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

Permission to Discuss

Patient 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)
- ☐ Appointments: Schedule, Verify and/or Cancel Appointments
- ☐ 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

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

Patient Registration and Consent for Treatment
Financial Policy, Consent for Billing & Receipt of Documents

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 #**: _____ - _____ - _____

Mailing Address:_____ **City/State:** _____**Zip Code:** _____

Street 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 you 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* *(fill out completely))*

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

PATIENT: Please initial this page ☐ **and continue to Page 2 for signature** CPS Update/Staff Initial ☐

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

Patient Registration and Consent for Treatment
Financial Policy, Consent for Billing & 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.

The above information on all pages of this document is thorough and accurate to the best of my knowledge. For any changes to the above information, I will notify the office.
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 authorize release of information, including treatment and protected health information to my insurance company that is needed to process payment for services. I authorize my insurance carrier to pay benefits for services rendered, directly to PMC Medical Group, LLC or any of its affiliates.
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.

Patient Name (Please print):_____ DOB _____

PATIENT/Authorized Person SIGNATURE: _____ Date: _____

Authorized Person NAME (print): _____ Relationship: _____

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

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

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

- 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**

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 only to: Disclosures to elements of the criminal justice system which have referred patients for participations in a Part 2 Program (Substance Use Disorder Program) as a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody. Information related to criminal justice system duty to monitor patient progress (prosecuting attorney, court, probation, parole) (NOT for DCYF.)

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

Mailing Address_____City/State/Zip_____

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

I hereby authorize ROAD to disclose my Protected Health information as follows:

Specific REASON for Release: Criminal Justice System: _____ _____

Disclosure is made **only to** those individuals within the criminal justice system who have need for the information in connection with their duty to monitor the patients progress (e.g. a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or post-trial release, probation or parole officers responsible for supervision of the patient) AND the patient has signed a written consent to release.

Specify Release to WHO: Facility & Person:_____

Address: _____ Phone: _____ Fax: _____

Specify DURATION of Release Consent: DATES OF SERVICES from _____ to _____

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

Specify RECORDS to be released: Mark or describe

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

____Office Visit Notes ____Lab Results ____Imaging Reports ____Procedure/Surgery Notes

____Consultations ____Test Results ____Medications/Pharmacy ____Billing Reports

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

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

___ Other: _____

I, the Patient, OR Authorized Person 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/Authorized Person SIGNATURE: _____ Date: _____

Authorized Person NAME (print)**: _____ Relationship: _____**

Substance Abuse Disorder treatment information (covered by 42 CFR Part 2 C 2.35): Notice to recipient of protected information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The Federal rules state that a person who receives patient information relative to this consent may re-dislcose and use it **only** to carry out person's official duties with regard to the patient's conditional release or other action in connection with which the consent is given.
The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

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:

Specify REASON for Release: __ Transfer of Care __ Ongoing Care/Specialist __ Legal __ Personal
__ Billing/Insurance __ Other: _____

Specify WHO: Obtain FROM: ___ Our Organization **Release TO:** ___ Our Organization

Facility & Person:_____ Facility & Person:_____

Address: _____ Address: _____

_____ _____

Phone: _____ Fax: _____ Phone: _____Fax: _____

Specify DATES & RECORDS to be released: Mark or describe

Specify Dates of Service: from _____ to _____

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

____Office Visit Notes ____Lab Results ____Imaging Reports ____Procedure/Surgery Notes

____Consultations ____Test Results ____Medications/Pharmacy ____Billing Reports

____HIV/AIDS ____Alcohol/Drug/Substance Abuse ____Genetic Testing ____Mental Health

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

____ Other: _____

_____

I, the Patient, OR Authorized Person 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/Authorized Person SIGNATURE: _____ Date: _____

Authorized Person NAME (print)**: _____ Relationship: _____**

Substance Abuse Disorder treatment information (covered by 42 CFR Part 2): Notice to recipient of protected information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

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

Vivitrol Treatment Consent and Agreement

I. Vivitrol Medication Guide:

VIVITROL® (viv-i-trol) (naltrexone for extended-release injectable suspension)
Read this Medication Guide before you start receiving Vivitrol injections and each time you receive an injection. There may be new information. This information does not take the place of talking to your healthcare provider about your medical condition or your treatment.
What is the most important information I should know about Vivitrol?

