1055 N. 500 W. Provo, UT. 84604 P| 801-429-8062 F| 801-374-2615

AUTHORIZATION TO **RELEASE** PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I, _____, authorize Revere Health to disclose to:
(Patient or Legal Representative(s))

Name: _____DOB:_____ Phone: _____

Name: _____DOB: _____ Phone: _____

Name: _____DOB: _____ Phone: _____

The following protected health care information (check one):

❑Entire medical record (NOTE: This may include records from other health care providers, patient history forms, insurance information, correspondence, etc. It is NOT strictly limited to records generated by the physician/health care provider indicated above.)

❑Entire medical record for specified date(s) of service: From: _____ To: _____

❑ONLY the following specific information: _____

_____

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below:

• Psychological / psychiatric conditions • Drug and/or alcohol abuse diagnosis and/or treatment • Genetic testing
• HIV/AIDS diagnosis and/or testing • Sexually transmitted disease(s) diagnosis and/or testing

List any restrictions: _____

The purpose of the disclosure is: _____

Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed physician/health care provider's office with a written revocation.

Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form.

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

Photocopy: A photocopy of this authorization, including a copy that is received by fax or electronically transmitted, shall be considered as effective and valid as the original.

Expiration Date: I understand that unless I provide a written revocation at an earlier date, this authorization will expire in **one** year or as otherwise noted below.

Expiration Date: _____/_____/_____

Signature of Patient or Legal Representative(s): _____
(Note: If patient is a minor child, both parents may be required by law to sign)

Date: _____/_____/_____ Printed Name(s): _____

Relationship to Patient (if signed by other than patient)_____

Revere Health
Rock Run
Family Medicine

Controlled Substance Agreement

1. All controlled substances must come from the physician listed below, or during his/her absence, by the covering physician, unless specific authorization is obtained for an exception.

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies our, office must be informed.

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any medications that you take. **You should not request any pain medications or controlled substances from other providers.**

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

5. **You may not share, sell, or otherwise permit others to have access to these medications.** Rock Run staff will cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of controlled medicine.

6. These medications should not be stopped abruptly, as an abstinence/withdrawal syndrome will likely develop.

7. Unannounced urine and/or serum toxicology screens may be requested, and your cooperation is required. Presence of
unauthorized substances may result in cessation of prescriptions for controlled substances and discharge from our clinic.

8. Prescriptions and bottles of these medications may be sought by other individuals sand should be safeguarded. **Lost, stolen, or ruined medications will not be replaced.**

9. Early refills WILL NOT be given.

10. Medications should be taken at the dose and frequency prescribed. You must speak with your provider BEFORE making any changes in dose or frequency of your medication.

11. Monthly follow up visits will be required. Renewals are contingent on keeping scheduled appointments with your provider. **Do not phone for prescriptions refills after-hours or on weekends. Such requests will not be completed and are considered aberrant behavior.**

By signing below you acknowledge that you have full right and power to sign and be bound by this agreement, and that you have read and understand and accept all of its terms.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Brannick Riggs, MD • Darlene Petersen, MD • Jeff Anderson, PA-C
5640 South 3500 West, Roy, UT 84067 • Phone: 801.773.2838 • Fax: 801.773.3025

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Chart No. _____

PATIENT INFORMATION

Date: _____

Name: _____ Preferred Name: _____

Mailing Address: _____ Apt# _____ City _____ State _____ Zip _____

Street Address: _____ Apt# _____ City _____ State _____ Zip _____

Preferred Phone:( ) _____ Alternate Phone:( ) _____ Date of Birth: ____/____/ ____
(Mo.) (Day) (Year)

Sex: M F Email: _____ Marital Status: Married Single Other

Preferred Language: _____ Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Race: ❑ Caucasian ❑ Native American ❑ Asian ❑ African American ❑ Pacific Islander ❑Other_____

Social Security No.: - - Employer: _____ Employer Phone: ( ) _____

Primary Care Physician: _____

Whom We Can Thank for Referring You to Us: _____

RESPONSIBLE PARTY INFORMATION (*If different from patient.*)

Name: _____

Relationship to Patient: (Circle One) Spouse Father Mother Other: _____

Mailing Address: _____ Apt# _____ City _____ State _____ Zip _____

Preferred Phone:( ) _____ Date of Birth ____/____/____ Social Sec. No.: - -
(Mo.) (Day) (Year)

Employer: _____ Employer Phone: ( ) _____

PERSON TO CONTACT IN CASE OF EMERGENCY (*If possible, list someone with a different phone number than your own.*)

Name: _____ Relationship to Patient: (Circle One) Spouse Father Mother Other: _____

Home Phone: _____ Mobile Phone: _____

INSURANCE INFORMATION

1) Primary Insurance Company: _____

Claims Address: _____ City _____ State _____ Zip _____

Group No. _____ ID No. _____

Relationship of Patient to Insured: (Circle One) Self Spouse Child Other

Policy Holder: _____ Date of Birth: _____/_____/_____
(Mo.) (Day) (Year)

2) Secondary Insurance Company: _____

Claims Address: _____ City _____ State _____ Zip _____

Group No. _____ ID No. _____

Relationship of Patient to Insured: (Circle One) Self Spouse Child Other

Policy Holder: _____ Date of Birth: _____/_____/_____
(Mo.) (Day) (Year)

(CONTINUED ON BACK)

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MEDICAL INFORMATION RELEASE

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of Revere Health and that Revere Health may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker's compensation carriers. I further acknowledge that Revere Health may disclose my patient information to referring or treating health care providers, and for payment and health care operations. I hereby authorize Revere Health to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, films/images, and other clinic information deemed necessary by Revere Health physicians or representatives. I understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with Revere Health's privacy policy.

