or third parties as necessary for these purposes and to companies who provide billing services for physicians or other providers Involved in my medical care.

I understand that complete, accurate health information must be readily available for my medical care. Therefore, I authorize Medsave Clinic to release health information to any family physician, referring physician or agency (les) in order to facilitate continuity of care. I understand that the information shared with healthcare professionals as a result of this authorization will remain confidential. The preceding authorizations for release of medical information include authorization for the release of information regarding drug and/or alcohol abuse, HIV (Human Immunodeficiency Virus) testing or HIV infection related conditions. This authorization shall remain valid for one (1) year.

ACKNOWLEDGMENT OF NOTICES OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of Medsave Clinic's Notice of Privacy Practices and have had a chance to object to the use or disclosure of my information for directory, disaster relief, or to provide information to family or persons involved in my care.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of all insurance benefits to be made directly to Medsave Clinic for services related to this admission. I understand that benefits could be directly to me if I did not provide this authorization. I acknowledge that if the ID card presented at the time of service is not valid, I will be responsible for payment.

STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS AND/OR COMMERCIAL INSURANCE BENEFITS TO PROVIDER AND PHYSICIAN I certify that the information given by me in applying for Medicare payment under Title XVII of the Social Security Act is correct, I authorize any holder of medical or other information about me to release this information to my health insurers. I request that payment of authorized benefits be made on my behalf. I authorize Medsave Clinic to bill Medicare Lifetime reserve Days, as necessary.

l assign the benefits payable for my physician services (including emergency, radiology, pathology, dialysis, EKG, EEG, physical therapy, anesthesia, and other urgent care facility-based physician services) to the urgent care facility based on the physician or organization furnishing the services (if assignment is accepted) and authorize the physician or organization furnishing the services to submit a claim to Medicare and/or commercial insurance carriers for payments.

I also assign the benefits payable for private and attending physician services to my private/attending physicians or his/her private practice organization, providing, however, that should my private/attending physician NOT ACCEPT THIS ASSIGNMENT AS PAYMENT IN FULL for his or her services, I understand I am responsible for the full charges.

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance benefits. I agree to pay Medsave Clinic for charges incurred including incidentals. I understand that charges due by the patient not paid within 30 days of billing may be subject to interest, I understand that services rendered to me may not be eligible for benefits under Medicare, Medicaid, or other insurances or payers. Services not eligible for benefits may include tests and procedures that are not covered, or those delivered by healthcare providers who do not participate with my insurance plan. Non-covered services may also include those my physician determines medically necessary but are later determined unnecessary by my insurance plan.

understand that Medsave Clinic does not accept responsibility for any lost, stolen, or damaged personal items. I accept responsibility for those items i choose to keep with me at Medsave Clinic.

I understand that if I am to be provided a series of ongoing services based on my physician's orders that I may be established by Medsave Clinic as a recurring patient. I understand that my consent and authorization will be acquired only once for all services provided in the series.

MEDICARE RIGHTS NOTIFICATION LETTER

If I have Medicare, I acknowledge receipt of the Medicare Rights Notification letter.

SOCIAL SECURITY ADMINISTRATION RELEASE

I authorize the Social Security Administration to release to Medsave Clinic information pertaining to my Medicare entitlement.

By signing below, I certify that I have read and agree to the contents of this consent and authorization document.

Patient Printed Name	Patient Signature	Date

Basic Treatment Agreement

246 E Campus View Blvd | Columbus Ohio | 43235

For ALL patients who have an Opioid Use Disorder that are treated for opioid dependence with the medicine Buprenorphine/Naloxone (B/N), the following important milestones and key points need to be understood and followed:

Milestones to Meet:

- You MUST have a PCP when you begin treatment at MedSave Clinic; if you do not have one, you have 60 days to find a Primary Care Provider AND establish a doctor-patient relationship by attending an office visit. Proof of this visit MUST be brought with you before the first 60 days of your program are up. If not, you will be in violation of that policy and each week that goes by from day 60, you will incur a violation infraction so long as you remain without one. MedSave Clinic will likely start a Primary Care Clinic; Inquire if interested.
- You have 30 days to secure a sponsor. Having a sponsor is crucial to your success in remaining clean and sober. After day 30, you will incur a violation infraction for each interval timeframe without a sponsor.
- You must have blood work done so that results are available 15 days after your first appointment should we be unable to draw blood at MAC. These results are critical for you and your doctor so you are safely treated AND Ohio State Code states doctors MUST have these results in this timeframe. Should you not have these results by this time, a violation infraction will be incurred each week w/o labs.

Other Key Points:

- You MUST attend all appointments made for you by MedSave Clinic staff. Should you repeatedly fail to attend and not have a legitimate excuse for missing the appointment(s) made, you will incur another infraction.
- You may NOT leave the waiting area once you have signed in. If you do leave, you will be sent home without any of your medications. Therefore, DO NOT leave the wait area for any reason except perhaps to use the bathroom. In that case, you need to notify the front desk and you will be helped.
- If you stop any of your prescribed medication(s) for any reason, you MUST bring the unused medicine with you in its bottle to your next appointment where it will be counted and disposed of accordingly.
- You must call the office at least ONE hour ahead of time if you are going to be late for your appointment. You need to refer to the hand-out called "Being Late at MedSave Clinic" as a guide for understanding what result should you be late and call -or not call- MedSave Clinic in a timely manner.
- You MUST provide us with a working phone number. If your phone is not functional or are illegitimate, you will be dismissed from MedSave Clinic.
- You will be courteous while in the office and adhere to all MedSave Clinic policies and procedures, including payment policies. Yelling and use of profanity will result in your dismissal.
- Should you have a medication allergy, you must provide documents from an emergency department or a PCP (or other legitimate provider) describing your reaction. Other information included in this documentation is whether or not the reaction was observed and treated, as well as the ultimate outcome. Just stating you have an allergy to a medication will not be enough to change your treatment plan.

