R.O.A.D.
To A Better Life

Patient Registration and Consent for Treatment

All New Patient forms: FAX to 603-692-1070

Services Interested in: ☐ Suboxone Treatment ☐ IOP ☐ Vivitrol

Name (First, MI, Last):_____ **Gender**: ☐ Male ☐ Female

Date of Birth: _____/_____ /_____ **Marital Status:** ☐ Single ☐ Married **Social Security #**: _____ - _____ - _____

Address:_____

City, State: _____ **Zip Code**: _____

Phone (Home):_____ **Phone** (Cell):_____ **Phone** (Work):_____

Email: _____ **Primary Care Provider:**_____ **Referring Provider:**_____

*We may wish to communicate upcoming appointment information, test results and/or other information regarding your medical care. What is the best phone number for contact where we may also leave messages? ☐ Home ☐ Cell ☐ Work

Emergency Contact: _____

Relationship: _____ Phone:_____

- Can the above listed contact (with photo identification) pick up prescriptions if you are unavailable? ☐ Yes ☐ No
- If you would like to give us permission to discuss personal information in your medical record with someone other than yourself, please fill out the **Permission to Discuss Form**.

Race
☐ White
☐ Black or African American
☐ Asian
☐ Other: _____
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

Preferred Language
☐ English
☐ Other:_____

Ethnicity
☐ Non-Hispanic or Latino
☐ Hispanic or Latino
☐ Other

Insurance Information* *(please present card for copying)*

Primary Insurance: _____
Insurer ID#:_____
Group #:_____
Claims Address: _____
Subscriber: _____
Subscriber's Date of Birth:_____
Relationship to patient:
☐ Self ☐ Spouse ☐ Other

Secondary Insurance: _____
Insurer ID#:_____
Group #:_____
Claims Address: _____
Subscriber: _____
Subscriber's Date of Birth:_____
Relationship to patient:
☐ Self ☐ Spouse ☐ Other

- **The above information is thorough and accurate to the best of my knowledge. Any changes to the above information will be communicated with the office.**
- **I consent to evaluation and treatment by any provider at ROAD to a Better Life. I hereby authorize release of medical information that is necessary for my further treatment.**

_____ _____
Patient Signature (or Guardian) Date

R.O.A.D.
To A Better Life

Financial Policy and Consent for Billing
Consent for Treatment
Receipt of Documents

Payment Policy:
We ask that you read through the financial policy and sign the bottom prior to treatment. Co-pays are due at the time of service, or full payment is due for self-pay patients unless prior arrangements have been made with our billing department. We accept cash or credit cards (Visa, MasterCard and Discover). On a limited basis checks may be accepted and there is a service charge on any returned check; payment in full will be required within 10 days of notice.

Insurance:
Our office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. Please realize that you have the **ultimate responsibility of verifying the coverage with your insurance.** You acknowledge that we may be an out of network provider with your insurance. You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. You will be responsible for any balance not paid or denied by your insurance carrier. Patients who do not supply accurate insurance information will be considered self-pay. You must inform our office of any changes in your insurance, as you are the policyholder and it is your responsibility.

Insurance Referrals:
If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you will be responsible for charges. You understand that you are financially responsible for claims denied or not covered by your insurance carrier for failure to obtain a referral.

Missed Appointments:
If you are unable to keep your appointment you must notify the office at least 24 hours prior to your scheduled appointment as courtesy to the doctors, staff and other patients. If you cancel or "no-show" without sufficient notice, you may be subject to a fee, payable by you, not your insurance company.

Please let us know if you have any questions regarding our Financial Policy.

I consent to evaluation and treatment by any provider at ROAD. I hereby authorize release of medical information that is necessary for my further treatment.
I have read and agree to the terms of the above information. I understand payment is expected at the time services are rendered and that I am responsible for any balance.
I, the undersigned, hereby authorize and direct my insurance carrier to pay benefits for services rendered, directly to PMC Medical Group, LLC or any of its affiliates.

