378 West Chestnut St
Suite 103
Washington PA, 15301
Office (412) 660-7064
Fax (724) 249-2825

Insurance Information

Name________________________________Phone Number________________________

Date of Birth___________________________Social Security Number_____-_____-_______

Address____

City_________________________State______________________Zip Code____________

Employer____

Employeer Address____

City____________________State____________________________Zip Code_______________

PRIMARY Insurance Company____

Policy Holder Name____

Relationship to Policy Holder____

POLICY NUMBER____

GROUP NUMBER____

Phone number (on back of card)____

SECONDARY Insurance Company____

POLICY NUMBER____

GROUP NUMBER____

Assignment of benefits: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical and private insurance and any other health plans to Positive Recovery Solutions LLC. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Patient Signature__________________________________DATE:____/____/_________________

PRS
Positive Recovery Solutions

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Positive Recovery Solutions Vivitrol Treatment Consent

I, ___________________________________ agree to treatment with Vivitrol. I understand that Vivitrol is an intramuscular injectable medication and needs to be given in the gluteal muscle. Positive Recovery Solutions LLC has explained the potential risks and side effects, including but not limited to pain at the injection site, unintended precipitation of opioid withdrawal, insomnia, nausea, vomiting, abdominal pain, dry mouth, local site reaction such as redness/rash, and muscle cramps with more serious but rare concerns including abscess formation at the injection site which may need further attention, serious allergic reaction, eosinophilic pneumonia, depression, and suicidality.

Known Medical History

Lives disease such as Hepatitis, A, B, and/or C _____Yes _____No

Elevated Liver Enzymes _____Yes _____No

HIV and/or AIDS _____Yes _____No

Urine Drug Screen result

____Date:___/____/_____

Patient Signature:_________________________________Date:___/____/_____

PRS medical staff signature:_________________________Date___/____/_____

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Patient Intake: Substance Abuse

Name:____Date:______________________________

Please List past or present use, Date of last use, quantity. Designate NA if not applicable

Alcohol____

Cocaine____

Amphetamine____

Heroin____

Hallucinogens____

THC____

Methadone____

Buprenorphine____

Benzodiazepine____

Ecstasy____

Other____

Opiate (Pain pills; specify brand)____

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Vivitrol and Alcohol Dependence

I,______________________understand that although I am receiving Vivitrol for Alcohol/Opiate dependence I am still subject to consequences of alcohol impairment if I choose to use alcohol while on Vivitrol. Consequences including, but not limited to, alcohol poisoning, slurred speech, drowsiness, distorted vision and hearing, cognitive function impairment, DUI, impaired gait and others are still applicable while receiving Vivitrol/Naltrexone. I have discussed any questions I may have and fully understand the use of Vivitrol for my alcohol/ opiate dependence.

Patient Signature:__________________________Date:__________________

Staff Signature:____________________________Date:__________________

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PRS Practices and Policies Regarding Discharge From Treatment

PRS strives to provide compassionate care for our patients. In the interest of ensuring that our patients receive appropriate care from PRS there are guidelines that the patient must adhere to or be immediately discharged from treatment

Any threat or act of violence (including verbal) towards staff or other patients will be cause for immediate discharge.

Any submission of a urine specimen that is not your own or altered in any way is cause for immediate discharge
In the event the urine specimen is not the appropriate temperature at time of submission, the patient agrees to resubmit a specimen with the supervision of PRS staff. If the patient refuses, PRS will consider the first specimen altered and the patient will be discharged immediately.
PRS considers a patient who has three positive urine drug screens during their treatment to be an inappropriate candidate for continued following on Vivitrol/naltrexone. Patient will be considered HIGH RISK for overdose and death and referred out to alternative treatment.
Discontinuing recommended Behavioral Health treatment as required by patient's insurance coverage will be cause for discharge.

By signing and dating this agreement, patient agrees that they understand the practices and policies regarding discharge from treatment. All questions have been asked and answered by the staff of Positive Recovery Solutions

Patient Signature:____Date:___/____/_______

- Staff Signature:____Date:___/____/________

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Safety Concerns: OVERDOSE

Risk of OVERDOSE and DEATH are significant if patient discontinues Vivitrol/Naltrexone treatment and resumes opiate use

"I understand that after stopping Vivitrol/naltrexone I may be more sensitive to the effects of heroin and other opiates/narcotics. The amount of heroin or narcotics I may have been using on a routine basis before I started Vivitrol/naltrexone might now cause overdose and death. I fully understand the nature and seriousness of this possible consequence. I have asked any questions I may have regarding this to PRS medical staff and have a full understanding of overdose and death risk.

If I am not sure that I can avoid opiate use, I understand that I may be referred to alternative treatment programs such as buprenorphine or methadone maintenance, which is an effective treatment for opiate dependence and has a reduced risk of fatal overdose.

I also understand that if I have recently used heroin or other narcotics, even if the urine drug screen is negative, that receiving Vivitrol/naltrexone could precipitate opioid withdrawal symptoms

Patient Signature:____________________________________Date___/____/____

Staff Signature:______________________________________Date___/____/____

NOTICE OF PRIVACY PRACTICES

Effective Date: _________

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

If you have any questions about this notice, please contact:

Positive Recovery Solutions
378 West Chestnut St.
Washington, PA 15301
412-660-7064

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from PRS. Your health information may include information created and received by PRS, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

• **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

Different personnel in our organization may share information about you and disclose information to people who do not work for PRS in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

 PT. Initial__________

• **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at PRS may be billed to and payment may be collected from you, an insurance company or a third party.

• **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

• **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

• **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

• **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

• **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

• **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your written agreement to do so. We may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*..

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing,** at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

• **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Positive Recovery Solutions LLC in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to *Positive*

 PT. Initial__________

Recovery Solutions LLC. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

• **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Positive Recovery Solutions LLC. To request an amendment, complete and submit a medical record amendment/correction form to Positive Recovery Solutions LLC.

• **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

• **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

• **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

ACKNOWLEDGEMENT

By signing I acknowledge that I have read and understand the Information contained here within.

Patient Print Name: ______________________________________

Patient Signature:____ Date:________________________

Staff Signature:____ Date:________________________

 PT. Initial__________