Primehealth
Medical Center P.C.

Primehealth Medical Center, P.C.
Office Policies and Patient Agreement

Welcome to Primehealth Medical Center, P.C.! We are pleased you have chosen us to assist in your medical care

Because we have a large number of recurring questions concerning our practice, we have prepared this "Patient Agreement" to help answer these questions. Please keep this agreement and return to the receptionist the signed/completed "Acknowledgement of Receipt", acknowledging that you have received these office policies.

APPOINTMENTS:
Although we prefer for you to make an appointment, walk-ins are accepted if time and space permits. In most cases, we will make your
next appointment prior to your leaving the office.

There is a $25.00 charge for missed appointments, unless the appointment is cancelled at least 24 hours in advance. This charge is waived if the weather is so inclement that city schools or city offices are closed.

We will call you in advance to remind you of your appointment. Unless you instruct us otherwise, we may leave the message about your appointment with any adult member of your family, or on the answering machine of telephone numbers you provide us as your home or personal answering machine.

LAB/OTHER TESTS
Within 24 hours of our receiving your lab or test results, we will call you if the results are abnormal in any way. It is not necessary for you to call our office regarding these results. In accordance with the "Notice of Privacy Practices for Protected Health Information" form provided within this agreement, we will leave your results directly with you, with an adult member of your family at your home or cell phone number, or on your answering machine.

MEDICAL RECORDS/FORMS
If you need medical records for any reason, we will be happy to copy them for you. Except in cases of true emergencies, we will need at least a two week advance notice. There will be a $20.00 fee for the first 45 pages of the records, and an additional charge of $0.25 per page after the 45 pages. This fee must be paid in advance.

If you need medical forms completed, there will be a charge of $15.00 per page, payable in advance.

MEDICARE PATIENTS
It is important for us to know if Medicare is your primary insurance. If you or your spouse are still employed and a group health plan is available, that group health plan is primary. If you have been in an automobile wreck, if your retirement offers group insurance, or if your visit is related to a workers' compensation claim, Medicare is not primary. Sometimes Medicare will deny a claim because they have information that they are not primary. If they are incorrect, you will need to call Medicare directly to clarify the issue. We will inform you by letter if we receive information from Medicare that they are not primary. After you contact Medicare to resolve the matter, please call the billing department at our office at (901) 372-5260 to provide updated information on the issue.

Unless you have secondary/additional insurance that covers coinsurance and deductibles, you will be expected to pay your annual deductible for physician services and your coinsurance amounts at each visit. Many secondary insurances do not cover your deductible. Many also have a secondary co-pay amount that you will be expected to pay.
If you have a change of insurance information, please call our office (901) 372-5260 to report the change. It is ver important that you keep us apprised of any change in insurance. Frequently an insurance company will not chang but a policy or group number will, or there will be a change of address for filing the insurance claim.

If your insurance does not pay your bill within 90 days, we will stop billing the insurance company and bill you directly for the charges. We will be glad to refile if you have other insurance; however, after 90 days you are still responsible for payment.

Any amount billed to you is due upon receipt of our statement. If the bill is not paid, or if payment arrangements a not made within 60 days after billing you, your account may be turned over to a collection agency. The collection agency fees will also be billed to you.

Please note, if you have Medicare or Blue Cross, your insurance will be filed where services are rendered. This is the "interplan" system of these two carriers. Thus, if you have Blue Cross of Michigan, the claim SHOULD be filec to Blue Cross of Tennessee if the services were rendered in Tennessee. The only exceptions to this are Medicare Railroad and Blue Cross plans that specifically call for filing with the "home plan". Should you fall under either of these exceptions, please advise us of this.

PRESCRIPTIONS

Due to the large number of calls we receive daily for prescriptions, we are requesting that you ensure you have enough medication to last until your next visit. If not, please do not leave the office without a written prescription.

Please remember to call at least five business days before your medications runs out. We will normally refill single prescriptions for chronic conditions for a maximum of three months before requiring a patient visit. Patients with multiple medications need to be seen more frequently.

Please remember to bring all your medications with you each time you visit the doctor.

REFERRALS

If you need a referral, please contact us at least three business days before it is needed. Of course, in cases of true emergency, we will rush the referral.