Patient Name (Please print):_____ **DOB** _____

Signature of Patient (or Legal Representative):_____ **Date:** _____

_____ **Patient:** ***Complete Receipt of Documents below at the ROAD Office*** _____

Receipt of Documents

I have received and understand the information contained in the following documents:

1. Notice of Privacy Policies
2. Patient Bill of Rights & Responsibilities
3. Patient Bill of Rights ~ Mental Health
4. Patient Complaint Procedure
5. Advance Directives Information
6. Alcohol & Drug Confidentiality Notice

Signature of Patient (or Legal Representative):_____ **Date:** _____

Signature of Witness:_____ **Date:** _____

R.O.A.D.
To A Better Life

Permission to Discuss

Name (First, MI, Last)_____

Mailing Address_____Town/City/Zip_____

Phone Number (H)_____ (C)_____ (W)_____

I _____give Permission to ROAD to a Better Life, to discuss/release the following medical information about me.

(Check all that apply):

- ☐ Medical information, including but not limited to, my symptoms, diagnosis, medications and treatment plan.
- ☐ Behavioral health information, including but not limited to, my symptoms, diagnosis, medications and treatment plan
- ☐ Chemical Dependency information, including but not limited to, my symptoms, diagnosis, medications and treatment plan
- ☐ Lab, X-Ray/other test results
- ☐ Only medical information related to: _____
- ☐ Billing Questions (Balances, Insurance Issues & Copies of Bills)
- ☐ Other (be specific) _____

ROAD to a Better Life, has my Permission to discuss/release the above information with: (spouse, parent, probation officer, lawyer)

Name: _____ Name: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

Medical records are defined as: *All health information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all health care information in your/our possession, whether generated by you/us or any other source, as well as health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, and HIV status an/or diagnosis of AIDS and /or other sexually transmitted diseases including hepatitis, unless restricted above.*

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Medical Records Department, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be re-disclosed by the recipient and no longer protected under federal law.

_____ **Date**: _____

Signature of Patient or Legal Representative

Witness _____ **Date**: _____

R.O.A.D. To A Better Life

Health History Form

Name: _____ **Date of Birth**:_____/_____/_____

Reason for today's visit: _____

CURRENT MEDICATIONS

Name of Medication	**Strength** (ex. 500 mg)	**Dosing Instructions** (ex. Twice a day)

ALLERGY HISTORY

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	**Reaction** (ex. Rash, nausea, respiratory, shock, etc.)

SOCIAL HISTORY *(Please circle all applicable responses)*

Marital Status	Single Significant Other Married Divorced Widowed	
Sexual Orientation	Heterosexual Gay Lesbian Bisexual Transgender	
Living Situation	Alone Spouse/Significant other Children/Family Homeless Residential Other:	
Females- Are you pregnant?	Yes / No Hysterectomy Menopause Tubal ligation	
What are your hobbies?		
Education (highest level)	9 10 11 12 Some college Associates Bachelors GED Masters PhD	
Employment?	Full-time Part-time Unemployed Seeking employment Disabled Retired	
If yes, Employer:	Occupation: # of Years:	
Previous work experience?	Yes / No	If yes, description:
Military History	None / Past / Current	Army Navy Marines Coast Guard National Guard
Combat?	Yes / No	If yes, Where:
Discharge?	Yes / No	If yes: Honorable General Dishonorable Retired Other
VA Disability?	Yes / No	If yes, due to:
Spiritual/ Religious Affiliation?	Yes / No	Practicing/ Role of Faith Past & Present?
Receiving Benefits?	Yes / No	APTD SSI SSDI Food Stamps Fuel Asst. Section 8 Disability Public/HUD Housing PASS Plan Workers comp Unemployment

			If applicable, amount?
Tobacco Use? *If no, have you ever?*	Yes / No Yes / No	Cigarettes / Cigars / Chew Cigarettes / Cigars / Chew	Per day: Per day:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	Per day:
Do you exercise?	Yes / No	Type?	
Do you wear your seatbelt?	Yes / No	If yes, percent of time:	