I understand these rules/policies at MedSave Clinic and I will abide by them. If I do not, I will be subject to added violation infractions which may, if too numerous, lead to my possible dismissal from MedSave Clinic.

Patient signed	Date
Printed name	
Witness	Date
Printed name	



MedSave Addiction Ctr

General Patient Agreement

246 E Campus View Blvd | Columbus Ohio 43235

p 614.431.4600 f 614.431.4601

***	Now accomplete the fe	Mowing inform	ration needed by	MedSave 2	Addiction Ctr (MAC):
	I am a new patient to I am a transfer patient I am a returning patient I was referred to MA I was referred by (cit A current MAC Please give name	the MAC (Never not from another facer to the MAC (a.C by my primary role one): patient e of patient or physical	treated or treated acility/provider to Natural to MAC < 20 care physician, Draw A previous MAC ysician/practice:	at MAC but : MAC 2 years ago) c	> 2 years ago) Another physician/practice
	I had no referral, I r Please note where th	nade an appointm he advert was see	ent myself after se n:	eing an adver	tisement about MAC.
.7.	ocuments, copies of the trough my treatment programmer Buprenorp Adjunctive Pharmacy Basic Treatment The federal	key agreements . cogram; these are hine/Naloxone A Medications Ag Agreement	I signed and with the listed below: greement reement t tions about confide	seu 10 / E30/ 1 /	ntment. It contains, among other to from time to time as I go
P A A J	will bring my PIP with orimary documents out desistant). I understant Ad/NA meetings which wear. I understand also individual meetings at	h me for the first lining my care pro d bringing my me have been mando o that I will likely MAC. I understa	FOUR visits of my ovided by my MAC eting logs in each outed by Ohio law as be required to atte	office visit is to a second to other specific to	MAC so I can go over the cian, Counselor, and Medical mandatory as is my attending a month for the first treatment etings designed to compliment my ecialists as required for my care.
	information I have rece receive better care and medical records are pi Finally, I understand l	eived. I know hav I keep me in good cotected by Feder may ask for a co	ong knowleage of the standing. I am aw all law as outlined by of any documen	ne office poil are that my p in the Code o t I sign.	C so I fully understand the cies and procedures will help me rivacy and confidentiality of my of Federal Regulations 42, Part 2.
	By signing below, I an listed above, as well a	n verifying that I I s this agreement, expectations my . remain in effect f	ave read, understo which collectively MAC Team has of or the entire durati	md, and agre contain both me regarding on of my trea	e with the content of all agreement the expectations I have of MAC for my treatment. I am aware that tment at MAC but that I may need
	Printed Name:	to the second se		nature:	KID CODE:
		AUA.			ZIP CODE:

MEDSAVE CLINIC

246 East Campus View Boulevard Columbus, OH 43235

Receipt of Notice of Privacy Practices
I have received a copy of Medsave Clinic's Notice of Privacy Practices.

re allowed to leave any and all information achine, or email account. I realize this	tion regarding my statu information may includ
Relationship to Patien	nt Date
Home # (10 digits)	Cell # (10 digits)
formation to the following people regar	rding my health status a
Phone Number (10 d	igits) Relationship to Pa
Phone Number (10 d	ligits) Relationship to Pa
Phone Number (10 d	
	nachine, or email account. I realize this ancial information. Relationship to Patier Home # (10 digits) Information to the following people regains

Fee Agreement		·
Admission Date:		
		Unit/Apartment #:
		County of Residence:
Phone Number:		<u> </u>
time of service. We accept Insurance copays are the p	t Medicare, Ohio Medicaid an atient's responsibility and are	
The patient or responsib insurance or other fundi		nyment of any portion of fees not covered by their
Assessment: \$150		Urine Drug Screen: \$8
Group counseling: \$30/ho	ur	Electrocardiogram: \$75
Individual counseling: \$80)/hour	Blood Draw; \$15
Physician visit: \$280		Injections: \$25
Urinalysis: \$25		Urine Pregnancy Test: \$6
Oral Drug Screen: \$10		
☐ No fees are asses	essed to the client due to finance	ial indigence.
this is accurate to my knowledg hereby authorize the exchange of	a. I fully agree to cooperate with Med of pertinent social and medical record lerstand that any such information with any such law, regulation, or contract	ally consent to its content. I certify that the information used in preparing ISave Clinic in securing reimbursement from the above mentioned party. I s of myself and the above mentioned parties for the purpose of seeking II be managed ethically, responsibly, and in accordance with the law by that provision. I understand that MedSave Clinic may provide such
I understand that this clie	nt fee agreement is effective f	or one year; from to
Client Signature:		Date:
Financially Responsible I	arty's Signature:	. Date:
	•	Date;



Client Name:	Date:
Agency Rendering Treatment: Medsave Clinic	Date of Birth:
County: Franklin	
MedSave Addiction Center provides treatment to individu substance use and mental health problems. MedSave Add are rendered by providers who are appropriately trained, I services are provided within their professional scopes of p	icensed, and/or certified. All providers
I have read and understand the aforementioned information behavioral health services.	on provided regarding consent to
I agree to treatment provided by MedSave Clinic.	
For myself Legal guardianship	of
Client Signature:	
Legal Guardian Signature:	
Staff Signature and Credentials:	

MedSave Addiction Center

Adjunctive Medication Agreement

Occasionally, medicines referred to as "adjunctive" are prescribed with certain medications for an added benefit, depending upon the circumstance. However, these medicines, if used at all, are only added for a short time frame and should be discontinued after several days to several week of use, at a maximum. These medications include benzodiazepines (such as Valium®), the muscle relaxer Soma®, and sleep aid drugs such as Ambien®. Neurontin® (or gabapentin) is an adjunctive seizure medication used in patients with nerve pain/damage or used in lower doses to help those with sleep difficulties and is not to be used either unless it is prescribed. Medications with barbiturates are also not allowed like Midrin or Fioricet.