Vivitrol can cause serious side effects, including:

1. Risk of opioid overdose. You can accidentally overdose in two ways.

•Vivitrol blocks the effects of opioids, such as heroin or opioid pain medicines. Do not take opioids, including opioid-containing medicines, such as heroin or prescription pain pills, to try to overcome the opioid blocking effects of Vivitrol. This can lead to serious injury, coma, or death.

•After you receive a dose of Vivitrol, its blocking effect slowly decreases and completely goes away over time. If you have used opioid street drugs or opioid-containing medicines in the past, using opioids in amounts that you used before treatment with Vivitrol can lead to overdose and death. You may also be more sensitive to the effects of lower amounts of opioids:

- ◦ after you have gone through detoxification
- ◦ when your next Vivitrol dose is due
- ◦ if you miss a dose of Vivitrol
- ◦ after you stop Vivitrol treatment

It is important that you tell your family and the people closest to you of this increased sensitivity to opioids and the risk of overdose. You or someone close to you should get emergency medical help right away if you:

•have trouble breathing •become very drowsy with slowed breathing
•have slow, shallow breathing (little chest movement with breathing)
•feel faint, very dizzy, confused, or have unusual symptoms

2. Severe reactions at the site of the injection (injection site reactions).

Some people on Vivitrol have had severe injection site reactions, including tissue death (necrosis). Some of these injection site reactions have required surgery. Call your healthcare provider right away if you notice any of the following at any of your injection sites: • intense pain • blisters • a dark scab • the area feels hard
• an open wound • lumps • large area of swelling

Tell your healthcare provider about any reaction at an injection site that concerns you, gets worse over time, or does not get better by two weeks after the injection.

3. Sudden opioid withdrawal.

Anyone who receives a Vivitrol injection must not use any type of opioid (must be opioid-free) including street drugs, prescription pain medicines, cough, cold, or diarrhea medicines that contain opioids, or opioid dependence treatments, buprenorphine or methadone, for at least 7 to 14 days before starting Vivitrol. Using opioids in the 7 to 14 days before you start receiving Vivitrol may cause you to suddenly have symptoms of opioid withdrawal when you get the Vivitrol injection.
Sudden opioid withdrawal can be severe, and you may need to go to the hospital. You must be opioid-free before receiving Vivitrol unless your healthcare provider decides that you don't need to go through detox first. Instead, your doctor may decide to give your Vivitrol injection in a medical facility that can treat you for sudden opioid withdrawal.
4. Liver damage or hepatitis. Naltrexone, the active ingredient in Vivitrol, can cause liver damage or hepatitis. Tell your healthcare provider if you have any of the following symptoms of liver problems during treatment with Vivitrol:

- yellowing of the whites of your eyes
- dark urine
- stomach area pain lasting more than a few days
- tiredness

Your healthcare provider may need to stop treating you with Vivitrol if you get signs or symptoms of a serious liver problem.

What is Vivitrol?

Vivitrol is a prescription injectable medicine used to:

- treat alcohol dependence. You should stop drinking before starting Vivitrol.
- prevent relapse to opioid dependence, after opioid detoxification. This means that if you take opioids or opioid-containing medicines, you must stop taking them before you start receiving Vivitrol.

To be effective, treatment with Vivitrol must be used with other alcohol or drug recovery programs such as counseling. Vivitrol may not work for everyone.

Who should <u>not</u> receive Vivitrol?

Do **not** receive Vivitrol if you:

- **are using or have a physical dependence on opioid-containing medicines or opioid street drugs**. To see whether you have a physical dependence on opioid-containing medicines or opioid street drugs, your healthcare

provider may give you a small injection of a medicine called naloxone. This is called a naloxone challenge test. If you get symptoms of opioid withdrawal after the naloxone challenge test, do not start treatment with Vivitrol at that time. Your provider may repeat the test after you have stopped using opioids to see whether it is safe to start Vivitrol.