TELEPHONE CALLS

Telephone calls are normally returned within 24 hours or the next business day. If your call is urgent, please advise this, and indicate that you need to speak to a nurse immediately.

RETURNED CHECK FEES

If a check that is presented for payment of services is returned to our clinic for NSF, you will incur a $35.00 returned check fee in addition to the original billed amount. You will no longer be permitted to pay for future services with a check. Cash, Credit Card or Money Orders will be the only form permitted for payment.

Notice of Privacy Practices For Protected Health Information

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.

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of **Primehealth Medical Center, P.C.**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permissio to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Communications With You. Unless you indicate otherwise, if we call a home or personal cell phone number provided by you, we will leave messages concerning appointments and lab results with those who identify themselves as adult members of your family, or on your answering machine. We will not leave messages at your work phone unless you specifically give us permission to do so.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for an purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before we received your notification of your decision.

ADDITIONAL USES OF INFORMATION

Appointment Reminders. Your health information will be used by our staff to contact you about appointments.

Information About Treatments. Your health information may be used to send you information on the treatment an management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Your Health Information Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning your medical condition and treatment
3. The right to inspect and copy your protected health information
4. The right to amend or submit corrections to your protected health information
5. The right to receive an accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of this notice

Primehealth Medical Center, P.C. and Staff's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Dr. Olu Faleye**.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Secretary of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

You may also email from the sight: **www.hhs.gov**.

If you believe that your privacy rights have been violated, you should call the matter to the attention of our privacy officer, **Dr. Olu Faleye**, by sending a confidential letter describing the cause of your concern to:

Dr. Olu Faleye
6637 Summer Knoll Circle, Ste. 101
Bartlett, TN 38134

You will not be penalized or otherwise retaliated against for filing a complaint.

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Registration Form

Medical Record # _____

Form Must be Completed in its Entirety

Last Name	First Name	MI	DOB	Sex M / F	Maiden Name

Street Address / Mailing Address	City	State	Zip

Home Phone	Day Phone	Cell Phone	Social Security #
( )	( )	( )	

Email Address	Employer

Marital Status Mar. Wid. Sing. Div. Sep. ☐ ☐ ☐ ☐ ☐	Spouse Name	Spouse Date of Birth

In Case of Emergency – Notify	Relationship	Telephone #	Address City State ZIP

Have you or any member of your immediate family been examined here before? Yes ☐ No ☐	If Yes, give name	Have you been in the Clinic under a different name? Yes ☐ No ☐	If Yes, give name

Primary Language (select one)
☐ English ☐ Spanish ☐ Other – Please List _____

Ethnicity	Race		
☐ Hispanic or Latino	☐ White	☐ Black or African American	☐ Asian
☐ NOT Hispanic or Latino	☐ Other _____	☐ American Indian	☐ Hispanic

Guarantor or Responsible Party for Household
(Must be Completed)

Last Name	First Name	MI	Social Security #	Relationship to Patient Self ☐ Spouse ☐ Parent ☐ Other ☐

Telephone Number	DOB	Mailing Address	City	State	ZIP
( )					

Occupation	Employer	Address	Phone

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group# _____

Policyholder name and birth date: _____

Employer: _____ Effective Date: _____

Secondary Insurance _____ ID# _____ Group# _____

Policyholder name and birth date: _____

Employer: _____ Effective Date: _____

Tertiary Insurance _____ ID# _____ Group# _____

Policyholder name and birth date: _____

Employer: _____ Effective Date: _____

(PLEASE PRESENT ALL INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST)

INSURANCE INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to process my claim.

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

We are required by law to protect the privacy of your health care information, offer a copy of our Notice of Privacy Practices, and to follow the guidelines described in that notice. Your signature acknowledges you have been offered this notice. If you wish to receive a copy of your health care information you may do so by contacting our Medical Records Department or our Security Officer. Occasionally we may send you information about products or services that we believe may be beneficial to you. You may contact our Security Officer to request that these materials not be sent to you.