You may NOT use Kratom, K2 (or similar), Bath Salts, or any other substance such as these at all.

For all patients seen who have been receiving any of these medications from other physicians falling into such categories, MedSave physicians will not be prescribing these agents even if you had received such medicines in the past. In fact, these medications, with perhaps the exception of gabapentin, must be discontinued within the first few weeks of your care at MedSave Clinic using a rapid down-titration. This titration can be done by your MedSave physician. Some medicines require a longer time to wean down and off such as benzodiazepines which may need up to 2-3 months,

These medications have no place in treating substance abuse (or non-cancer chronic pain) and, as such, will NOT be allowed unless these medicines are required based on the opinion of the specialist that prescribed them (a psychiatrist, sleep specialist, etc). It will be up to your physician at MedSave Clinic to determine if gabapentin will be used for your condition(s) and if you will have to obtain this medicine, or perhaps others such as psychiatric medications, from your primary care physician or a psychiatrist.

The reasons these medicines are not allowed include:

- These medications can be dangerous when combined with opioids including buprenorphine causing respiratory depression and possibly death;
- These medications have a high addiction potential and, as such, should be used ONLY short term (days- several weeks) as in <u>acute</u> pain situations where they may serve as a muscle relaxer or as a sleep aid medicine, or both;
- These medications-like benzos- should only be used longer-term if prescribed by a psychlatrist due to their side effect profile and high addiction potential;

If any of these medicines are being used for sleep, you should be seen by a sleep specialist for an evaluation of why you cannot sleep and what part of your sleep is being affected because these medications will not be used in your treatment plan.

Benzodiazepines can be used for severe anxiety and this diagnosis must be established by a psychiatrist. These medicines may only be used on an "as needed" basis provided your psychiatrist is willing to prescribe them while you are using buprenorphine. Written confirmation must be obtained from your psychiatrist as to this matter first prior to receiving buprenorphine. Other, safer medications can be used in place of the medicines mentioned above depending upon what they were being used for (that is; for sleep, as a muscle relaxant, for headaches or severe anxiety) and this discussion should be had with your PCP or psychiatrist as soon as possible.

Patient Printed:	Date:
Patient Signed :	
Witness Printed:	Date:
Witness Signed:	<u>'</u>
	\



Pharmacy Agreement ,the undersigned patient of MedSave Addiction Center (MAC), have been instructed to use ONE pharmacy while under the care of my physician there. One pharmacy is defined as a single location, not a chain of stores having a pharmacy such as Kroger's, Walgreen's, or CVS, where multiple locations exist and may be used. The Pharmacy I will use is: The Phone Number is: There may be circumstances when my pharmacy has either run out of a medicine or does not have the strength or type of medication prescribed by my doctor. If this is the case, I will inform my MAC physician at my next appointment to allow the transparency required of me as part of my doctor-patient relationship concerning the prescribing of my medications (whether narcotic or not). I can be subject to random pill counts where I will receive a call from MAC staff and be instructed to take the medications I receive from my MAC physician - that day -to either my selected pharmacy (preferred) or bring them to MAC by 5pm -that day- to be counted and reconciled. Dear Pharmacist & Staff: You have been provided this agreement by one of our patients for the purpose of a pill count. Please call MedSave Clinic at (614) 431-4600 to disclose this amount. If MedSave Clinic is closed (after 6pm), kindly fax this information to (614) 431-4601 by 10pm (the fax must be time-stamped by 10pm). Thank you for your cooperation in-helping-MedSave Clinic-deliver responsible, high-quality care. If, for any reason I change my pharmacy, I must inform the MAC staff of this change within 72 hours and the reason reported as to why the pharmacy was changed. I understand I will be charged with an infraction if it is discovered that I have used more than one pharmacy for my medication unless the change was necessary or temporary. Failure to fulfill any of these conditions above may result in my dismissal from care at MedSave Clinic. I understand the above and I am in agreement with the conditions as mentioned. I have been given a copy of this agreement for my records and will take this with me, when I have a pill count, to the pharmacy as proof I am part of this agreement. Date . Patient Signature Date Witness Signature



Medication Reconciliation Agreement

There will be times when a medication is used that, for whatever reason (inability to tolerate the medicine, for example), a different drug must be prescribed to take its place. Or, a previously used medication is re-prescribed because a new drug that was tried wasn't tolerated or there was a documented aliergy or unwanted side effect. In these cases, the medication must be returned. Any time a controlled-medication is stopped for reasons such as these or others, that medication must be returned to MedSave Clinic, reconciled, and then destroyed.

