



REFERRED BY WHOM (DOCTOR, PERSON) : \_\_\_\_\_

“Begin Your journey to Sobriety Today Specializing in Suboxone Treatment, helping you achieve Sobriety.” – Dr. Larry Warner M.D.

## About Our Program:

### WE DO NOT TAKE INSURANCE AT NEW BEGINNINGS.

If you have never been on suboxone or it has been over 30 days since you have taken any medications, you will be considered a New Patient at our office. To schedule an appointment, you must come into our office, fill out all necessary paperwork and pay a deposit fee in order to hold your spot (deposit fee is based on how long it's been since you've taken medication) Patients that have been established on the medication for longer than six months are required to pay **\$200** for the first appointment, new patients are required to pay **\$300** for a 2 day induction. **THIS IS NON – REFUNDABLE.** All first appointments are first come first serve.

### Patient induction visits are as follow:

- 1<sup>st</sup> visit consist of a 2-day induction. Day 1 is roughly 2 hours long, depending on the patient. Day 2 is about 1 hour. Patients must have someone drive them during the two-day induction and come with a full bladder, and **NO** drugs in system within **24 HOURS BEFORE** the appointment. We do the assessment in the office to go over all of your paperwork and Dr. Warner will determine what dosage of medication you should be on (basing this on your history of drug use) You will be given a prescription, go to the pharmacy we appoint you to, fill the medication, **AND COME BACK TO THE OFFICE** where Dr. Warner will then administer the medication and monitor you and your vitals. You will go home and based on how the medication did overnight you will come back on the 2<sup>nd</sup> day and then Dr. Warner will determine if the dosage needs to be adjusted at which time you will return to the pharmacy with a prescription and return to the office to have it administered again. After the monitoring process you will be given a two-week prescription and asked to return to the office for a 2 week follow up.
- Follow up visits are basic follow up visits, checking on medication dosage and making sure the patient is doing well with the treatment. These visits are **\$200.00** which include your drug screen and written prescription for the month.
- Each patient is responsible for their medication as far as purchasing it, this is **NOT** included in the office visit. Most insurance companies will pay for portions of the medication, but that is something that you would need to disclose with your insurance company.
- **EVERY VISIT YOU WILL BE DRUG SCREENED,** if you have a positive drug screen, we **WILL** send it to our lab to be placed under review.
- We **RECOMMEND THERAPY.** Whether it may be group therapy, individual therapy NA, AA, any type of meeting deemed appropriate for patient's recovery, we would like 1 day a week, or 2 times every 2 weeks making it a total of 4 times a month you are in class. A sign in sheet must be turned in for this. If you don't comply you will be discharged. Please do not forget the sheets. We do know majority of classes around the area and we do call to verify. Please see remainder of packet for further information! Thank you for choosing New Beginnings.

# **PSYCHOLOGICAL SUPPORT TREATMENT CONTRACT**

As a participant in substance use disorder treatment, I freely and voluntarily agree this treatment contract. I understand that addiction is a bio-psycho-social disease and that all three components of the disease must be treated in order to stabilize from the disease process. The biologic part of the disease is treated with counseling and psychiatric care. The social aspect is to treat with a 12-step support and or other supportive groups for substance use problems.

- I agree to take my medication exactly as prescribed and not change the dosing in any way without discussing this with Dr. Warner at New Beginnings. This includes increasing, decreasing or changing the time of medication doses.
- I agree to see a substance abuse counselor during the first week of treatment. I will continue counseling, preferably individual and group, during the first several months of treatment, and I will bring documentations of counseling visits to New Beginnings.
- I agree to have a psychiatrist evaluation and ongoing psychiatric care, if Dr. Warner feels this is necessary for stabilization of my recovery process.
- I agree to attend 12 step meetings or other psychosocial support and bring documentation of this to each visit with Dr. Warner.
- I agree to sign releases for confidential information for all therapists, counselors, and psychiatrists so that Dr. Warner can coordinate care and have ongoing communication with them.
- I understand that violation of the above may be grounds for termination of my treatment.
  1. Dr. Warner must be informed of any additional medications that are currently being prescribed for you, regardless of the nature of the prescription.
  2. Patient agrees not to receive suboxone from any other physician. Refusal to comply with this will result in discharge from New Beginnings
  3. Lost or stolen medication WILL NOT be replaced under any circumstances.

I, the undersigned, agree to the above terms of this agreement.