• **are having opioid withdrawal symptoms.** Opioid withdrawal symptoms may happen when you have been taking opioid-containing medicines or opioid street drugs regularly and then stop. **Symptoms of opioid withdrawal may include:** anxiety, sleeplessness, yawning, fever, sweating, teary eyes, runny nose, goose bumps, shakiness, hot or cold flushes, muscle aches, muscle twitches, restlessness, nausea and vomiting, diarrhea, or stomach cramps. Tell your healthcare provider if you have any of these symptoms before taking Vivitrol.

• are allergic to naltrexone or any of the ingredients in Vivitrol or the liquid used to mix Vivitrol (diluent).

What should I tell my healthcare provider before receiving Vivitrol?

Before you receive Vivitrol, tell your provider if you:

• have liver problems • have kidney problems • use or abuse street (illegal) drugs
• have hemophilia or other bleeding problems • have any other medical conditions
• are pregnant or plan to become pregnant. It is not known if Vivitrol will harm your unborn baby.
• are breastfeeding. It is not known if Vivitrol passes into your milk, and if it can harm your baby. Naltrexone, the active ingredient in Vivitrol, is the same active ingredient in tablets taken by mouth that contain naltrexone. Naltrexone from tablets passes into breast milk. Talk to your doctor about whether you will breastfeed or take Vivitrol. You should not do both.

Tell your healthcare provider about all the medicines you take,

including prescription and non-prescription medicines, vitamins, and herbal supplements. Especially tell your healthcare provider if you take any opioid-containing medicines for pain, cough or colds, or diarrhea. If you are being treated for alcohol dependence but also use or are addicted to opioid-containing medicines or opioid street drugs, it is important that you tell your healthcare provider before starting Vivitrol to avoid having sudden opioid withdrawal symptoms when you start Vivitrol treatment. Know the medicines you take. Keep a list of them to show your healthcare provider and pharmacist when you get a new medicine.

How will I receive Vivitrol?

• Vivitrol is injected by a healthcare provider, about 1 time each month.
• Vivitrol is given as an injection into a muscle in your buttocks using a special needle that comes with Vivitrol.
• After Vivitrol is injected, it lasts for a month and it cannot be removed from the body.
• If you miss your appointment for your Vivitrol injection, schedule another appointment as soon as possible.
• Whenever you need medical treatment, be sure to tell the treating healthcare provider that you are receiving Vivitrol injections and mention when you got your last dose. This is important because Vivitrol can also block the effects of opioid-containing medicines that might be prescribed for you for pain, cough or colds, or diarrhea.
• Carry written information with you at all times to alert healthcare providers that you are taking Vivitrol, so that they can treat you properly in an emergency. Ask your healthcare provider how you can get a wallet card to carry with you.

What should I avoid while receiving Vivitrol?

Do not drive a car, operate machinery, or do other dangerous activities until you know how Vivitrol affects you. Vivitrol may make you feel dizzy and sleepy.

What are the possible side effects of Vivitrol?

Vivitrol can cause serious side effects, including:

• **Depressed mood.** Sometimes this leads to suicide, or suicidal thoughts, and suicidal behavior. Tell your family members and people closest to you that you are taking Vivitrol. You, a family member, or the people closest to you should call your healthcare provider right away if you become depressed or have any of the following symptoms of depression, especially if they are new, worse, or worry you:

• You feel sad or have crying spells. • You feel hopeless or helpless.
• You have trouble paying attention • You feel tired or sleepy all the time
• You are more irritable, angry, or aggressive than usual.
• You are no longer interested in seeing your friends or doing things you used to enjoy.
• You are sleeping a lot more or a lot less than usual.
• You are more or less hungry than usual or notice a big change in your body weight.
• You have thoughts about hurting yourself or ending your life.

• **Pneumonia.** Some people receiving Vivitrol treatment have had a certain type of pneumonia that is caused by an allergic reaction. If this happens to you, you may need to be treated in the hospital. Tell your healthcare provider right away if you have any of these symptoms during treatment with Vivitrol:

• shortness of breath or wheezing • coughing that does not go away

• **Serious allergic reactions.** Serious allergic reactions can happen during or soon after an injection of Vivitrol. Tell your ROAD provider or get medical help right away if you have any of these symptoms of a serious allergic reaction.