This agreement documents the return of the medication and protects all those involved with witnessed destruction of the medicine that was returned.

l,			, have ret	turned to MedSave Clinic today,	
the	day of	, 20	my	mg	. •
It was orig	ginally prescribed to take	1			٠.
The reaso	on I am returning the med	dication is			_•
It was pre	escribed initially by Dr			on	٠.
It was dis	pensed by		phari	rmacy. Phone:	 •
The pres	cription number was:			- '	
The pill c	ount was	after	days	s of use.	
The initia	ıl pill total was	for	the time p	prescribed which was weeks.	
The med	lication above is is not	reconciled. (I	f not, docum	ment details on the reverse side of this agreeme	nt)
I certify entirety	that the above medicat and this has been witn	ion has been essed by the	disposed undersigr	d of into the waste water system in i ned below:	Ĺs
Patient s	igned			Date	
Printed na	ame				
Dr. Witne	988			Date	
Printed n	ame				
Witness				Date	
Printed n	ame				

Medication Return Agreement

I,	nic (MSC), agree to return	atient of one of the Opioid any prescribed medication to
> I am asked to return any medi	ication by my physician or	staff member, OR
> I need a different medication	due to on-going intolerable	side-effects, OR
Y had an unexpected interaction of the prescribed to me by my MSC	on/reaction with a medicat physician.	ion with another medication
When a situation occurs where a MSC office right away to report the problem	prescribed medicine must be I was having to my doctor'	e returned, I will call the MSC s medical assistant.
I will bring in the medication that is se my next scheduled appointment so properly. I will speak with my doctor a the one I just returned. Should I forge MedSave Clinic for its accounting. I prescription to replace the medication I	that it may be accurately about a new, different medic at to do so, I will have one will I forget again, my MSC 1	ine that may be used to replace veek to get the medication(s) to physician will not write a new
I understand that I may not STOP and not helping or that <i>I feel</i> it is the wrong	return any of my medication g dose or an incorrect interva	n myself because <i>I believe</i> it is all for taking a medication.
Should I just STOP a prescribed m medical assistant and dispose of it wi my status as a patient at MSC and t require if I am dismissed.	thaut returning it as descrit	ед ароуе, 1 іттешиныў зогзын
•		· ·
Patient Name	Patient Signature	Date
Witness Name	Witness Signature	Date

Basic Treatment Agreement

246 E Campus View Blvd | Columbus Ohio | 43235

For ALL patients who have an Opioid Use Disorder that are treated for opioid dependence with the medicine Buprenorphine/Naioxone (B/N), the following important milestones and key points need to be understood and followed:

Milestones to Meet:

- You MUST have a PCP when you begin treatment at MedSave Clinic; if you do not have one, you have 60 days to find a Primary Care Provider AND establish a doctor-patient relationship by attending an office visit. Proof of this visit MUST be brought with you before the first 60 days of your program are up. If not, you will be in violation of that policy and each week that goes by from day 60, you will incur a violation infraction so long as you remain without one. MedSave Clinic will likely start a Primary Care Clinic; inquire if interested.
- You have 30 days to secure a sponsor. Having a sponsor is crucial to your success in remaining clean and sober. After day 30, you will incur a violation infraction for each interval timeframe without a sponsor.
- You must have blood work done so that results are available <u>15.days</u> after your first appointment should we be unable to draw blood at MAC. These results are critical for you and your doctor so you are safely treated AND Ohlo State Code states doctors MUST have these results in this timeframe. Should you not have these results by this time, a violation infraction will be incurred each week w/o labs.

Other Key Points:

- You MUST attend all appointments made for you by MedSave Clinic staff. Should you repeatedly fall to attend and not have a legitimate excuse for missing the appointment(s) made, you will incur another infraction.
- You may NOT leave the waiting area once you have signed in. If you do leave, you will be sent home without any of your medications. Therefore, DO NOT leave the wait area for any reason except perhaps to use the bathroom. In that case, you need to notify the front desk and you will be helped.
- If you stop any of your prescribed medication(s) for any reason, you MUST bring the unused medicine with you in its bottle to your next appointment where it will be counted and disposed of accordingly.
- You must call the office at least ONE hour ahead of time if you are going to be late for your appointment. You need to refer to the hand-out called "Being Late at MedSave Clinic" as a guide for understanding what result should you be late and call -or not call- MedSave Clinic in a timely manner.
- You MUST provide us with a working phone number. If your phone is not functional or are lilegifimate, you will be dismissed from MedSave Clinic.
- You will be courteous while in the office and adhere to all MedSave Clinic policies and procedures, including payment policies. Yelling and use of profanity will result in your dismissal.
- Should you have a medication allergy, you must provide documents from an emergency department or a PCP (or other legitimate provider) describing your reaction. Other information included in this documentation is whether or not the reaction was observed and treated, as well as the ultimate outcome. Just stating you have an allergy to a medication will not be enough to change your treatment plan.

I understand these rules/policies at MedSave Clinic and I will abide by them. If I do not, I will be subject to added violation infractions which may, if too numerous, lead to my possible dismissal from MedSave Clinic.