R.O.A.D.
To A Better Life

MEDICAL HISTORY *(Please check any of the following that you have or have had in the past)*

☐ Acid Reflux/GERD	☐ Cancer	☐ Headaches	☐ Liver Disease
☐ ADHD	☐ Chronic Cough	☐ Hearing Loss	☐ Osteoporosis
☐ Alcoholism	☐ Chronic Pain	☐ Heart Disease	☐ Seizure Disorder
☐ Anemia	☐ COPD/Emphysema	☐ Hepatitis	☐ Sexually Transmitted Disease
☐ Anxiety	☐ Dementia	☐ High Blood Pressure	☐ Stroke
☐ Arthritis	☐ Depression	☐ High Cholesterol	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ HIV/AIDS	☐ Tuberculosis
☐ Bleeding Disorders	☐ Eating Disorder	☐ Kidney Disease	☐ Other: _____
☐ Bowel Problems	☐ Glaucoma/Cataracts	☐ Immune Disorders	

- Are you/do you have: Obsessive compulsive? _____ Eating disorder? _____ Panic Attacks?_____
- Have you participated in high-risk sexual practices?_____ If so, please describe: _____
- Have you had Hepatitis? Yes ☐ No ☐ Venereal Disease? Yes ☐ No ☐ Last HIV test _____

  Results? _____
- Do you now have, or have you ever had, seizures or convulsions? Yes ☐ No ☐

  If yes, when, and what condition caused them? _____When was the last seizure or convulsion? _____

For Women Only:

At what age did you start to menstruate? _____

Do you now have, or have you had, any problems with your menstrual period? ☐ Yes ☐ No

If yes, please describe these problems: _____

Have you had any:

Pregnancies? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Miscarriages? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Abortions? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Menopausal symptoms or treatment? If yes, when?_____

For Men Only:

Do you now have, or have you had, problems with your prostate, difficult or painful urination, or impotence?

Yes ☐ No ☐ If yes, please describe those problems: _____

FAMILY HISTORY (*Please tell us about your immediate family)*

CHILDREN ☐ None

First Name	Last Name	Age	Living With?	Custody?	Quality of Relationship
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	

SPOUSE/SIGNIFICANT OTHER ☐ None

Name	Age	Occupation	Quality of Relationship

Relationship	Age	Marital Status	Occupation	Living with?	Quality of Relationship
Mother				Yes / No	
Father				Yes / No	
Sibling:				Yes / No	
Sibling:				Yes / No	
Sibling:				Yes / No	
Other:				Yes / No	

Place of Birth: **Place of upbringing**:

Family is: Intact Parents Separated/Divorced Parents Remarried

Resided with: Mother Father Adopted Orphaned Other:

Health History	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/ Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy					
Asthma					
Blood Disease					
Other:					

Contact with Family (check all that apply)

☐ Visit at least monthly
☐ Supportive
☐ Non-supportive
☐ Not satisfied with family relationship/contact
☐ Involved with treatment providers
☐ Knowledgeable about mental illness
☐ Involved in NAMI or other support group
☐ Family is available locally
☐ Family members not available
☐ Satisfied with family/relationship contact

SUBSTANCE ABUSE HISTORY

Family Substance Abuse (*Please check any family that apply, and list substance abused)*

☐ None ☐ Parents:_____ ☐ Siblings:_____ ☐ Extended Family:_____

Do you or your family think you have a problem with:

Shopping? Yes ☐ No ☐ Barbiturates? Yes ☐ No ☐ Internet? Yes ☐ No ☐

Sex Addiction? Yes ☐ No ☐ Gambling? Yes ☐ No ☐

Have you had any previous rehab or **treatment of substance abuse?** Yes ☐ No ☐

Where?	Reason there?	How Long?	In patient/ Outpatient?	Date

(Please indicate which of the following drugs you have used, if any)