Patient/Responsible Party Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby consent to the medical treatment, diagnostic and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). Revere Health will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Patient/Responsible Party Signature: _____ Date: _____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I hereby authorize any benefits due me to be paid directly to Revere Health, 1055 North 500 West, Provo, Utah 84604. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

A finance charge (1.5% per month/APR 18%) may be added to any amount for which payment has not been received within 60 days from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of $20.00 for each check or other instrument tendered by me but returned to this facility. Additional service charges may be levied for accounts placed with third-party collection agencies, or failure to make necessary co-payments at the time of service.

It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs incurred for collection of this account.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of Revere Health's financial policy and agree to pay for said medical services according to such terms.

I hereby expressly consent to receiving voice and SMS (text) messages (including pre-recorded messages) on my mobile phone number and any other telephone number(s) that I provide (either directly or through an intermediary) to Revere Health or any of its affiliates, agents or contractors (including third-party billing and/or collection companies). I understand and agree that such messages may be sent by Revere Health and/or by its affiliates, agents or contractors and may be sent via automated dialing technology (i.e. autodialer) and may consist of such things as offers, advertisements, solicitations for business, and/or collection efforts.

Patient/Responsible Party Signature: _____ Date: _____

MEDICARE PATIENT AGREEMENT

(Required by Medicare for all Medicare claims)

_____

Entitlee's Name Medicare Subscriber Number

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to REVERE HEALTH for any services furnished me by that provider. I authorize any holder of medical information about me to release to Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it in writing.

Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Revere Health
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Family Medicine

Informed Consent for Buprenorphine Therapy

Dr. Petersen is prescribing you Buprenorphine for your diagnosis of Opioid Dependence.

Your doctor has discussed alternative treatments that do not involve the use of Buprenorphine. The other treatments discussed include:

Individual Counseling, Inpatient rehab-if necessary, group therapy (where appropriate), Depo-Naltrexone (Vivitrol), and/or no treatment.

My provider has also discussed the potential side-effects (listed below) and risk of dependence and withdrawal syndrome if discontinued abruptly. Side effects include but are not limited to:

- Sleepiness, confusion, difficulty thinking
- Nausea, vomiting, constipation
- Respiratory depression
- Increased sweating
- Low hormones-such as testosterone, which may affect mood, stamina, sexual desire and physical performance.
- Physical dependence of babies born to mothers who are taking these medications
- Potential for allergic reaction
- Potential for interaction with other medications-increase in side effects of other medications taken together.
- Potential for dependence on medication-physical symptoms of withdrawal should medication be stopped abruptly. Symptoms include nausea, vomiting, abdominal pain, sweating, and aches
- Death from unintentional/intentional oversdose

If you have read and understand this form in its entirety, and all of your questions have been answered, please sign below to acknowledge your consent for treatment with opiod medications.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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Missed Appointment Policy

Due to an increasing number of missed appointments, all new Buprenorphine patients, will need to come into our office to provide a $50.00 deposit and complete their new patient paperwork.

Your cash will not be deposited UNLESS you do not show up for your first visit. If you need to change your appointment time, please call to cancel or reschedule your appointment 24 hours in advance, OTHERWISE you will be billed the non-refundable missed appointment fee.

IF you come in for your scheduled appointment, your payment can either be applied to that day's visit or returned to you.

Patient Signature: _____ Date: _____

Printed Patient Name:_____

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Medical History Form

Today's Date:_____ Patient Date of Birth: _____

Last Name:_____First Name:_____Middle Name:_____

Allergies: _____
Chronic or Long Lasting Medical Problems: _____
_____

Current Medications: Strength Frequency
_____
_____
_____

Surgeries:
Type: Where: Approx Year or Age
_____
_____
_____

Hospitalizations:
Where Reason Approx Year or Age
_____
_____
_____
_____

Medical History:
Date of Your Last Complete Physical Exam: _____ Date of Last Tetanus Shot:_____
Date of Last Cholesterol Panel: _____Date of Last Colonoscopy:_____
Date of Last Pap Smear:_____Date of Last Mammogram: _____

Family History: Health Problem Alive or Deceased?
Mother:_____
Father:_____
Sisters:_____
Brothers:_____
Grandparents: _____

Habits: Yes/No/Formerly How Often? How Many Years?
Alcohol: Y N F _____ _____
Tobacco: Y N F _____ _____
Drug Abuse: Y N F _____ _____

Social History:
Marital Status: (please circle) Married Single Divorced (Number of Times?) Separated
Children? Yes No Number of Sons: _____ Number of Daughters: _____
Occupation: _____
Education:_____

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Additional History

Name_____

Date_____

Please fill out completely and honestly. All information is kept confidential. Substance abuse treatment requires multidisciplinary treatment. Your doctor will work with you on a treatment plan which may include medications that will include referrals for individual counseling, and in some cases, inpatient or residential treatment facilities.