FINANCIAL POLICY

Our office is committed to providing quality and cost effective healthcare to our patients. In today's insurance environment it is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with us. It is your responsibility to understand the limits and restrictions affecting coverage for services provided by our speciality. If your insurance company requires you to use a specific lab, it is your responsibility to notify us of that. Insurances reimbursement is a contract between you and your insurance company. As a courtesy to you we will file all primary and secondary claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of any change in insurance status. You will be responsible for all co-pays, deductibles, and co-insurance amounts not covered by a secondary insurance policy along with the entire amount of any non-covered service. We appreciate payment for services at the time they are rendered. For your convenience, we accept cash, personal checks, Visa, and MasterCard. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account. I understand that interest of 1% per month compounded annually will be added on all unpaid balances over 90 days. I understand I am responsible for my spouse/dependent charges.

X SIGNATURE: _____ **DATE:** _____

PREVENTATIVE CARE

Your health insurance plan may not provide coverage for preventive services. It is important that you contact your insurance provider to determine if your plan offers benefits for this service and what their scheduling guidelines are for it. We use industry standard codes and guidelines to submit claims to the insurance companies based on the scheduled encounter and documentation in the patient's medical record. Current laws regarding fraud and abuse with billing procedures prohibit us from changing the procedure codes and /or diagnosis codes in order to get the claim paid by the insurance company.

To protect the healthcare team who may accidentally be exposed to my blood or body fluids, I consent to have my blood tested for transmissible disease (such as hepatitis virus, HIV (AIDS), others). If this testing is necessary it will be done at no charge. Your physician will inform you if this should become necessary.

X SIGNATURE: _____ **DATE:** _____

AUTHORIZATION TO SHARE HEALTH CARE INFORMATION (optional)

You may share the following health care information with:

Name: _____ Relationship: _____

Please check all that apply:

☐ All health care information in my medical record. ☐ Insurance and billing information

☐ Health care information in my medical record relating to the following treatment: _____

☐ Other (appointments, test results, etc.) _____

This authorization ends:

☐ In 1 year from the date signed or upon written revocation.

X SIGNATURE: _____ **DATE:** _____

Olu. Faleye MD, FACP.
Primehealth Medical
6637 Summer Knoll Circle, #101
Bartlett, TN 38134
Phone: (901) 372-5260
Fax: (901) 386-8726

Suboxone Financial Agreement

Primehealth is not filing insurance for the outpatient suboxone program unless you have 'lennCare, Medicare or unless your insurance has agreed to a special authorization covering Primehealth's required rates and fees. If an agreement has been attempted per your request but has not been made prior to the first visit or second visit, the patient agrees to pay the discounted fees below. If an agreement is made between Primehealth and your insurance company and upon payment by the insurance company, the patient payment excluding any deductible or copays will be refunded to the patient. The patient is 100 responsible for our discounted fees listed below before treatment and if an agreement has been reached and the insurance company fails to make payment based on the negotiated rates' agreed upon by Primehealth. Primehealth is contracted to perform STANDARD psychiatric treatment **ill** the office which excludes any opioid detox or treatment. However, if you see a therapist for individual therapy, Primehealth will file your insurance because this is considered standard treatment; you will be responsible for any copays or deductibles.

You may use your insurance card at the pharmacy for your medication if your insurance covers Suboxone. If your insurance requires a prior authorization to fill your medication, there is an additional $25.00 charge for the Primehealth staff to obtain authorization. However, if you chose to use the on-site pharmacy, there will NOT be a charge because the pharmacy will perform this service for their patients free of charge as long as the patient uses the pharmacy to fill the medication. For patients with no insurance coverage, Pharmacy has discounted the medication and we have been told that they are cheaper than most pharmacies located in our area. You are welcome to choose your own pharmacy but we request you check to ensure you are getting the best price.

We do require each patient enrolled in the Suboxone program to attend at least (2) therapy sessions per month and regular drug screening. If you are referred by your Primehealth provider to attend the intensive outpatient provider, you are NOT required to also attend additional therapy sessions while you are attending the intensive outpatient program. The intensive outpatient program consists of 24 required IOP visits. Failure to attend the IOP program upon the recommendation of the Suboxone provider will result in termination in the program.