Substance	Age at first use	How often you use	How much you use	Method (s) you use	How long since last use
Alcohol					
Methamphetamine					
Amphetamine					
Barbiturates					
Cocaine (powder)					
Cocaine (crack)					
Hallucinogens					
Heroin					
Methadone					
Morphine					
Opium					
Inhalants					
Marijuana/Hashish					
PCP (Angel Dust)					
Ketamine (Special K)					
Ecstasy (x)					
Other: _____					

Did/do you go to "meetings?" _____ Do you have a sponsor? _____

Do you see a psychiatrist and if so who and how long? _____

Do you see a therapist or counselor and if so who and how long? _____

Have you ever been treated for depression if so when? _____

LEGAL HISTORY (*Please report any and all legal issues)*

Legal or Criminal Involvement?	Yes / No	*Court order* *Probation* *Parole* *Restraining Order*	
Found not competent to stand trial *Homicide or attempted homicide* *Sexual Assault* *Arson* *Assault* *Felony*			
Probation/Parole Officer	Current / Past	Name:	County:
DUI (date):	**Warrants** (date):		**Violent Crime** (date):
Incarceration, date(s):		How long:	Reason:
Do you have firearms at home?	Yes / No	*If yes,* Are they locked?	Yes / No

MENTAL HEALTH

***Stressful events over the last year*:**

- ☐ Recent Hospital Discharge
- ☐ Death/ Divorce/ Separation
- ☐ Relationship problems
- ☐ Move
- ☐ Educational Problems
- ☐ Housing Problems
- ☐ Access to Healthcare
- ☐ Witness/Victim of Violence
- ☐ History/Current Abuse
- ☐ Disability (self or family)
- ☐ Parenting Issues
- ☐ Job Loss
- ☐ Financial Problems
- ☐ Legal Problems
- ☐ Social/Environmental Problems
- ☐ Other Family Problems
- ☐ Health Problem: _____
- ☐ Other: _____

Please check symptoms experienced in the last 4 weeks:

MOOD ☐ Depression ☐ Anxiety ☐ Hopelessness	☐ Mood Changes ☐ Sadness ☐ Elation (happier than normal) ☐ Anger/Rage	☐ Overwhelming guilt/shame ☐ Difficulty enjoying life ☐ Irritability
BEHAVIORS ☐ Hurting yourself ☐ Doing the same thing repeatedly	☐ Uncontrolled spending/gambling ☐ Increased alcohol/drug use	☐ Reckless behavior ☐ Social Isolation
PHYSICAL ☐ Increased Sleep ☐ Decreased Sleep ☐ Difficulty Sleeping	☐ Panic/ Anxiety Attacks ☐ Increased Appetite/ weight gain ☐ Decreased Appetite/ weight loss ☐ Disturbing nightmares/dreams	☐ Agitation/Restless ☐ Unusual sensory experience (smell, taste) ☐ Other (specify):
THINKING ☐ Wanting to take your life ☐ Wanting to hurt someone else ☐ Seeing/Hearing things that aren't there ☐ Difficulty concentrating	☐ Intrusive negative thoughts ☐ Flashbacks ☐ Irrational fear ☐ Racing thoughts ☐ Paranoia	☐ Low self-esteem ☐ Academic/work problems ☐ Easily distracted ☐ Thinking same thought repeatedly ☐ Memory problems
INTERPERSONAL ☐ Increased conflict w/ others ☐ Increased family conflict ☐ Difficulty making/keeping friends	☐ Socially withdrawn/isolation ☐ Increased sexual problems/concerns ☐ Increased social anxiety ☐ Problems with intimacy	☐ Increased difficulty tolerating others ☐ Trouble with law/authority figures ☐ Intermittent relationships

TREATMENT QUESTIONAIRE

Have you had any previous **psychiatric hospitalizations?** Yes ☐ No ☐

Where	When	Reason

Have you had any previous **outpatient mental health treatment?** Yes ☐ No ☐

Where	When	Reason

Have you had any previous **prescribed psychiatric medications?** Yes ☐ No ☐

Medication	Prescribing Doctor	Dates

Have any family members had a history of **mental illness?** Yes ☐ No ☐

Persons	Diagnosis or Symptoms	Treatments

Have you ever experienced any **trauma**? Yes ☐ No ☐

If yes, have you been: ☐ Neglected ☐ Physically Abused ☐ Emotionally Abused ☐ Sexually Abused ☐ Don't Know

Any other incidents of **trauma**: ☐ Acts of War ☐ Witness/Victim of violence ☐ Serious Accidents ☐ Fire ☐ Other

Describe:

How are you **sleeping**? (Describe any recent changes or problems)

How is your **appetite**? (Include any recent weight changes)

What **leisure or stress reduction activities** do you use?

