Diligence Anesthesia Services, LLC
2860 S. Circle Drive suite 230
Springs, CO 80906

Phone: 719-464-6752 Colorado
Fax: 719-434-9925
Email: jana@ketaminecosprings.com

PATIENT INTAKE: MEDICAL HISTORY

Name _____

Address _____

City/State_____ Zip Code_____ E-mail_____

Phone (w) _____ (h) _____ (c) _____

DOB _____ Age _____SS# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

Current or past medical conditions (check all that apply)

( ) Asthma/respiratory	**( )** Cardiovascular	**( )** STDs
( ) Hypertension	**( )** Epilepsy or seizure disorder	**( )** GI disease
( ) Head trauma	**( )** HIV/AIDS	**( )** Diabetes
( ) Liver problems	**( )** Pancreatic problems	**( )** Thyroid disease

Other (Please describe) _____

_____

Have you ever had **surgery** or been **hospitalized**? (Please describe_____

_____

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

_____

Have you ever taken or been prescribed **antidepressants**? **( )** N For what reason _____
Medication(s) and dates of use _____ Why stopped _____

Please list all **current** prescription medications and how often you take them (DO NOT include medications you may be currently abusing (that information is needed later) _____

_____

_____

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)

_____

Tobacco History: Y/N Type: _____ Average / day_____ How many years?_____

Substance History

Have you ever been **treated for substance misuse**? Y/ N (Please describe when, where and for how long)

_____

Response to Treatment:_____

Period of Recovery:_____

History of overdose:_____

How long have you been using substances? _____

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							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Benzos							
Ecstasy							
Other							

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SOCIAL/FAMILY HISTORY

(Circle one) Married Single Long-term relationship Divorced/Separated

Children? **( )** N **( )** Y Current ages (list) _____

Residing with you? **( )** N **( )** Y If no, where? _____

Where are you currently living? _____

Do you have family nearby? **( )** N (Please describe) _____

Education (check most recent degree):

( ) Graduate school **( )** College **( )** Professional or Vocational School

( ) High School Grade _____

Are you currently employed? **( )** N Where (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? **( )** N

( ) DWI **( )** Drug-related **( )** Domestic violence **( )** Other

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

( ) Physically **( )** Sexually **( )** Verbally **( )** Emotionally

Have you ever attended:

AA **( )** Current **( )** Past **NA** **( )** Current **( )** Past

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

Have you ever been in counseling or therapy? Y N (Please describe) _____

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PATIENT TREATMENT CONTRACT

Patient Name _____ **Date** _____

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

1. I agree to keep and be on time for my scheduled appointments and report for random & scheduled urine drug tests when directed.

2. I agree to adhere to the payment policy outlined by this office. In particular, cancellations with less than 24 hours notice or failure to show for an appointment are subject to a $100 fee and may be cause for dismissal.

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 medication 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 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 without any recourse for appeal.

7. I agree that my 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 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 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, Ativan 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 counseling as discussed and agreed upon with my doctor.

13. I agree to abstain from opioids, and other addictive substances (excepting nicotine).

14. I agree to provide random urine samples and be subject to random pills/ filmstrip counts. Failure to provide updated telephone numbers and addresses or failure to respond to telephone calls or mail may be grounds for dismissal.

15. I understand that violations of the above may be grounds for termination of treatment.

Patient Signature _____ Date _____

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Rural Outreach Program, Telemedicine
Consent Form

There is a $35 annual fee to engage in this service. I am required to have at least one face to face visit every 12 months for a physical exam.

I understand the following:
1. I will engage with my provider in a telemedicine consultation at doxy.me/drgainok. I will be asked to report for random and scheduled urine drug tests as appropriate by my provider. Failure to do so within 72 hours is grounds for dismissal from the telemedicine program.
2. How the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. My healthcare information may be shared with other individuals to schedule, coordinate care, or clarifying pharmacy issues. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. Emergency medical services during the visit may be limited as part of the nature of telemedicine. If the telemedicine visit is not conducted in a medical facility, emergency medical services will be limited to contacting 911 for assistance.
8. I have had a face to face conversation with my doctor, during which I had the opportunity to ask questions regarding my treatment. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
9. Payments are due at least 4 hrs prior to their scheduled follow up visit, otherwise my appointment will be canceled.
10. If my card is declined, I am required to pay by a different card or my visit will be cancelled.
11. Two reschedules due to credit card decline is reason for termination.
12. If I do not connect to my appointment link within 10 minutes of my scheduled visit, I will be considered a no-show and a $100 fee will be charged to my credit card on file, and I will not be able to reschedule unless my fee is paid.
13. I need to be in a location that has adequate wi-fi or cellular service to allow an uninterrupted and private video conference with the prescriber. If there is an issue with connection I will contact Diligence Anesthesia Services by phone, within that 10 min window to be assisted.
14. I may log on beforehand to ensure setup is done prior to the visit. After I click on the link I will be placed in a virtual waiting room for my visit. It is my responsibility to ensure my audio and video capabilities are operating correctly, otherwise my visit will not be successful.

_____ _____
Patient Signature Date

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TELEPHONE APPOINTMENT REMINDER CONSENT

I _____ give _____
Patient Name (Print) Physician Name (Print)

and members of his/her staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):

□ Home _____

□ Work _____

□ Cell _____

Yes, this office may leave (check all that apply):

□ Voice mail at my Home □ Voice mail at my Work □ Voice mail on my Cell

□ Messages with people at my Home □ Messages with people at my Work

□ NO, do not text or email

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.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

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CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Diligence Anesthesia Services, LLC at the above address to:

□ Receive/ release my treatment records from the following providers:
Name and address:

_____

_____

_____

This information is for the following purposes (any other use is prohibited): Treatment of substance dependence.

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 in 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.

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 Date

_____ _____ _____
Parent/Guardian Signature if applicable Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

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APPOINTED PHARMACY CONSENT

I _____ do hereby:
Patient Name (Print)

□ Authorize Center for Diligence Anesthesia Services, LLC at the above address to disclose my treatment for opioid dependence to employees of any pharmacy. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my prescriptions directly to the pharmacy.

□ Agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary, so that my 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 in reliance on it. This consent will last while I am being treated for opioid dependence by my treatment provider unless I withdraw my consent during treatment.

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, As of January 25, 2021.

_____ _____
Patient Signature Date

_____
Parent/Guardian Signature if appropriate

_____ _____
Parent/Guardian Name (Print) Date

_____ _____
Witness Signature Date

Witness Name (Print) _____

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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.

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Notice of Privacy Practices

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information and treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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

This notice is effective as of January 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Diligence Anesthesia Services, LLC
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Colorado Springs, CO 80906
Phone: 719-464-6752
Fax: 719-434-9925

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775