Primehealth's designated laboratory is now filing to all insurance companies for the drug screenings. In most cases we only charge a $50.00 payment for drug screens. In addition, Primehealth will send most of your screenings for lab confirmation and the outside lab will bill your insurance. If you get a bill from the outside lab please call them directly. There is an agreement with the outside lab to adjust any balances left by insurance in which the patient is unable to financially pay or if the patient does not have insurance and can't afford to pay. Please ask lab personnel for applicable forms or contact lab directly

Primehealth discounted self-pay fees are non-negotiable and are as follows:

I" MD Session which will include any additional office visits needed to determine the correct Suboxone dose during the first 30 days:	$250.00
2nd Session and continued office visits follow-ups	$125.00
Prior Authorizations for Medications	$25.00
Fail Appointment	$50.00
Drug Screen	~~$75.00~~ $40.00

Confirmatory Drug Screens are extra and separately billed by reference Lab.

All fees are due and must be paid before you see the physician.

We DO NOT call in medication if you miss an appointment. We reserve the right to discontinue your treatment if you fail to show for an MD appointment or failure to comply with MD treatment recommendation or failure to show for the required two sessions per month therapy appointment or not show for a random or scheduled drug screen or if you have a positive drug screen. Each physician has a limited number of patients they are allowed legally to prescribe Suboxone. There will be a charge of $50.00 for any failed appointments and must be paid in full before your next appointment.
If your account is turned over to a collection agency, an additional 33 plus any court fees will be added to your account balance. Your account is considered delinquent after the balance is 60 days past due.

Patient Signature _____ Date _____

PRIMEHEALTH MEDICAL CENTER, P.C.

Financial Agreement Additional Services.

Patient Name: _____

Primehealth Medical Center, P.C. is a private practice where all services require a fee which is the responsibility of the patient or guardian. Copayments are required to be paid at the time of each visit before being seen by the physician. Copayments are required to be paid at the time of each group and individual session for Intensive Out Patient Therapy and Focus Groups and Suboxone Therapy. The patient's responsibility is to find out what their copayment will be for seeing the physician and for Intensive Out Patient Therapy and Focus Groups and Suboxone Therapy.

Please understand that the filing of any insurance claim and sending of all statements are performed as a courtesy. All services that are not covered by the insurance company will be the responsibility of the insured party to follow up with the insurance company and to pay all remaining balances unless there is a contract between the insurance company and the practice that states differently. You may check with the insurance department at the practice for said contracts and carriers.

All balances remaining where the insurance carrier does not pay is the patient's or guardian's responsibility. Statements will be sent out with the balances that need to be paid. If the balances are not paid or balances increase to a point the patient or guardian are not able to pay in full, a practice associate will explain the circumstances of the balance and may be able to set the patient or guardian on a monthly payment plan at practice discretion. Once the payment plan is set, it is up to the patient or guardian to either send in payment or call the billing department to pay over the phone each month.

Patient's unpaid account will become delinquent after it has matured to 60 days from the date of service of last office visit. Patient's unpaid account will become delinquent after it has matured to 60 days from the date the payment plan agreement was signed. Once the account has become delinquent, it will be sent to collections, and there will be an added 33% to the account balance. Patient or guardian will be responsible for all collection fees or/and attorney fees for delinquent accounts.

Payments for Services:

$30 for telephone consults that exceeds more than 10 minutes
$50 for "No Show" appointments; must call to cancel appointment 24 hours in advance
$20 for Medical Records Requests which a request must be filled out
$20 for Non-Routine Medication Requests to refill medication for missed-appointments
$50-$150 depending on time required for Medical Forms and Letters and Legal Documents which requires a request filled out.

Patient or guardian is fully responsible for the payment of these miscellaneous fees whether paid or denied by the insurance company unless stated otherwise in our contractual agreement with the insurance carrier. Primehealth Medical Center, P.C. does not file any fees to the insurance company unless requested by patient or guardian, but if the insurance denies then the responsibility falls back onto the patient or guardian.

The terms of this contract are contingent on any contractual agreement made between Primehealth Medical Center, P.C. and the insurance company in that any terms here in stated that violate the provider's contractual" agreement are voided and/or non-applicable.

By signing this form, you have read and agreed to the terms.

Patient/Guardian _____ Date _____

PRIMEHEALTH MEDICAL CENTER, P.C.