• skin rash • chest pain • trouble breathing or wheezing
• feeling dizzy or faint • swelling of your face, eyes, mouth, or tongue

Common side effects of Vivitrol may include:

- nausea. Nausea may happen after your first Vivitrol injection and usually improves within a few days. Nausea is less likely with future injections of Vivitrol.
- sleepiness • headache • dizziness • trouble sleeping • decreased appetite
- toothache • painful joints • muscle cramps • cold symptoms • vomiting

Tell your healthcare provider if you have any side effect that bothers you or that does not go away. These are not all the side effects of Vivitrol. For more information, ask your ROAD provider or pharmacist. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088. **General information about Vivitrol:** For more information about Vivitrol, call 1-800-848-4876, Option #1 or go to **www.vivitrol.com.**

What are the ingredients in Vivitrol? Active ingredient: naltrexone Inactive ingredient: polylactide-co-glycolide (PLG) Diluent ingredients: carboxymethylcellulose sodium salt, polysorbate 20, sodium chloride, and water for injection.

II. Vivitrol Patient Treatment Counseling and Treatment Agreement:

Patient Initial Each Item:

_____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/IOP and maintenance of individual 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 (ROAD provider): I may be asked to return to more frequent visits, may not have my medication refilled until I am seen again, and I may be discharged. I understand that if I am not seen in the office as prescribed by my provider, I will be unable to obtain my prescription since the injection is coordinated with monthly visits.

_____2. I agree to have my Vivitrol Rx mailed directly to the ROAD facility or to bring it directly from the pharmacy after picking it up, in its original packaging, without signs of tampering. It will be injected or stored for my future use due to storage and refrigeration requirements.

_____3. I agree not to take any **other medications** with Vivitrol without prior permission from my ROAD provider.

_____4. I understand that **goal of treatment** for alcohol and opioid dependency is to learn to live without abusing alcohol and drugs. Vivitrol injections should continue as long as necessary to prevent relapse and then stopped

_____5. I will submit a **urine specimen** (my own urine) for drug screen (narcotic, pot, cocaine, amphetamine, PCP, alcohol, benzodiazepine, and others) upon my providers request as often as directed. My 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, I may be discharged.

_____6. I understand that if I have previously used opioids, I may be more **sensitive to lower doses of opioids** and at risk of accidental overdose if I use opioids when my next dose is due, if I miss a dose, or after Vivitrol treatment is discontinued. It is important that I inform family members and people close to me of this increased sensitivity to opioids and the risk of overdose. I understand that because Vivitrol can block the effects of opioids, I may not perceive any effect if I self-administer heroin or any other opioid drug in small does while on Vivitrol. Further, I understand that administration of doses of heroin or any other opioid to try to bypass the blockade and get high while on Vivitrol may lead to serious injury, coma, or death. I understand that overdose deaths have occurred in the cases where opioid tolerant patients have tried to "over ride" the blocking action of Vivitrol with larger doses of opioids (even at doses previously tolerated).

_____7. I understand that I may not experience the expected effect from **opioid-containing** analgesic, antidiarrheal, or other antitussive (anti-cough) medications.

_____8. I understand that a **reaction at the site of Vivitrol injection** may occur. Reactions include pain, tenderness, induration, swelling, redness, bruising and itching. Serious injection site reactions including tissue death may occur. Some of these injection site reactions have required surgery. I should seek medical attention for worsening skin reactions.

_____9. I understand that I need to be off all opioids, including opioid-containing medicines, for at least 7-14 days before starting Vivitrol in order to avoid precipitation of **opioid withdrawal**. If I am transitioning from buprenorphine or methadone, I may be at risk for withdrawal for as long as two weeks. I understand that withdrawal caused by an opioid antagonist (Vivitrol) may be severe enough to require hospitalization if I have not been opioid-free for a sufficient number of days, and the withdrawal is different from the experience of spontaneous withdrawal that occurs with discontinuation of opioid in a dependent individual. I am not to take Vivitrol if I have any symptoms of opioid withdrawal. I understand that it is absolutely imperative that I notify my healthcare provider of any ALCOHOL dependence or of any recent use of opioids, or any history of opioid dependence before starting Vivitrol in order to avoid precipitation of opioid withdrawal.

