I, _____
understand that mixing methadone/buprenorphine with other depressants (such as alcohol or benzodiazepines) is especially dangerous and will refrain from doing so. I agree to take methadone/buprenorphine only as prescribed, and to inform other healthcare providers that I take methadone/buprenorphine to avoid potentially harmful interactions. Until I know how methadone/buprenorphine will affect me, I will use caution when driving or operating machinery. I have made the physician aware of all medical conditions I have and medications (prescription, over-the-counter, or illicit) I take, and will keep this information current throughout treatment.

Name (print)

Signature

Date

Witness signature

Receipt of Client Handbook

Print Name: _____ DOB _____ PT #_____

Sign Name: _____

Date: _____

I acknowledge that I have received the Client Handbook and that I am responsible for following the rules as stated in the Handbook

CONSENT TO PARTICIPATION IN OPIOID PHARMACOTHERAPY TREATMENT

Patient's Name: _____ Date: _____

I hereby authorize and give voluntary consent to the ALT Recovery Group (ARG) and its medical personnel to dispense and administer opioid pharmacotherapy (including methadone or buprenorphine) as part of the treatment of my addiction to opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve my taking the prescribed opioid drug at the schedule determined by the program physician, or his/her designee, in accordance with federal and state regulations.

It has been explained that, like all other prescription medications, opioid treatment medications can be harmful if not taken as prescribed. I further understand that opioid treatment medications produce dependence and, like most other medications, may produce side effects. Possible side effects, as well as alternative treatments and their risks and benefits, have been explained to me.

I understand that it is important for me to inform any medical provider who may treat me for any medical problem that I am enrolled in an opioid treatment program so that the provider is aware of all the medications I am taking, can provide the best possible care, and can avoid prescribing medications that might affect my opioid pharmacotherapy or my chances of successful recovery from addiction.

I understand that I may withdraw voluntarily from this treatment program and discontinue the use of the medications prescribed at any time. Should I choose this option, I understand I will be offered medically supervised withdrawal.

For Female Patients of Childbearing Age: There is no evidence that methadone pharmacotherapy is harmful during pregnancy. If I am or become pregnant, I understand that I should tell my medical provider right away so that I can receive appropriate care and referrals. I understand that there are ways to maximize the healthy course of my pregnancy while I am in opioid pharmacotherapy.

_____	_____	_____
Signature of Patient	**Date of Birth**	**Date**

Witness: _____

PATIENT NAME: _____
DOB_____

ALCOHOL/SUBSTANCE USE HISTORY

Substance	Age at 1st use	By mouth, smoke, snort, IV	Amount used daily at heaviest use	Amount spent daily at heaviest use	Date of last use
ALCOHOL					
BENZODIAZAPINES (Xanax, valium, Ativan, klonopin, Librium)					
BARBITUARATES (seconal, phenobarbital)					
OPIATES (Vicodin, Percocet, opium, codeine, morphine, fentanyl, OxyContin)					
HEROIN					
COCAINE					
MARIJUANA					
AMPHETAMINES (meth, Adderall, Ritalin)					
ECSTACY					
LSD					
INHALANTS					
MUSHROOMS					
SPICE/K2					
BATH SALTS					

Please check all that apply:

___Continuing to use opioids despite negative personal consequences (problems with family, friends)

___Repeatedly unable to carry out major obligations at work, school, or home due to opioid use

___Recurrent use of opioids in physically hazardous situations (driving, operating heavy machinery)

___Continued use despite social or interpersonal problems caused or made worse by opioid use

___Tolerance as defined by either a need for increased amounts of opioids to achieve desired effect or diminished effect with continued use of the same amount

___Opioid is used to avoid withdrawal

___Using greater amounts or using over a longer time period than intended

___Persistent desire or unsuccessful efforts to cut down or control opioid use

___Spending a lot of time obtaining, using, or recovering from using opioids

___Stopping or reducing important social, occupational, or recreational activities due to opioid use

___Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids

___Craving or a strong desire to use opioids

Do you have any problems related to gambling, food, internet, sex or gaming?

Yes No

If so, please describe:

_____

What has been your longest period of sobriety and why?

_____

Patient signature:

_____ Date:

_____

CONSENT TO TREAT

Patient Name: _____ Date: _____

Consent to Treat With 42CFR Part 2 Confidentiality

As a patient, you have the certain rights to your privacy and treatment. ALT Recovery Group adheres to the following regulations concerning patient confidentiality.

We comply with the confidentiality requirement outlined in Title 42, Code of Federal Regulations, Part 2; and Title 45, Parts 160 & 164.

There are some disclosures that we are required and permitted to report:

Mandatory Disclosures

42 CFR Part 2 allows for disclosure where the state mandates child-abuse-and neglect reporting (42 C.F.R. § 2.12(c)(6);
45 C.F.R. §164.512 (b)(1)(ii)); when cause of death (42 C.F.R. § 2.51(b)) is being reported; or with the existence of a
valid court order.