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Patient Copy

Patient/Guardian _____ Date _____

Olu. Faleye, MD, FACP.
Primehealth Medical Center, P.C.
6637 Summer Knoll Circle,
Bartlett, TN 38134

Phone: (901)372-5260 Fax: (901)386-8726

PATIENT TREATMENT CONTRACT

Patient Name _____ Date _____

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

1. I agree to keep and be on time to all of my scheduled appointments.
2. I agree to adhere to the payment policy outlined *by* this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medic ail on 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.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing, stealing or if any illegal or disruptive activities are observed or suspected by the employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without recourse for appeal.
7. 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.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of *why it* was lost.
9. I agree not to obtain controlled or schedule 2 medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. 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).
11. 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.
12. I understand that medication alone is not sufficient treatment for my condition and I agree to participate in the counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (Except nicotine)
14. I agree to provide random urine samples and have my doctor test my blood alcohol level as necessary.
15. **This practice has a "2-strike and you are out policy" without exception.**

Date

Patient
Signature _____

Date-------

[1]Valium© is a registered trademark of Roche Products Inc.

*Klonopin© is a registered trademark of Roche Laboratories

*Xanax© is a registered trademark of Pharmacia & Upjohn

Olu. Faleye, MD, FACP.
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5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing, stealing or if any illegal or disruptive activities are observed or suspected by the employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without recourse for appeal.
7. 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.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of *why it* was lost.
9. I agree not to obtain controlled or schedule 2 medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. 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).
11. 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.
12. I understand that medication alone is not sufficient treatment for my condition and I agree to participate in the counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (Except nicotine)
14. I agree to provide random urine samples and have my doctor test my blood alcohol level as necessary.
15. **<u>This practice has a "2-strike and you are out policy" without exception.</u>**

Date

Patient
Signature_----------

Date-------

'Valium© is a registered trademark of Roche Products Inc.
*Klonopin© is a registered trademark of Roche Laboratories
*Xanax© is a registered trademark of Pharmacia & Upjohn

PATIENT COPY

MEDICAL QUESTIONNAIRE

NAME: _____ DOB: _____

If you do not understand a question or you do not feel comfortable in answering a question, leave it blank and go on to the next question. Some questions may not apply to you.

AGE: _____

DATE OF LAST MAMMOGRAM: _____ REFERRING MD _____

DATE OF LAST BREAST ULTRASOUND: _____ PRIMARY MD _____

PAST MEDICAL HISTORY

ILLNESSES:

			DATE DISCOVERED
Yes _____	No _____	High blood pressure	_____
Yes _____	No _____	Diabetes	_____
Yes _____	No _____	Heart problems	_____
Yes _____	No _____	Cancer (type) _____	_____
Yes _____	No _____	Stroke	_____
Yes _____	No _____	Blood clots	_____
Other: _____			_____

CURRENT MEDICATIONS

Name	Amount and frequency taken	Name	Amount and frequency taken

HERBAL, VITAMIN OR NUTRITIONAL THERAPIES

Name	Amount and frequency taken	Name	Amount and frequency taken

ALLERGIES

Medication or substance	Describe reaction or symptom

PAST SURGERIES (check those that you have had)

		DATE (year)			DATE (year)
_____	C-section	_____	_____	Left Breast Biopsy	_____
_____	Removal of ovary	_____	_____	Right Breast Biopsy	_____
_____	Removal of uterus	_____	_____	Tubal Ligation	_____
_____	Other: _____				_____

OB-GYN HISTORY

Age at first menstrual period. _____

How many pregnancies have you had? _____

How many children have you given birth to? _____

Age at first delivery? _____

Date of last menstrual period? _____

Date of last Pap Smear? _____

Have you taken estrogen or female hormones in the last 10 years? _____

Date Started? _____

Date Stopped? _____

SOCIAL HISTORY

Occupation _____

Martial status ___ Never Married ___ Married ___ Divorced ___ Widowed

Where do you currently live? City: _____ State: _____

Do you smoke cigarettes now? _____ Yes _____ No

Have you smoked in the past? _____ Yes _____ No

When did you start? Date: _____

When did you quit? Date: _____

Do you drink alcohol? _____ Yes _____ No Quantify _____

FAMILY HISTORY

Is there anyone with breast cancer in you blood family? If so, list them by their relation to you, their age and when the cancer was found.

Relation:	Age when cancer was discovered	Age at Death

Are there any women with ovarian cancer in your blood family? If so, list them by their relation to you, their age and when the cancer was found.