Patient signed	Date	
Printed name		
Witness	Date	
Printed name		



Financial Agreement	
Patient Name:DOB:	
I, the undersigned patient (from here on in this agreement will be referred to as patient" or "I"), understand and agree that I am financially responsible for the and all charges incurred by me, residual or otherwise, while a patient at MedSa while under the care of its physicians,	D41222
I agree to pay MedSave Clinic for charges due, including any incidentals, that appropriated to me that insurance has not or will not pay for,	may have been
I understand that charges due by the patient not paid for within 30 days of billito interest and that this interest is added to my outstanding balance or principal	ing may be subject l,
I understand that services rendered to me by MedSave Clinic may NOT be eliquider my Medicare, Medicaid, or other insurance payers and, therefore, I am	gible for benefits responsible for,
Services that are not eligible for reimbursement by my insurance company where tests and procedures that are not covered or those delivered by healthcare proparticipate with my insurance plan,	nich may include viders who do not
"Non-covered" services may also include those my physician determines meare later determined to be unnecessary by my insurance carrier's plan or their	dically necessary but representatives,
I understand that any lab work or specimens ordered which includes any blood through Labcorp or any urine drug screens ordered through Selectox is through and, as such, are separately billed through those entities. Medsave Clinic is not any billing patient receives by these separate entities. Additionally, when recurring drug screen is required. Once you submit a specimen, Medsave Clinic I what is done with the specimen once given to lab if patient decides not to go treatment. Any billing received by patient is patient's responsibility.	ot responsible for eiving treatment, a has no control of
I understand that once I sign the MedSave Clinic Buprenorphine/Naloxone office fee for each appointment made, is no longer refundable, whether I recently,	Agreement, my eive a prescription or
I understand that my fee is for medical services, not a prescription,	
Finally, I understand that should I NOT call to cancel my appointment in a to outlined by MedSave Clinic's policy and it is considered to be a "missed appointment as a "No Call/No Show", I will be charged a reasonable for missing such an appointment, which otherwise would have to revenue from another patient who could have taken my appointment time in	a fee deemed fair and been used to garner
Patient's Signature:Date:	

Buprenorphine/Naloxone Therapy Agreement

The purposes of this agreement are to (1) define the terms and conditions that you, the patient, and your physician will be cooperating under in the doctor-patient relationship and (2) to provide basic information about medications you will be taking for the management of your Opioid Dependence (OD) and (3) to help assure that you appreciate that your physician must comply with state and federal regulations concerning the prescribing of buprenorphine/naloxone (B/N) using best practices. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition.

The success of your treatment depends on mutual trust and honesty in the physician/patient relationship, following physician orders, and attending required counseling and any other modalities, i.e., psychiatric care, that may be required. It is imperative you read and understand any and all documents given to you while you are a MedSave Clinic patient.

WHILE UNDER THE CARE OF MedSave PHYSICIANS:

- 1. I will use only MedSave physicians to prescribe and monitor B/N and adjunctive medications. If my primary care physician (PCP) has already prescribed adjunctive medications (muscle relaxants, antidepressants, or other non-narcotics), it will be up to me to obtain in writing from that office, my PCPs permission to have a MedSave Clinic doctor continue these medications.
- **2.** I will use one pharmacy to obtain all my prescriptions prescribed. I will sign a separate pharmacy agreement and it will be in my chart. One pharmacy means ONE pharmacy, not one chain or string of stores with the same name.
- 3. I have been instructed to attend <u>mandatory</u> substance abuse and/or mental health counseling. I will-ensure I obtain my initial assessment from my counseling facility within the 30 days of my first B/N prescription. I will sign an information release form for my MedSave physician so s/he can follow this progress.
- 4. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment. I understand that my B/N must be approved by my insurance company (if I have/use insurance) before I can fill my prescription. If prior approval/pre-authorization (PA) is not made in a timely fashion, I will either have to purchase my B/N myself until my next appointment or wait without B/N until my PA has been authorized by my insurance company.

The MedSave staff will expedite the PA as quickly as possible. We do not, however, have control over how quickly your insurance company will act, especially if it is Friday afternoon. We try not to schedule new appointments during this time.

Buprenorphine/Naloxone Therapy Agreement

- 5. Prescriptions for B/N or any other prescriptions will be written only during an office visit. No refills of any medications will be written or called in during the evening or on weekends except emergencies. These emergencies will be considered on a case-by-case basis and only enough called in for the patient to make it to the next appointment day your MedSave physician is working.
- 6a. I will bring back any medications prescribed by my physician in their original containers when:
 - I am requested to do so <u>OR</u>
 - I voluntarily stop taking my medication for ANY reason

These medications will be destroyed upon their return after their amounts are reconciled. This destruction will be witnessed by the MedSave staff and I will sign a medication reconciliation form at such time. If I (or anyone else) dispose of my medication(s) I have stopped taking (i.e., flushing them down the toilet) that prevents me from returning my medications to MedSave, I will be dismissed from the practice immediately.

- 7. I am responsible for keeping my medication in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from <u>all children</u> as accidental consumption by a child may lead to their death. Stolen medications should be reported to the police and to my physician immediately. If my medication is lost, misplaced or stolen, your physician will NOT replace them (even if a police report is filed).
- 8. I may not give or sell my medications to any other person under any circumstances. If I do, I may endanger that person's health. It is also against the law and, as such, I will be discharged as a patient and reported to the proper authorities.
- 9. Evidence of obtaining other B/N medication or other pain medication(s) from other physicians (which includes emergency depts), is grounds for termination. The sale of any of my prescription(s) will result in my termination after I am discharged from the practice.
- 10. I will communicate fully to my physician, to the best of my ability, at all of my visits, any and all symptoms and functional activity, as well as any side-effects of medications provided to me. This information allows my physician to adjust my treatment plan accordingly and make it safe.
- 11. I will not use any illicit drugs, such as cocaine, marijuana, etc. while taking my medications for my opioid dependence. This will place my treatment in jeopardy. Either a safe discontinuation schedule of my medication will be used or supply of medicine will be provided upon the termination of the doctor/patient relationship. The use of alcohol is also forbidden and, if discovered, places my patient status in jeopardy. These *incidents* are added to the total number of infractions per Phase/Level.