What are you seeking treatment for?

_____

Have you been in treatment before? Yes / No
If yes, please tell us where, when, and why:

_____

_____

_____

Substance Used	Amount	Most Ever Used	Age 1st Use	Last Use	Comment
Example: Lortab	10 mg tabs 10 pills/day	15 pills/day	19	Yesterday 2 p.m.	Buying pills off street
Tobacco					
Alcohol					
Marijuana					
Prescription Drugs					
Heroin/PCP IV Drugs					
Amphetamines					
Cocaine					
LSD					
Ecstasy					
Inhalants					

History of Depression/Anxiety?

Previous Depression/Anxiety Medications?

Suicide Attempts? Psychiatric Hospitalizations?

Any history of physical/sexual abuse?

Current stressors in your life?

Who is your support system (ie parents, siblings, spouse, significant other, friends)?

Legal Issues/Drug/Alcohol Charges etc.? Are you in court ordered treatment? If yes, who is your parole officer?

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We offer Vivitrol injection or Suboxone as part of comprehensive treatment program for opioid abuse and addiction at Rock Run Medical. Our suboxone treatment program can be an effective treatment option for those struggling with opioid addiction but it is not your only option. Please read the following guidelines before considering Rock Run Medical.

- Regular office visits will be required; initially you will follow up in 1 week, then 2 weeks and then monthly. You will only move to once a month visits if drug screens are negative and you are established with a counselor. Most insurances cover outpatient addiction treatment. Please check with your individual insurance company to find out what your insurance covers.

- If you are a self pay, here is an estimate of your anticipated cost for the office visits.
  Initial visit: $302
  Subsequent visits: $206
  We offer a 30% self pay discount if paid at the time of service. The prices listed do not reflect that self pay discount.

- Please remember that this is an addiction treatment program and counseling is the most important part of your treatment. Counseling with a licensed therapist is a requirement regardless of insurance or lack of insurance coverage - you may check with your county mental health department for reduced or free counseling.

- We do not prescribe Subutex (buprenorphrine only) unless you are pregnant. We only prescribe Suboxone tablets when it is the only preferred drug on your insurance formulary.

- To prevent diversion and monitor compliance you will be required to participate in medication counts and urine drug screens.

- If you are paying cash for your Suboxone it will vary from pharmacy to pharmacy. A good resource to check is www.goodrx.com to get an up to date cost of Suboxone film at your local pharmacy - but plan on about $7 dollars/film. If you have insurance you may check with your insurance provider regarding copays, etc.

- There are several habit forming medications that you can not be taking while on Suboxone. Some examples of these include, but are not limited to: Xanax, Ativan, Klonopin, Valium and Ambien. You will be given a complete list when you complete your new patient paperwork.

- Prior to your first visit you may either print the new patient paperwork from our website or pick up a packed from our office. A $50 no show fee is required for a deposit, along with the completed packet, prior to scheduling your first visit. The $50 will be refunded upon arriving to your first scheduled appointment. Please plan on your first appointment taking 1 hour.

If you feel that office based outpatient addiction treatment is a good treatment option for you, but would like more information on other Suboxone providers, you may call the toll free Suboxone help line at 1-877-782-6966 or visit www.suboxone.com. If you feel like our office is your best treatment option please contact Rock Run Family Medicine at 801-773-2838 to schedule an appointment or to ask any further questions.

Revere Health
Rock Run
Family Medicine

Unapproved Medication List

Dear Patient,

Our Buprenorphine treatment program at Rock Run Family Medicine can be an effective treatment option for those struggling with opiod addiction, but it is not your only option. Please consider the following requirements to be enrolled in our Suboxone program:

1) All patients must participate in counseling regardless of insurance coverage.

2) For your safety, I have listed highly abused/highly addictive medications that interact with Buprenorphine and **YOU CANNOT** be taking these medications while on Buprenorphine. There are no exceptions.

If you do not feel that you can comply with these requirements, I would strongly recommend you consider an inpatient treatment program or discuss your options with another Buprenorphine provider. You may contact 1-866-973-4373 for assistance in locating other Suboxone providers.

Thank you,
Darlene Petersen, MD

All OPIOID containing medication
Please note Tramadol/Ultram is an Opiod

Benzodiazepines
Xanax (Alprazolam)
Klonopin (Clonazepam)
Ativan (Lorazepam)
Valium (Diazepam)
Librium (Chlordiazepoxide)
Restoril (Temazepam)
Halcion (Triazolam)

Muscle Relaxants
Soma (Carisoprodol)

Sleep Aids
Ambien (Zolpidem)
Sonata (Zaleplon)

Migraine Medication
Fiorcet (Butalbital)

I have read and understand the instructions listed above and by signing agree to comply.

Signature: _____ Date:_____

Printed Name: _____

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