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**Signature**

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**Date**

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**If Guardian, Full Name**

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**Date**

# PATIENT INTAKE: MEDICAL HISTORY

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Work) \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever had an EKG? \_\_\_ ( Y ) \_\_\_ ( N ) Date: \_\_\_\_\_

### Current of past medical Conditions (Check all that apply)

<input type="checkbox"/> Asthma/respiratory	<input type="checkbox"/> Cardiovascular (heart attack/ high cholesterol	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Epilepsy or seizure disorder	<input type="checkbox"/> GI disease
<input type="checkbox"/> Head Trauma	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Pancreatic problems	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> STDs	<input type="checkbox"/> Abnormal Pap smear	<input type="checkbox"/> Nutritional Deficiency

Other (Please Describe):

\_\_\_\_\_

\_\_\_\_\_

**If there is a family history of any of the illnesses listed above, please put an "F" next to that illness**

Is there family history of anything NOT listed here? (Please Explain):

\_\_\_\_\_

\_\_\_\_\_

Have you ever had surgery or been hospitalized? (Please Describe):

\_\_\_\_\_

\_\_\_\_\_

### Childhood Illnesses

Measles ( Y ) ( N )	Mumps ( Y ) ( N )	Chicken Pox ( Y ) ( N )
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Have you ever been treated for **substance misuse**? ( Y ) ( N )

If yes, please provider where and for how long?

\_\_\_\_\_

\_\_\_\_\_

How long have you been using substances?

\_\_\_\_\_

Have you or a family member ever been diagnosed with a **psychiatric or mental illness**? (Please describe):

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Have you ever taken or been prescribed **antidepressants**? ( Y ) ( N )  
If yes, for what reason?

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Medication(s) and dates of use:

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Why did you stop the medication(s)?

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Please list all current **PRESCRIPTION MEDICATIONS** and how often you take them (Example: Dilantin 3x daily). **DO NOT** include medications you may be currently misusing (that information is needed for later).

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Please list all current Herbal medicines, vitamin supplements, etc. and how often you take them:

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Please list any allergies you have: (Penicillin, bees, peanuts)

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## **TOBACCO HISTORY**

Cigarettes: Now? ( Y ) ( N )

In the past? ( Y ) ( N )

How many per day on average? \_\_\_\_\_

In the past? ( Y ) ( N )

Pipe: Now? ( Y ) ( N )

In the past? ( Y ) ( N )

How often per day on average? \_\_\_\_\_

For how many years? \_\_\_\_\_

## SUBSTANCE USE HISTORY

	NO	YES/PAST OR YES/NOW	ROUTE	HOW MUCH	HOW OFTEN	DATE/TIME OF LAST USE	QUANTITY LAST USED
Alcohol							
Caffeine (Pills or beverages)							
Cocaine							
Crystal Meth - Amphetamine							
Heroin							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Inhalants							
Other							

Did you ever stop using any of the above because of dependence? (Y) (N)

Please List:

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What was your longest period of abstinence?

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# PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(Circle One) - Married Single Long-term Relationship Divorced/Separated

Years married/in long – term relationship \_\_\_\_\_ Times married \_\_\_\_\_ Times Divorced \_\_\_\_\_

Children? (Y) (N)

Current ages (List): \_\_\_\_\_

Resident with you? (Y) (N) - If no, where? \_\_\_\_\_

Where are you currently living? \_\_\_\_\_

Do you have family nearby? (Y) (N)

Please describe: \_\_\_\_\_

Education ( Check most recent degree):

(O) Graduate School (O) College (O) Professional or Vocational School

(O) Highschool Grade: \_\_\_\_\_

Are you currently employed? (N) (Y) / If “NO” where were you last employed?

\_\_\_\_\_

What type of work do/did you do? \_\_\_\_\_

How long have/did you work(ed) there? \_\_\_\_\_

Have you ever been arrested or convicted? (Y) (N)

(O) DWI/DUI (O) Drug-related (O) Domestic Violence (O) Other

Have you ever been abused? (Y) (N)

(O) Physically (O) Sexually (including rape or attempted rape)

(O) Emotionally (O) Verbally

Have you ever attended:

AA – (O) Current (O) Past NA- (O) Current (O) Past CA- (O) Current (O) Past

ACOA – (O) Current (O) Past OA – (O) Current (O) Past

If you are not currently attending meeting, what factors led you to stop?

\_\_\_\_\_

Have you ever been in counseling therapy? (Y) (N) - (Please Describe)

\_\_\_\_\_

# PATIENT TREATMENT CONTRACT

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

1. I agree to comply to the payment policy outlined by this office.
2. I agree not to sell, share, or give any of my medications to another person. I understand that such mishandling of my medication is a serious violation of this agreement.
3. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
4. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by 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.
5. I agree that my medication/prescription can only be given to me at my regular office visits.
6. 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.
7. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
8. 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).
9. 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.
10. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
11. I agree to abstain from opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).