Buprenorphine/Naloxone Therapy Agreement

- 12. The use of any benzodiazepine is UNACCEPTABLE as mixing these with B/N may be dangerous. Deaths have occurred due to combining these medications, especially when used outside of a physician's care. If it is discovered I am using "benzos", my treatment as a B/N patient will be jeopardized. It will be up to my MedSave physician to determine if I will continue as a patient.
- 13. I agree and understand that my physician will perform urine drug testing at each office visit. When requested to provide a urine sample, I agree to cooperate, including the possibility of collecting a directly observed specimen. If I decide not to provide a urine sample, I understand that my doctor will consider this a "positive test" unless an oral drug screen is agreed to. If not, this may result in complete termination of the doctor/patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in my urine are counted as an infraction which may lead to my termination. It is also very likely I may be tested using saliva—and possibly blood- to look for medications and/or their metabolites.
- 14. There are side effects with B/N therapy which may include, but not exclusively limited to, skin rash, itching, constipation, sexual dysfunction, sleeping abnormalities, sweating, and other signs of withdrawal. During the first week, I understand is where I may have the most of these side-effects due to the dose of B/N being up-titrated (increased to maintenance). The likelihood of overdosing with B/N is small; there still exists a small danger of this if I abuse my B/N or use it with other illicit drugs of abuse.
- 15. I will inform my physician of <u>all medications</u> I am taking. This includes herbal remedies, over-the-counter medications, and other prescribed medications.
- 16. I understand that although B/N contains an opioid; it also contains naloxone which helps prevent the full effect of the opioid component. While unlikely to cause significant drowsiness which may delay my response/reaction times, I will still exercise care if and when driving or operating any machinery while on B/N, especially if my dose has just been increased.
- 17. If I suddenly stop or decrease my B/N medication by half, I could possibly have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that withdrawal is quite uncomfortable, but not a lifethreatening condition.
- 18. If I have a history of depression or other mental health issues, I must notify the MedSave physician of such history. Failure to disclose this information may result in my dismissal.
- 19. I agree to allow my physician or MedSave Staff to contact <u>anyone</u>: health care professionals, family members, spouses/significant others, pharmacles, legal authorities, or regulatory agencies to obtain or provide information about my care or behaviors, should my MedSave physician feels it is necessary.



Buprenorphine/Naloxone Therapy Agreement

- 20. I agree to keep my appointments and be on time. If late, I will call at least ONE HOUR ahead of time to keep my appointment. I will conduct myself in a respectful and courteous manner while a MedSave patient and I will follow and understand the hand-out entitled "Being Late at MedSave Clinic".
- 21. I agree to be pregnancy tested should my physician deem this necessary. I understand that if I am pregnant or become pregnant while taking B/N medications, this will alter my care and I will be referred to a Ob/Gyn specialist as I would then be considered a high risk pregnancy.
- 22. I understand that it is the primary goal of MedSave physicians in using B/N medications to treat my opioid dependence and NOT necessarily my pain condition (if I have one). My dose will NOT be raised to accommodate pain issues, rather only to augment the suppression of withdrawal signs and symptoms, should they be present.
- 23. I understand and agree that I MUST have a primary care provider (PCP) and a Sponsor while a patient at MedSave Clinic. If I do not have a either, for whatever reason, I understand I have 60 days to find AND secure my PCP/Sponsor. If I do not establish a doctor-patient relationship with a PCP and/or secure a Sponsor within 60 days, I will be charged with a violation infraction for each week past 60 days until I provide proof of having one or the other.
- 24. I understand I will receive my B/N medication usually at the initial visit and typically as part of an up-titration schedule. I also understand I may not obtain a dose that I think will be the best for me or a dose that I was getting previously or "off the street" or even if given by another previous physician. If II am not in mild-moderate withdrawal, I will have to return to MdSave Clinic when I am.
- 25. Lagree to random pill counts. It is my responsibility to supply MedSave with functional phone numbers and a correct address where I live so I can be contacted for my care (ex, for a pill count or lab results). Also, I agree to all conditions related to pill counts at MedSave Clinic as outlined elsewhere.

I have read each page of this agreement and my initials on each page testifies to this. Questions I had have been explained to me. I agree to its terms and conditions fully and I appreciate that these terms and conditions are set forth in this agreement so that I may be provided a responsible opioid dependence management experience when using B/N therapy to help increase my daily function and improve my life.

upitali marriga y	•	
Patient's Signature:	Date:	
Printed Name:		
		—
Witness Signature:		
Printed Name:		
	MSD02B-091417	Initials



246 East Campus View Boulevard Columbus, OH 43235 (614) 505-3126 (614) 431-4601 Fax

AGREEMENT OF TREATMENT EXPECTATIONS

This is an agreement between two parties: Medsave Clinic facility and Medsave Clinic patient.

The purpose of this document is a positive one. It attempts to make clear the rights and responsibilities of both parties. It says who is to do what.

You may think it is unusual, and perhaps unnecessary, to have such an agreement, but an agreement between Medsave Clinic and a patient is really no different than any other agreement for services.

We promise to treat your medical condition(s) to the best of our abilities, consistent with the standards of care in our community. You, in turn, promise to be as understanding, cooperative, and responsible as possible.

This agreement can be used as a checklist for both parties to review from time to time, to see whether or not we both are doing what we said we would do.