Relation:	Age when cancer was discovered	Age at Death

Father's age _____ Alive? _____ Yes _____ No

Cause of death _____ Age at death _____

Mother's age _____ Alive? _____ Yes _____ No

Cause of death _____ Age at death _____

Brothers:			Sisters:		
Age	Alive	Illnesses	Age	Alive	Illnesses

Children:		
Age	Sex	Health

Race

___ American Indian/Alaskan Native
___ Asian
___ Native Hawaiian / Pacific Islander
___ Black or African American
___ White

Ethnicity:

___ Hispanic or Latino
___ Not Hispanic or Latino

HEALTH REVIEW (last 3 months):

		YES	NO
GENERAL:			
	Weight change, greater than 5 lbs?		
	Persistent fatigue:		
SKIN:			
	Any new skin rashes, lumps or bumps?		
	Hot flashes?		
EYES:			
	Recent vision change?		
MOUTH:			
	Sore throat?		
	Sore mouth?		
NECK:			
	New lumps?		
	Thyroid problems?		
LUNGS:			
	Cough?		
	Shortness of breath?		
HEART:			
	Chest pain?		
	Ever been told you had a heart murmur?		
	Abnormal EKG?		
GASTROINTESTINAL:			
	Nausea or vomiting?		
	Constipation?		
	Change in bowel habits?		
	Change in appetite?		
	Any liver or colon problems?		
GENITOURINARY:			
	Problems with urination?		
	Vaginal dryness?		
JOINTS / EXTREMITIES:			
	Any bone or joint pain or stiffness?		
	Arm swelling / lymphedema?		
	Ever had a blood clot?		
NEUROLOGIC:			
	Have you ever had a seizure?		
	Do you have weakness of an arm, leg or other part of your body?		
BLOOD:			
	Any history of anemia or blood disorder?		
PSYCHOLOGICAL:			
	Have you ever been treated for depression or anxiety?		

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Dr. Olu Faleye
6637 Summer Knoll Circle, Ste. 101
Bartlett, TN 38134

Effective Date

This Notice is effective on or after August 1, 2014.

Primehealth
Medical Center P.C.

Acknowledgement of Receipt

I acknowledge that I have received a copy of Primehealth Medical Center, P.C.'s Patient Agreement, including the Notice of Privacy Practices For Protected Health Information.
I have been given an opportunity to ask questions about this agreement and the privacy practices described therein.

I agree to be bound by the terms of this agreement except for those areas listed below.

I understand that I may revoke this agreement at any time in writing. Such revocation will be effective when received by the practice and will not be effective for any privacy disclosure previously made under the terms of this agreement or for any payment obligations for services already rendered.

Signature: _____

Printed Name: _____

Date: _____

Restrictions on the use of my protected health information_____

BUPRENORPHINE MAINTENANCE TREATMENT

Patient information and consent to treatment with buprenorphine

Suboxone® (a tablet with buprenorphine and naloxone) is an FDA approved medication for treatment of people with heroin or other opioid addiction. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opiate addiction, including methadone, naltrexone, and some treatments without medications that include counseling, groups and meetings.

If you are dependent on opiates - any opiates - **you should be in as much withdrawal as possible when you take the first dose of buprenorphine. It you are not in withdrawal, buprenorphine can cause severe opiate withdrawal.** For that reason, you should take the first dose in the office and remain in the office for at least 2 hours. We recommend that you arrange not to drive after your first dose, because some patients get drowsy until the correct dose is determined for them.

Some patients find that it takes several days to get used to the transition from the opiate they had been using to buprenorphine. During that time, any use of other opiates may cause an increase in symptoms. After you become stabilized on buprenorphine, it is expected that other opiates will have less effect. Attempts to override the buprenorphine by taking more opiates could result in an opiate overdose. You should not take any other medication without discussing it with the physician first.

Combining buprenorphine with alcohol or other sedating medications is dangerous. The combination of buprenorphine with benzodiazepines (such as Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) has resulted in deaths.

Although sublingual buprenorphine has not been shown to be liver-damaging, your doctor will monitor your liver tests while you are taking buprenorphine. (This is a blood test.)

