Essential Healing
ADDICTION & RESTORATION THERAPIES

1795 Alysheba Way, Ste 1001
Lexington, KY 40509
Phone: 859.687.0416Fax: 859.353.4200
E-Mail: info@essentialhealingiop.com

New Patient Intake Form

Today's Date: _____

Name: _____

Date of Birth: _____ Age: _____

Address: _____

State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____

Relationship: _____

Contact Phone: _____

Medical Insurance (please provide card at first visit):

Primary Insurance Company Name: _____

Policy Number/Member ID: _____

Group Number: _____

Insured Name: _____

Insured DOB: _____

Patient relationship to insured if not self: _____

Secondary Insurance Company Name: _____

Policy Number/Member ID: _____

Group Number: _____

Insured Name: _____

Insured DOB: _____

Patient relationship to insured if not self: _____

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Past Medical History: _____

_____

Contraception: _____

Women Only – Last Menstrual Period: _____

Past Surgical History: _____

_____

Current Medications, doses, and when taken (including over the counter medications and vitamins):

_____

Allergies: _____

Pharmacy: _____

Primary Care Provider: _____

Office Phone: _____

Highest Level of Education: _____

Any visual or hearing problems that interfere with communication? Yes ☐ No ☐

Current Living Environment: _____

Family Medical History (immediate family, include living/deceased - cause):

Father: _____

_____

Mother: _____

_____

Siblings (specify brothers/sisters & ages): _____

_____

Children (specify male/female & ages): _____

_____

_____

Do you have custody of your children: Yes ☐ No ☐

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Consent to Treatment

Please read the below information carefully, initial and sign where indicated:

_____ I voluntarily consent to any and all health care treatment and diagnostic tests provided by Essential Healing IOP and its associated medical providers, clinicians and other personnel. I am aware that medicine is not an exact science and I further understand that no guarantee has been or can be made as a result of treatments or examinations at Essential Healing IOP.

_____ I agree to contact via preferred method (phone, text/SMS, or email) with information related to my visit and/or care.

_____ I consent to the use and disclosure of my protected health information for purposes of obtaining payment for services I rendered to me, treatment, and health care operations consistent with Essential Healing IOP Notice of Privacy Practices. ROI has been completed and signed.

_____ I authorize payment of medical benefits to Essential Healing IOP or their designee for services rendered.

_____ I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

_____ I have received a copy of the Notice of Privacy Practice and Financial Policy Notice.

Signature: _____

Date: _____

Printed Name: _____

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Consent to Treatment with Medication Assisted Therapy

Please read this information carefully, initial and sign where indicated.

_____ Buprenorphine/Naloxone (Suboxone®), extended-release injectable buprenorphine (Sublocade®), naltrexone, and extended-release injectable naltrexone (Vivitrol®) are provided at Essential Healing IOP for treatment of opioid use disorder (OUD). These are all FDA approved medications for treatment of OUD, and each have their own risks and benefits. I have been educated on these medications. Naltrexone and extended-release injectable naltrexone (Vivitrol®) are FDA approved medications for treatment of alcohol use disorder (AUD).

_____ I agree to keep appointments as scheduled. If I am unable to attend my scheduled appointment, I will provide 24-hour's notice. There may be a fee for late cancellations less than 24-hour's notice is provided.

_____ If I miss an appointment without notice, I will not receive my medications until seen by provider at next available appointment.

_____ Violence, threatening language/behavior, or participation in illegal activities may result in termination from treatment.

_____ I have informed my provider of all medications (including OTC, herbs, and vitamins) and medical problems.

_____ If I know in advance that I will be undergoing a medical procedure that may cause pain, I will discuss this with my provider additional methods of pain management. It may be necessary for my providers to collaborate surrounding my procedure.

_____ I understand that treatment of OUD/AUD involves more than taking my medications. I agree to comply with my provider's recommendations for additional counseling, group therapy, or other recovery communities.

_____ I understand there is no fixed time for being maintained on medications for OUD/AUD. The goal of treatment is to stop using all illicit substances/alcohol, improve quality of life, and have a plan for remission and recovery.

_____ I will take my medications exactly as prescribed. If I want to change my dose, I will speak with my provider.

_____ There may be additional specific items unique to my treatment plan as discussed with my provider, clinician, and other personnel as appropriate.

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If I am on a buprenorphine containing product:

_____ I understand that people have died by mixing Suboxone® or other buprenorphine containing products with other full agonists, benzodiazepines (such as Valium®, Klonopin®, and Xanax®), and alcohol.

_____ I understand I may experience opioid withdrawal symptoms if I suddenly stop buprenorphine containing products (Suboxone® & Sublocade®) or skip doses.

_____ I understand that random urine drug testing is a requirement for treatment with medications for OUD. If I do not provide a urine sample when asked, it will count as a positive drug screen.

_____ I understand random pill counts are required and a mandatory part of my treatment.

_____ I understand that it is illegal to give away or sell my medications – this is diversion.

_____ I understand that my medications must be protected from theft, unauthorized use, and out of the reach of children/pets. If my medications are ingested by someone other than myself, I will call 911 and notify the poison control (1.800.222.1222) immediately.

_____ If my medications are lost or stolen, *my provider will not be requested or expected to provide me with additional medications*. However, documentation of police report will be expected to be brought to next scheduled appointment.

_____ Per Kentucky Revised Statute regulations, suboxone sublingual mono-product will only be prescribed if documented medical contraindications are provided.

_____ Per Kentucky Revised Statute regulations, medications cannot be called in to a pharmacy or be provided with hand-written prescriptions. All medication prescriptions will be sent electronically (EPCS).

_____ Per Kentucky Revised Statutes, I will provide consent and authorization to obtain prior medical records for OUD.

_____ Per Kentucky Revised Statute regulations, all follow up appointments will be scheduled as outlined in 201KAR 9:270.

_____ If female, I have been educated on methods for preventing pregnancy and can be provided resources for contraception.

Signature: _____

Date: _____

Printed Name: _____