Past **interests/activities**:

Do symptoms interfere with your ability to work or get things done? Yes ☐ No ☐

Additional Comments/Information:

The above information is thorough and accurate to the best of my knowledge.

_____ _____

Patient Signature (or Guardian) **Date**

R.O.A.D. To A Better Life

www.roadtoabetterlifenh.com

Informed Consent and Treatment Agreement for Subutex®/Suboxone® (Buprenorphine)

Name of Patient _____ Date of Birth:_____

Please initial all items

1. ☐ I understand the frequency of visits will be weekly at first and then biweekly. As my recovery progresses, with the completion of group therapy and maintenance of personal psychotherapy, my visits may extend out to 4 weeks. I understand that if I relapse or miss appointments then I will return to weekly visits until assurance in my recovery is reestablished. I must call 24 hours prior to canceling an appointment. If I miss an appointment without contacting my provider: I may be asked to return to more frequent visits, I may not have my medication refilled until I am seen again, and I may be discharged.

2. ☐ I understand that if I am not seen in the office as prescribed by my provider, I will be unable to obtain my prescriptions and I will be discharged from the ROAD program.

3. ☐ I agree to take Buprenorphine as prescribed/directed at the dosage determined by my providers; and not to allow anyone else to take medications prescribed for me.

4. ☐ I understand that I **will be required** to attend AA/NA meetings (with proof of attendance) and/or therapy/counseling in a group or individual setting.

5. ☐ I agree not to take any other medications with Buprenorphine without prior permission from my provider. I understand that overdose deaths have occurred when patients have taken other medications (particularly medications like **Librium®, Valium®, Xanax®, Klonopin®** or other benzodiazepines) with Buprenorphine.

6. ☐ I understand that combining illegal substances with prescribed medication increases my risk of breathing difficulties, heart disorders, and sudden death. If I do so, I may be discharged from the practice.

7. ☐ I understand that the Buprenorphine providers **will not be available** to prescribe medication during evenings, weekends, or after 12 noon on Fridays**.** It is my responsibility to **call my provider at least 2(two) *business* days in advance** of running out of medications.

8. ☐ It has been explained to me and I understand that Buprenorphine itself is an opiate drug, although a partial agonist, it can still produce physical dependency in non-opiate dependent patients.

9. ☐ The goal of treatment of opiate dependency is to learn to live without abusing drugs. Buprenorphine treatment should continue as long as necessary to prevent relapse to opiate abuse/dependence and then be weaned off.

10. ☐ If I have been on Methadone maintenance, I agree that my provider can coordinate my medication switch with the provider of Methadone. This may involve exchange of medical records and discussions with the Methadone clinic, physician or staff. **After switching to Buprenorphine, I will not take Methadone.**

11. ☐ I will submit my own urine specimen for drug screen (narcotic, pot, cocaine, amphetamine, PCP, alcohol, benzodiazepine, and others) upon my provider's request as often as directed. My Buprenorphine provider may ask that a clinical staff member observe me providing the appropriate specimen. If my drug screen indicates the presence of illegal/inappropriate substances, or has no buprenorphine or buprenorphine metabolites, I will be discharged.

12. ☐ I understand that I will be required at any time with short notice to bring in my medication for inspection and counting. If I do not show or have the appropriate amount of medication, I may be discharged. I may never dispose of medication myself without a staff member as a witness.

13. ☐ I understand that I must call **at least 24 hours** prior to any appointment if I need to cancel. If I do not come for my appointment or I fail to provide sufficient notice, I am subject to a 'no show' cash fee.