Read this document carefully before you sign it. it over with a member of the treatment team.	If there is something you do not agree with, talk
I have read (or have had read to me) the "Agreement of its contents. I have been given an opportunity to ask qu	f Treatment Expectations" and fully understand estions.
Patient/Responsible Party	Date
If not Patient, Relationship to Patient: Medsave Clinic Staff Witness / Title	Date

Facility Responsibilities

We recognize that we have the responsibility to provide you with treatment that meets state and federal regulations and conform to the current standards of care. Therefore, we will:

- Provide services according to current guidelines and standards
- Provide doctors, medical assistants, and counselors who are trained, licensed, or certified in their professions to help in meeting your needs
- Practice universal precautions and other policies/procedures to prevent or control infections and maintain a safe and sanitary environment

To educate you about your treatment options. Therefore, we will:

- Provide you information about your program and options of treatment
- Inform and educate you about the facility and our policies and procedures

To provide a treatment environment that is safe for both patients and staff. We will:

 Respond to a situation where visitors, family members, other patients, or staff members exhibit behavior deemed by the facility personnel to be hazardous to the safety and well being of everyone in the facility. This may include contacting the appropriate law enforcement authorities

To treat you with respect, consideration, and dignity, we will:

- Introduce ourselves to you and explain our responsibilities and duties
- Assist with trying to solve any problem(s) related to your treatment that you bring to our attention
- Maintain confidentiality of your communications and medical records
- Ensure that no staff member discriminates against you because of age, race, sex, medical disease, or physical disability

Patient Responsibilities

I understand and agree that it is important that I participate in the decisions about my health and treatment. Therefore, I will:

- Learn about my disease and its treatment
- Provide accurate information about my medical and social history
- Participate in my program and follow it accordingly
- Notify my doctor or medical assistant of any changes in my health condition and status
- Comply with all physicians' requests for office visits and referrals.
- Participate in activities or efforts leading to rehabilitation

- Acknowledge that it is my responsibility to arrange for my own transportation and that Medsave Clinic nor its staff members shall not be responsible for providing transportation for me
- Acknowledge that my failure to comply with my appointment times, medications, and other physician orders may result in other health problems and possible dismissal or termination from doctor/clinic

I agree to be knowledgeable regarding the facilities policies and procedures and follow them. Therefore, I will:

- Arrive on time for my scheduled appointment
- Inform the facility if I am going to be late or need to be rescheduled, with the understanding that if I am late I may not be seen right away and may have to be rescheduled
- Arrive free of the influence of illegal drugs, alcohol and without a weapon. I also agree to refrain from having them in my possession or using them while I am on the premises of this facility.
- Cooperate with the staff member assigned to provide care to me. I understand that I cannot require specific staff members to care for me. If I am uncomfortable with a specific staff member assigned to my care, I will make the clinic manager aware of my concern(s)
- Inform the facility about personal changes such as address, phone number, or marital status
- Agree to bring my medications into the facility for review when requested to do so
- Once I check in, I will not leave before doing urine drug screen. If I do, I may be subject to an observed urine drug screen
- If I am a smoker, I will not smoke in front of the building at entrance. I will smoke to the right of the building where there is a cigarette receptacle which is 50 ft away from the building per the Ohio Code

I agree to respect the rights of other patients and staff members. Therefore, I will:

- Treat other patients and staff members with respect, dignity, and consideration
- Respect the rights of other patients to have a safe, clean, and calm environment
- Refrain from any form of verbal abuse, physical abuse, or sexual harassment of other patients, staff or visitors
- Refrain from giving gifts to staff members. Gifts are not allowed to be accepted. Providing gifts can undermine our obligation to provide services fairly to all patients.
- Refrain from making sexual advancements to other staff members, patients, or visitors. Staff members are prohibited from becoming romantically involved with patients. This can distract the staff member or patient from being able to provide or get proper care. It can also cause emotional distress. Any patient or other staff member who continues to treat a member of the staff in this way or harasses a member of the staff may possibly be either discharged or terminated. We have a no tolerance policy for this type of behavior
- Reports of discrimination, harassment, or sexual assault will not be tolerated

Patient Information Form

Last		First			
ddress:		ущаг		Mon	th/Day/Yr
		Town:		Zip:	
Transportation: 🗆	I have a car and drive U	I ride the bus 🛭	I have someone dri	veme □Iuse	a taxi service
hysicians (1 Lhave no PCP	at my initial ap	pominent.
	<u>Name</u>			<u>Pho</u>	one .
Primary Care:		•			
Specialis <u>is:</u>			,		
Neurologist			•		•
Psychiatrist					
Pain Specialist				<u></u>	<u> </u>
Surgeon*					
Other**					
*This may be an orthop	edic or neurosurgeon	**This may b	e rheumdiologist, p	hysiatrist, or ar	ıy other specialis
Employment Statu	\$ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\				
Working? (circle all t	hat apply): Full-time	Part-time	Seeking SSDI	Disabled	Unemployed
Employer:			Position:		
	why were you granted o				
	when were you first ap		ı; <u> </u>		
> If seeking S	SDI, do you have an at	tomey? 🗆 No	☐ Yes, who?		
> If a veteran	, are you service connec	oted? 🗆 No	O Yes If Yes	s, what %	



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Patient	Name:	Date:	
	Risk Assessment		
1.	In the past few weeks, have you wished you were dead?	Yes	No
2.	In the past few weeks, have you felt that you or your family would be better off if you were dead?	Yes	No
3.	In the past few weeks have you been having thoughts about killing yourself?	Yes	No
4.	Have you ever tried to kill yourself? If yes, how (method used)?	Yes	No
	Where?	Yes	No
5.	. If yes, are you having thoughts of killing yourself right now? Describe	, C.J	
6 7	. In the past, have you ever displayed violence towards others?	Yes	No
3	3. Have you ever had issues with displaying sexually inappropriate behavior with others? If yes, describe	Yes	No
!	 Do you have thoughts of harming or wanting to kill others? If no, your assessment is complete. 	Yes	No
	10. If ves. do you have a plan to do this?	Yes	No