Permitted Disclosures

Programs are permitted to disclose patient-identifying information in the following cases:

- medical emergency (45 C.F.R. § 164.506 (c); 42 C.F.R. § 2.51)
- reporting crimes that occur on program premises or against staff (45 C.F.R. § 164.502(j)(2), 164.512(f)(2); 42 C.F.R. § 2.12 (c)(5))
- to entities having administrative control (45 C.F.R. § 164.502(a)(1), 164.506(a),(c); 42 C.F.R. § 2.12 (c)(3))
- to qualified service organizations (45 C.F.R. § 160.103, 164.504(e), (c); 42 C.F.R. § 2.12 (c)(4))
- and to outside auditors, evaluators, central registries, and researchers (45 C.F.R. § 164.501, 164.506, 164.512; (c);

42 C.F.R. § 2.53 (c)-(d); 42 C.F.R. § 2.52; 45 C.F.R. § 164.512(i)(1)(ii)).

You are not be denied treatment at the ALT Recovery Group on the basis of ethnicity, race, creed, religious preference, political affiliation, gender, age, sexual orientation or handicaps, or in any manner prohibited by the laws of the United States or the applicable state.

Review, determination, and correction of any alleged violation of rights consent to have ALT Recovery Group provide ongoing assessment and treatment for my behavioral, emotional, social, and educational problems. I understand that my care is provided by a team of professionals under the guidance and supervision of a licensed clinician. I understand that my assessment may include psychiatric and psychological questionnaires and evaluations, physical and neurological evaluations, educational and vocational evaluation/instruction to assess skills and career goals, and ongoing urine and breath tests for drugs and alcohol. Females will also be tested for pregnancy on admission and prior to any decrease in medication.

I understand that I can end my treatment at any time and that my referring agency will be notified of my termination and that this could result in consequences for me if I am court ordered to treatment or for an evaluation.

I hereby authorize and give my voluntary consent to ALT Recovery Group to be involved in mental health and substance abuse treatment. I willfully enter into this treatment and understand my responsibility in working towards my treatment goals. I have been offered a copy of this form.

Patient Signature: _____ Date _____

Witness Signature: _____ Date _____

Client's Name: _____DOB_____PT. #_____

METHADONE TAKE-HOME AGREEMENT

I hereby agree to participate in this Methadone/Buprenorphine Take-Home Agreement, which is offered by the ALT Recovery Group. I understand that the amount of take-homes I am given increase with the amount of time I've been on the program, the progress that I have made in staying off mood-altering drugs and the clinic staff assessment of the safety of taking home methadone/buprenorphine.

Regarding take-home methadone dose(s), I agree to the following:

- Methadone/Buprenorphine is a potent medication. A single dose taken by a client not used to taking narcotics can be fatal, especially if taken by a child. For this reason, I agree to store take-home dose(s) in a locked box, in a location where they are unlikely to be stolen or accidentally taken by another person.
- I agree that the number of take-home dose(s) I receive will be decided by my physician, with input from therapists, nurses and pharmacy staff, as I progress in my treatment.
- I agree not to give, lend or sell my take-home dose(s) to anyone.
- I agree that I will consume the methadone/buprenorphine on the dates specified on the medication label and in the appropriate manner – that is, a full dose is taken within 24 hours.
- I agree that take-home doses will only be given if I leave urine screens according to the schedule arranged with my physician.
- I agree to the conditions of the Call-Back Agreement

CALL-BACK AGREEMENT

I understand that a call-back involves ALT Recovery Group therapist contacting me by telephone call, text message or voice message periodically during the course of my treatment and asked to physically bring in all medication, all take-home bottles and to submit a urine sample for drug screening. It is expected that I present to the clinic within 24 hours of being contacted and agree to the following:

- To return all my unused take-home doses to the clinic
- To provide a supervised urine sample, if requested
- To provide ALT Recovery Group with my current telephone number and information on how I may be contacted regarding the call-back of take-homes.
- I agree that my carry status will be reviewed if I fail to present at the clinic within 24 hours.
- It is my responsibility to notify my therapist in advance when I change my telephone number, person of contact, leave for vacation or if I'm working out of town.
- Failure to notify clinic of changes, answering machines/voicemail malfunctions, or failure to receive messages does not relieve me from consequences of failure to return within 24 hours of a call back.

My signature below indicates that I agree to follow the responsibilities outlined in the agreement. Should I fail to meet my responsibilities as a participant in this agreement, I understand my take-home level will be reduced for an indefinite period of time.

I have had an opportunity to ask questions about this agreement, and my questions (if any) have been answered to my satisfaction.

Date: _____

Client Name (print): _____

Client Signature: _____

Guardian Name (print): _____

Guardian Signature: _____

Witness Signature: _____ *A copy of the agreement will be given to the client.*

Revised 08/21/17

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the ALT Recovery Group Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in ALT Recovery Group's Notice of Privacy Practices, please do not hesitate to contact a clinic representative.

Patient Name (Printed): _____DOB_____PT#_____

If Patient Representative, Name (Printed): _____

If Patient Representative, Relationship to Patient (Printed): _____

Signature: _____

Date Notice Received: _____

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