☐ 14. I allow my provider to communicate with other providers regarding my medical care, consistent with HIPAA guidelines. Treatment disclosure may include, but is not limited to, discussing my medications with the pharmacist. I understand that records released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may contain confidential information about communicable diseases including HIV (AIDS) or related illnesses.

☐ 15. I will not sell, share, or trade my medication with anyone. It is understood that if caught doing so, I will be discharged without the chance to be readmitted.

☐ 16. **I will safeguard my written prescription** and medication from loss**,** damage or theft. We recommend a lock box especially for those with children. Lost, stolen or damaged prescriptions/medications may be replaced at the provider's discretion. If replaced, no prior authorization will be completed and you will be responsible for any prescription costs in such cases.

☐ 17. I will never alter a prescription in ANY way. I understand this is a felony, punishable by incarceration.

☐ 18. I authorize the Buprenorphine provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including New Hampshire's Board of Pharmacy and the DEA, in the investigation of any possible misuse, prescription forgery, sale or any other diversion of my medication.

☐ 19. I allow my Buprenorphine provider to receive information from any pharmacy I have used.

☐ 20. I will have all my medications filled only at the pharmacy I have listed below. I will inform my Buprenorphine provider of any pharmacy changes

☐ 21. I understand that rude or disrespectful treatment of staff is not tolerated and may result in my discharge. (Ex: using profanity, raising my voice, making vulgar or inappropriate comments)

☐ 22. [For women of childbearing potential] I agree to tell my physician if I become pregnant or even think I may be pregnant.

☐ 23. I understand that I must provide a viable contact number at all times (and will update the office of any changes) or my provider may not prescribe medications.

☐ 24. I understand the commitment to the program and the many appointments, therefore transportation cannot be an issue or a reason for short notice cancelations or no show appointments.

☐ 25. I understand that my prescription will need to be filled immediately following my appointment while our staff is still available to take care of any questions or issues at the pharmacy.

I have read and understand the above details about buprenorphine treatment and I wish to be treated with buprenorphine.
I have been given the opportunity to have any questions addressed regarding the above.

Name _____

Pharmacy _____ Town _____ Phone _____

Primary Care Provider _____ Town _____ Phone _____

Signature _____ Date _____

Witness _____ Date _____

☐ **2 copies given to patient**
Two copies of this form are to be given to the patient after they sign; one for their records and one for the Pharmacy's records.

Road to a Better Life
Main Office: 255 Route 108, Somersworth, NH 03878
Ph: 603.841.2301 **Fax**: 603.692.1081
RoadtoabetterlifeNH.com

Protected Health Information (PHI) Release Authorization-Criminal Justice

Applies to: information related to criminal justice system duty to monitor patient progress (prosecuting attorney, court, probation, parole)

Name (First, MI, Last)_____DOB _____-_____-_____

Mailing Address_____City/State/Zip_____

Phone Number (H)_____ (C)_____ (W)_____

I hereby authorize disclosure of my Protected Health information as follows:

Duration of consent: DATES OF SERVICES from _____ to _____

(Duration: anticipated length of treatment, type of criminal proceeding, expected final disposition)

TYPE OF RECORDS REQUESTED: (please check your request)

Specific Items (may include information related to Mental Health, Drug/Alcohol, Genetic Testing, HIV/AIDS and Psychotherapy, & External Records)

____Office Visit Notes ____Lab Results ____Imaging Reports ____Procedure/Surgery Notes

____Consultations ____Test Results ____Medications/Pharmacy ____Billing Reports

____Mental Health ___HIV/AIDS ____Alcohol/Drug/Substance Abuse ____Genetic Testing ____Psychotherapy

___ Entire medical record (includes Mental Health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, Psychotherapy, & External Records)

___ Other: _____

_____

TO BE OBTAINED FROM:

or Facility:__ **ROAD to a Better Life** _____

Address: _____

_____

Phone: _____ Fax: _____

TO BE RELEASED TO:

Entity: _____

Address: _____

_____

Phone: _____Fax: _____

REASON FOR RELEASE: (Check only one) ____ Criminal Justice System ____ Legal

____ Other: _____

I, THE PATIENT OR LEGAL REPRESENTATIVE OF PATIENT, UNDERSTAND:

- I understand that this consent is revocable upon the passage of the specified amount of time or the occurrence of a specified event. This consent becomes revocable no later than the final disposition of the conditional release or other actions in connection with which this consent is given. (except where a disclosure has already been made in reliance on my prior authorization.)
- I may choose to refuse to sign this form.
- I have the right to inspect or copy the information I am consenting to release within the organization's established policies.
- My right to healthcare treatment is not conditioned on this authorization.
- I understand that disclosure of this information carries with it the potential for re-disclosure and the information may not be protected by federal/state confidentiality rules.
- There may be a charge for the requested records.
- Unless otherwise specified, release may be in any reasonable manner including: verbal, paper, unencrypted fax/electronic.

PATIENT/REPRESENTATIVE SIGNATURE: _____ Date: _____

Legal Representative Name: _____ Relationship: _____

WITNESS SIGNATURE: _____ Date: _____

Drug or Alcohol Abuse treatment information (covered by 42 CFR Part 2 C 2.35): The Federal rules state that a person who receives patient information relative to this consent may redislcose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent is given.

Road to a Better Life
Main Office: 255 Route 108, Somersworth, NH 03878
Ph: 603.841.2301 **Fax**: 603.692.1081
RoadtoabetterlifeNH.com

Protected Health Information (PHI) Release Authorization

Name (First, MI, Last)_____DOB _____-_____-_____

Mailing Address_____City/State/Zip_____

Phone Number (H)_____ (C)_____ (W)_____

I hereby authorize disclosure of my Protected Health information as follows:

FOR THE <u>DATES OF SERVICES</u> from _____ to _____

<u>TYPE OF RECORDS</u> REQUESTED: (please check your request)

Specific Items (<u>may</u> include information related to Mental Health, Drug/Alcohol, Genetic Testing, HIV/AIDS and Psychotherapy, & External Records)

____Office Visit Notes ____Lab Results ____Imaging Reports ____Procedure/Surgery Notes

____Consultations ____Test Results ____Medications/Pharmacy ____Billing Reports

____Mental Health ___HIV/AIDS ____Alcohol/Drug/Substance Abuse ____Genetic Testing ____Psychotherapy

___ Entire medical record (<u>includes</u> Mental Health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, Psychotherapy, & External Records)

___ Other: _____

_____

TO BE OBTAINED <u>FROM</u>: ___ Our Organization **TO BE RELEASED <u>TO</u>:** ___ Our Organization

or Facility:_____ or Facility: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Fax: _____ Phone: _____Fax: _____

REASON FOR RELEASE: (Check only one) ___ Transfer of Care ____ Ongoing Care/Specialist

____ Legal ___ Personal ____ Billing/Insurance ____ Other: _____

I, THE PATIENT OR LEGAL REPRESENTATIVE OF PATIENT, UNDERSTAND:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I may choose to refuse to sign this form.
- I have the right to inspect or copy the information I am consenting to release within the organization's established policies.
- My right to healthcare treatment is not conditioned on this authorization.
- I understand that disclosure of this information carries with it the potential for re-disclosure and the information may not be protected by federal/state confidentiality rules.
- There may be a charge for the requested records.
- This release will expire 12 months after date of signature unless date is specified: _____
- Unless otherwise specified, release may be in any reasonable manner including: verbal, paper, unencrypted fax/electronic.

PATIENT/REPRESENTATIVE SIGNATURE: _____ Date: _____

Legal Representative Name: _____ Relationship: _____

WITNESS SIGNATURE: _____ Date: _____

Drug or Alcohol Abuse treatment information (covered by 42 CFR Part 2): The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CPR Part 2. A general authorization for the release of medical or other information is not sufficient of this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.