The form of buprenorphine (Suboxone®) you will be taking is a combination of buprenorphine with a short-acting opiate blocker (Naloxone). **It will maintain physical dependence,** and if you discontinue it suddenly, you will likely experience withdrawal. If you are not already dependent, you should not take buprenorphine, it could eventually cause physical dependence.

Buprenorphine tablets must be held under the tongue until they dissolve completely. You will be given your first dose at the clinic, and you will have to wait as it dissolves, and for two hours after it dissolves, to see how you react. **It is important not to talk or swallow until the tablet dissolves.** This takes up to ten minutes. Buprenorphine is then absorbed over the next 30 to 120 minutes from the tissue under the tongue. Buprenorphine will not be absorbed from the stomach if it is swallowed. **If you swallow the tablet, you will not have the important benefits of the medication, and it may not relieve your withdrawal.**

Most patients end up at a daily dose of 16 mg to 24mg of buprenorphine. (This is roughly equivalent to 60mg of methadone maintenance) Beyond that dose, the effects of buprenorphine plateau, so there may not be any more benefit to increase in dose. It may take several weeks to determine just the right dose for you. The first dose is usually 2mg.

If you are transferring to Suboxone® from methadone maintenance, your dose has to be tapered until you have been **below 30mg for at least a week.** There must be **at least 24 hours** (preferably longer) between the time you take your last methadone dose and the time you are given your first dose of buprenorphine. Your doctor will examine you for clear signs of withdrawal, and you will not be given buprenorphine until you are in withdrawal

I have read and understand these details about buprenorphine treatment. I wish to be treated with buprenorphine.

Signed _____ .Date _____

Witness _____

BUPRENORPHINE MAINTENANCE TREATMENT

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I have read and understand these details about buprenorphine treatment. I wish to be treated with buprenorphine.

Signed _____ PATIENT COPY .Date _____

Witness _____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☐ In three years

The person named above is or has been a patient of

Name of Person, Provider, or Facility _____

Address _____

Phone _____

Fax _____

The person named above hereby authorizes _____ **to**

Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Discuss health information with
- ☐ Send health information to
- ☐ Discuss health information with

The person named above authorizes information to be requested or released by representatives of

Name Of Person, Provider, Or Facility _____

Address _____

Phone _____

Fax _____

Scope

- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- ☐ All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)
- ☐ Other information (specify): _____

Authorization

_____
Printed name of Patient or Authorized Representative

_____ Date _____ Date
Signature of Patient or Authorized Representative — Signature of witness

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual

PRIMEHEALTH MEDICAL CTR. : MEDICATION CONSENT FORM

Patient Name: _____

I have been informed of the recommendation of the medication(s) listed below are being prescribed as a part of my treatment program. I have been informed of the nature of my condition, the risks and benefits of treatment with the medication(s) listed below, of other forms of treatment, and the risks of no treatment.

Signing this form indicates that I have received information explaining the most common side effects of the medication(s) and have understood the explanation of the side effects.

I understand that medication is only one aspect of my overall treatment, and that success and improvement depends on my active involvement and participation in all aspects of the treatment plan developed for me. I also understand that although this medication is expected to be helpful in the treatment of my condition, there is no absolute guarantee as to the results. I am required to report to my provider the side effects I experience while taking the medication. Before given the medication, the psychiatrist will explain in detail the nature of your condition, why you are being prescribed the medication, the risks and benefits of treatment by taking the medication, and/or forms of other treatments if you do not want to take the medication.

FOR FEMALES: Because the medication(s) could be harmful to a developing fetus, you need to notify your provider of the medication(s) given immediately if you suspect pregnancy or have plans to become pregnant.

_ Birth Control __Birth Control Pills__IUD__DepoProvera__Tubal Ligation__OTHER

_ I give permission and consent to the administration of the prescribed medication(s) knowing the risks, benefits, and side effects.

_ **I REFUSE** to allow the administration of the recommended medication(s) and **REFUSE** what alternative medication(s)/treatment given.

_____ _____

Signature of Patient or Guardian Date

TO BE FILLED OUT BY PHYSICIAN ONLY

Medication: _____	Sig	_____ Qty
Medication: _____	Sig	_____ Qty
Medication: _____	Sig	_____ Qty

Pharmacy Consent Form for Buprenorphine Treatment

Description: By signing this Appointed Pharmacy Consent Form, the patient authorizes a physician to disclose to the pharmacy that he or she is being treated for opioid dependence; the pharmacy is also authorized to contact the physician to discuss treatment.