L1. If yes, do you want to take anyone with you?	Yes	No
When?		
Where?		
How?		
Who?		
12. Do you have access to guns or other weapons?	Yes	No
13. Have you ever had thoughts of harming others and carried out those thoughts? If yes, when (dates)	Yes	No
Method used		•
Describe injury to others		
Comments / Anything else you would like to tell us:	•	
	•	

Initial Visit Questionnaire

Name:		DOB:)	Date:	
						PAGE 1
<u>Substance Abuse Histor</u>	Ý:					
I first started using OPIOID	S/OPIATES in (year	·)	_at age	c	urrent Age	·
I started using drugs like ox	ycodone (or heroin):	□ To get hi	gh □To	o treat pa	in 🗆 At	fter a surgery
I began using heroin at age □ I don't use heroin and never did □ I only used heroin a few times						
Order 1st, 2nd, 3rd, how 3	,					
(Circle one): I am I am I	not mandated to con	nplete this tre	atment by a	a drug co	urt magistra	ate.
Please complete the Table						
Drug Used/Abused- Currently	Route Used* (IV, Or, Sn, Sm)	Avg Amt' Used	Ant	(mattern)	r' mni	Last Used (2012年) (Day & Approx Time
Heroin		g	g			•
Suboxone/Zubsolv#						
Opiates/Opioids						
Oxycodone (Percocet)		mg	mg			
OxyContin		mg	mg			
Hydrocodone (Vicodin)		mg	mg			•
Morphine (Kadian)		ng	mg			
Fentanyl		mg	mg			\
Hydromorphone (Opana)		mg	mg			
Methadone		mg	mg			
Tramadol :		mg	mg			
Stimulants						
Meth/Amphetamines		.mg	mg		_	1
Marijuana	Smoke	joints	joints			
Cocaine		E	g			
Alcohol				ı		
Beer	Oral					
Hard Liquor	Oral					,
Wine	Oral		<u> </u>	1	<u> </u>	
*TV- Intravenous, Or-Oral, S ** -Max amount used in the *** -Last time used prior to 6 # Suboxone or Zubsolv: If obtained off the street	last 3 months of using	the drug or if it limio. May use	> 3 months : o days, week egularly	s, or mont	g, put max ar hs ago. en I can get i	
Physician Notes ONLY:				*************************************		
MEDD=						



Initial Visit Questionnaire

Name:	DOB:	Date:	
			PAGE 2
Substance Abuse Counseling (SAC) History:		
☐ I am not attending SAC current ☐ I am attending SAC currently a ☐ I attend ☐ I attend ☐ I have attended SAC in the past ☐ I have NEVER attended any kin	at; /week for individual couns /week for group counseling . Last attended (<i>molyr</i>):	eling	
AA or NA Meetings (check those that	apply):		
☐ I have never gone to a meeting, either ☐ I have been to meetings in the past Al ☐ I have been to meetings before but no ☐ I do not have a sponsor NOW and I (a ☐ I have a sponsor, his/her name is	ND I CURRENTLY go to t now. I last went to a mee circle one) have have not	ting had a sponsor in the p	east
Living Arrangements/Incarceration	(please check all that appl	v)	
I live in: I An Apartment I live with: Spouse/Sig Other* I live with "users" currently I have been: In prison/jail	□ House □ Ti □ My children □ Fa I do NOT live with "t □ Stayed in homeless	mily D Friend users" currently D	□ Other
Employment History:			
☐ I am currently working ☐ F. ☐ I am not working now but I wil ☐ I am already disabled due to	ll be seeking; 🛮 employr		
Treatment History: (List Previous Doc	ctors/Clinics who have treated	you for Opioid Dependen	ce)
Physician/Clinic/Office	Suboxone used/day	When?(mo/yr)	Freatment Length
Education History:			
☐ High School Grad ☐ Some College☐ I have trouble reading ☐ I have to☐ I was diagnosed with a learning disal	rouble <u>understanding</u> what		le attended:



Medical/Surgical History	•
Patient Name:	DOB:
MEDICAL HISTORY: check boxes that apply and	d circle items as needed
Asthma: Seasonal or allergy-induced Exercise Arthritis: Rheumatoid Osteoarthritis Blood Clots Legs Lung Brain Cardiac Disease: Coronary Artery Disease	pus
COPD: \square w Emphysema \square TB Other lung di	. □ In Remission since
Diabetes: Dippe 1 Dippe 2 Depression: Seasonal Chronic Dipole Psychiatric Illness (other):	☐ Gestational or Disorder ☐ Schizophrenia ☐ ADD/HD
Gastrointestinal Disease ☐ Hepatitis B ☐ Hepatitis C ☐ H	☐ IBS ☐ Celiac Disease
Hepatitis B Hepatitis C H	V
Headaches TYPE: Migraine Migr	iscie-tension Li Traumatic Li Other
Neurologic Illnesses: Seizures	
l Peripheral Neuropathy	
Psoriasis 🛘 Hidradenitis Suppurativa	Other Skin Disease
Sleep Disorders Insomnia Apnea	Other:
Vision or Hearing Disorder(s):	
Addiction: Heroin/Opioids Cocaine D	Marijuana □ Stimulants □ Benzos □ Alcohol
Other(s):	
SURGICAL HISTORY: List Only MAJOR Procedu	res
Procedure If none, check box □	Month/Year
•	
MEDICATIONS: Allergies will be asked of you an	different on department and
Name Dose (mg or mcg)	The state of the s
pose (ing of fileg)	Frequency For
•	
,	
Physician Notes:	444