_____10. I understand that Vivitrol may cause **liver injury** and I need to notify my healthcare provider if I develop symptoms and or signs of liver disease.

_____11. I understand that I may experience **depression** while taking Vivitrol. It is important that I inform family members and people close to me that I am taking Vivitrol and that they should call a doctor right away if I become depressed or experience symptoms of depression.

_____12. I understand that Vivitrol may cause an allergic **pneumonia**. I should immediately notify my physician if I develop signs and symptoms of pneumonia, including shortness of breath, coughing or wheezing.

_____13. I understand that I may experience **nausea/vomiting** following the initial injection of Vivitrol. These episodes of nausea tend to be mild and subside within a few days post-injection. Nausea is less likely with subsequent injections. I may also experience tiredness, headache, vomiting, decreased appetite, painful joints and muscle cramps.
_____14. I understand that **dizziness or fainting** may occur with Vivitrol treatment and I should avoid driving or operating heavy machinery until I have determined how Vivitrol affects me.
_____15. I understand **other side effects** include muscle cramps, somnolence or sedation, anorexia, decreased appetite or other appetite disorder, an elevation in eosinophils which resolves over time (and in rare instances eosinophilic pneumonia), inflammation of my nose and throat, insomnia, and toothache.
_____16. I understand that Vivitrol is **contraindicated** in individuals with acute hepatitis or liver failure, fulminent AIDS, opioid positive drug screens and any individual who have previously exhibited hypersensitivity to naltrexone, PLG (polylactide-co-glycolide), carboxymethylcellulose or any other component of the diluent.
_____17. I understand that once Vivitrol is injected, it is **not possible to remove it from my body**.
_____18. I understand that the use of Vivitrol is a form of **Medication Assisted Therapy** (MAT) helping me stay sober while I receive the appropriate psychotherapy needed for long term recovery. Vivitrol has been shown to treat alcohol and opioid dependence only when used as part of a treatment program that includes counseling and support. I will be required to attend AA meetings (with proof of attendance) and group therapy or IOP here at ROAD
_____19. I understand that I am to notify my ROAD provider if I am **breast-feeding**, if I **become pregnant**, if I think I might be pregnant, or if I am thinking about becoming pregnant.
_____20. 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 Hepatitis, HIV(AIDS) or related illnesses.
_____21. I will **never alter a prescription** in ANY way. I understand this is a felony, punishable by incarceration.
_____22. I authorize ROAD 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.
_____23. I allow ROAD to receive information from any pharmacy I have used.
_____24. 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).
_____25. 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.
_____26. I understand the **commitment** to the program and the many appointments, therefore transportation cannot be an issue or a reason for short notice cancellations or no show appointments.
_____27. Regarding **alcohol**: I understand that I am required to not have used alcohol or alcohol containing products for the past 4 days and that I am not having any signs of Delerium Tremens (DT's). I understand that DT's may be life threatening and if any signs occur I will call 911.
_____28. Regarding **opioids**: I understand that **I must be opioid drug free (detoxed) for 7 days and for 14 days detoxed from Methadone and Buprenorphine.** If I am not detoxed than the Vivitrol injection **will** precipitate immediate and sometimes severe opioid withdrawal (to include but not limited to nausea, vomiting, muscle cramps, tremors, headache and sweating).
_____29. I understand that I need to **carry documentation** to alert medical personnel to the fact that I am taking Vivitrol (naltrexone for extended-release injectable suspension). This is important information if I need to obtain medical treatment in an emergency and am unable to tell other health care providers that I am on Vivitrol.. I agree to wear a medical alert (card, bracelet, dog tags).

I have read and understand all the information about Vivitrol treatment. I have received answers to any questions I have. I agree that I am responsible to abide by these instructions. I wish to be treated with Vivitrol.

Name _____ Date of Birth _____

Pharmacy _____ Town _____ Phone _____

Primary Care Provider _____ Town _____ Phone _____

Patient Signature _____ Patient Initials:_____ Date _____

I, the Provider, have reviewed Vivitrol risks and side effects with the patient.

Provider Signature _____ Date _____

One copy of this form is given to the patient after signing.