Name/Practice: **Primehealth Medical Center, P.C.**
Address: 6637 Summer Knoll Circle
Address: Suite 101
City, State : Bartlett, TN 38134
Phone: (901)372-5260
Fax: (901)386-8726

APPOINTED PHARMACY CONSENT

I, _____ [Patient Name- Print], do hereby:

(MD check all that apply)

1) I Authorize Dr. Olu. Faleye at the above address to disclose my treatment for opioid dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy.

2) __ I Agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary so that my buprenorphine prescriptions can be filled and either delivered to the office addressed given above or picked-up by employees of the same.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Patient Signature _____ Patient Name (Print) _____ Date _____

Appointed Pharmacy: Name: _____ Phone: _____

Address: _____

Confidentiality of Alcohol- and Drug-Dependence Patient Records

The confidentiality of alcohol- and drug-dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol- or drug-dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Substance Appointment Agreement

Please be advised that all follow-up appointments need to be made as you leave the office at the time of your current appointments. The doctor's schedules are usually booked 2 to 3 weeks in advance. It is your responsibility to make your future appointments in the office at the time of your current visit. We DO NOT accept walk in appointments.

If you do not, you need to be aware there is a possibility no appointments will be available at the time you call to make an appointment. For the Substance Program, you have to be seen monthly by your physician. *You cannot receive a refill without being seen.* Please make every effort to keep this from happening.

If you should run into an emergency, and need to reschedule, we will try to work with you. You should contact our Office Program Coordinator or Manager at (901) 372-5260. Please note this will not be allowed to be an ongoing practice. These special incidents will be noted in your chart for future calls.

If you have any questions regarding appointments, please ask the staff and we will be glad to help you. By signing below you agree to the appointment rules.

Patient Name (print) Date

Patient Signature Date

Chart # _____

6637 Summer Knoll Circle, Suite 101 • Bartlett, TN 38134". Phone (901) 372-5260 * Fax (901) 386-8726

www.primehealthclinic.com

Primehealth Medical Center, P.C. 6637 Summer Knoll Circle, Suite 101 Bartlett, TN. 38134	MR#	
ADULT INITIAL ASSESSMENT	Date	

SUBSTANCE ABUSE

- o No known / evident history of current or past drug/alcohol usage
- o History of daily drug / alcohol usage

Check all that apply:

oAlcohol	0 Inhalants	o Barbiturates	o Opioids
oMarijuana	0 Heroin	o Hallucinogens	o Other Substances
oCocairie	0 Crystal Meth	o Prescription	o Tobacco
oPCP	0 Amphetamines	o OTC drugs	

List all agents checked above	Age at first use	Current pattern and frequency of use	Increased tolerance	Last use	Amount used in past 24 hours	Route Taken (How was used)

O Previously used Methadone?
Last used: _____

Milligrams per day: _____ Daily Quantity: _____

Patient Name: _____ Date: _____ Admit

Adult Version

These questions refer to the past 12 months.

	Circle Your Response
1. Have you used drugs other than those required for medical reasons?	Yes No
2. Have you abused prescription drugs?	Yes No
3. Do you abuse more than one drug at a time?	Yes No
4. Can you get through the week without using drugs?	Yes No
5. Are you always able to stop using drugs when you want to?	Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes No
7. Do you ever feel bad or guilty about your drug use?	Yes No
8. . Does your spouse (or parents) ever complain about your involvement with drugs?	Yes No
9. Has your drug abuse created problems between you and your Spouse or your parents?	Yes No
10. Have you lost friends because of your use of drugs?	Yes No
11. Have you neglected your family because of your use of drugs?	Yes No
12. Have you been in trouble at work (or school) because of drug abuse?	Yes No
13. Have you lost your job because of drug abuse?	Yes No
14. Have you gotten into fights when under the influence of drugs?	Yes No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes No
16. Have you been arrested for possession of illegal drugs?	Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when You stopped taking drugs?	Yes No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, ect.)?	Yes No
19. Have you gone to anyone for help for a drug problem?	Yes No
20. Have you been involved in a treatment program specifically related to drug use?	Yes . No