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**Patient Signature**

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**Date**

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**Physician Signature**

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**Date**

# **EXPLANATION OF TREATMENT**

## **PLEASE BRING YOUR LICENSE AND INSURANCE CARD**

### **INTAKE:**

You will be given a comprehensive substance dependence assessment, as well as an evaluation of mental status and physical exam. The pros and cons of the medications, SUBOXONE, will be presented. Treatment expectations, as well as issues involved with maintenance versus medically supervised withdrawal will be discussed.

### **INDUCTION:**

You will be switched from your current opioid (heroin, methadone, or prescription painkillers) on to suboxone. At the time of induction, you will be asked to provide a urine sample to confirm the presence of opioids and possible other drugs. You must arrive for the first visit experience mild to moderate opioid withdrawal symptoms. Arrangements will be made for you to receive your first dose shortly after your initial appointment. Your response to the initial dose will be monitored. You may receive additional medication, if necessary, to reduce your withdrawal symptoms.

Since an individual's tolerance and reaction to Suboxone **VARY**, daily appointments may be scheduled and medications will be adjusted until you no longer experience withdrawal symptoms or cravings, Urine drug screening is typically required for all patients at every visit during this phase.

**Intake and induction may both occur at the first visit, depending on your needs and your doctor's evaluation.**

### **Stabilization:**

Once the appropriate dose of suboxone is established, you will stay at this dose until steady blood levels are achieved. You and your doctor will discuss your treatment options from this point forward.

### **Maintenance:**

Treatment compliance and progress will be monitored. Participation in some form of behavioral counseling is strongly recommended to ensure best chance of treatment success. You are likely to have scheduled appointments on a weekly basis, however, if treatment progress is good and goals are met, monthly visits will eventually be considered sufficient. The maintenance phase can last from weeks to years the length of treatment will be determined by you and your doctor, and, possibly, your counselor. Your length of treatment may vary depending on your individual needs.

### **Medically Supervised Withdrawal:**

As your treatment progresses, you and your doctor may eventually decide that medically supervised withdrawal is an appropriate option for you. In this phase, your doctor will gradually taper your suboxone dose over time, taking care to see that you do not experience any withdrawal symptoms or cravings.



# EXPLANATION OF 1<sup>ST</sup> – VISIT – NO IN – OFFICE SUPPLY

Your first visit is generally the longest, and may last anywhere from 1 to 4 hours

When preparing for your 1<sup>st</sup> visit, there are a couple of logistical issues you may want to consider.

- You may not want to return to work after your visit-this is very normal, so just plan accordingly.
- Because suboxone can cause drowsiness and slow reaction time, particularly during the 1<sup>st</sup> few weeks of treatment, driving yourself home after the 1<sup>st</sup> visit is generally not recommended, you may want to make arrangements for a ride home.
- It is very important to arrive for your 1<sup>st</sup> visit already experiencing mild to moderate opioid withdrawal symptoms. If you are in withdrawal, buprenorphine will help lessen the symptoms. However, if you are not in withdrawal, buprenorphine will “override” the opioids already in your system, which will cause severe withdrawal symptoms.

The following guidelines are provided to ensure you are in withdrawal for the visit. (If this concerns you, it may help to schedule your first visit in the morning: some patients find it easiest to skip what would abnormally be their first dose of the day).

- **No methadone unless dosage is 30 mg or less and the last usage was at least 24 hours ago.**
- **No heroin or short-acting painkillers for a least 12 – 16 hours to prevent withdrawal symptoms.**

Bring ALL medication bottles with you to you 1<sup>st</sup> appointment.

Before you can be seen by Dr. Warner, all of your paperwork must be completed. So, bring all your completed forms with you or arrive about 30 minutes early. In addition, you will need to pay Dr. Warner’s fees prior to treatment.

Urine drug screening is a regular feature suboxone therapy, because it provides Dr. Warner with important insights into your health and your treatment. Your 1<sup>st</sup> visit will include urine drug screening. If you haven’t had a recent physical exam, Dr. Warner may require one. To help ensure that suboxone is the best treatment option for you, Dr. Warner will perform a substance dependence assessment and mental status evaluation. Lastly, you and Dr. Warner will discuss suboxone and your expectations of treatment.

After this portion of your visit is completed, you will be evaluated after 1 hour and possibly again after 2 hours. Once Dr. Warner is comfortable with your response, you can schedule your next visit and go home. Dr. Warner may ask you to keep a record of any medications that you take at home to control withdrawal symptoms. You will also receive instructions on how to contact Dr. Warner in emergency, as well as additional information about treatment.