OPIATE DEPENDENT PROGRAM FEE SCHEDULE

INSURED PATIENT FEES

NEW PATIENT:		ESTABLISHED PATIENT:	
EVALUATION AND MANAGEMENT	$400.00	EVALUATION AND MANAGEMENT	$275.00
DRUG SCREEN CUP	$ 50.00	DRUG SCREEN CUP	$ 50.00
SUBSTANCE ABUSE SCREENING	$ 55.00	SUBSTANCE ABUSE SCREENING	$ 55.00
BEHAVIOR HEALTH SCREENING	$ 75.00	BEHAVIOR HEALTH SCREENING	$ 75.00
DRUG SCREEN CONFIRMATION	$415.08	DRUG SCREEN CONFIRMATION	$415.08
DAST	$150.00	COUNSELING - GROUP	$ 75.00
ALCOHOL AND/OR DRUG ASSESSMENT	$250.00	COUNSELING – INDIVIDUAL	$150.00
COUNSELING ASSESSMENT	$250.00	PREGNANCY TEST	$ 32.00
PREGNANCY TEST	$ 32.00	CASE MANAGEMENT	$50-100
CASE MANAGEMENT	$100.00		

FEES - NON-INSURED

NEW PATIENT:

EVALUATION AND MANGEMENT	$400 1ST MONTH
COUNSELING ASSESSMENT	$ 50.00
CASE MANAGEMENT	$ 50.00

ESTABLISHED PATIENT:

EVALUATION AND MANAGEMENT	$300 PER MONTH
COUNSELING - GROUP	$ 40.00
COUNSELING – INDIVIDUAL	$50.00
CASE MANAGEMENT	$ 50.00

I have read and understand the fee schedules for my treatment in the Opiate Dependent Program at Westbrook Medical Center. Nonpayment of fees and/or copays, etc. will result in termination of care.

_____ _____

Printed Name Patient Signature

Date_____

WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600

SUMMARY OF BUPRENORPHINE PROGRAM

1) The first month of care patients may be seen several times. Once a dosage is established, patients may be seen on a 28 day cycle as long as all drug screens are appropriate and they are following treatment recommendations. Patients cannot be seen earlier than their scheduled appointment except in an emergency and then only 24 hours prior to a scheduled appointment.

2) Urine drug screening is a regular feature of BUPRENORPHIONE therapy because it provides physicians with important insights into the health and treatment of the patient. Patients will be drug screened on EVERY visit and the screen may be observed. If a patient cannot submit a urine specimen within five minutes of being given the specimen cup, the patient will be rescheduled for the next business day. The patient will be charged a nurse visit charge for the day and, if applicable, will be required to pay the copay or coinsurance. This sample will be tested in-house and the patient and/or their insurance company will receive a bill. Furthermore, if a drug screen is failed, the patient may be asked to return for weekly drug screens. (Note: These visits are at a charge of $75.00 or appropriate copay.)

3) All patients are required to participate in a regular program of professional counseling while in treatment with buprenorphine and evidence of attendance will be required at each visit. During the first month of care or after a relapse, patients are required to attend two counselling sessions per month.

4) Patients may obtain all controlled medications from the pharmacy of their discretion.

5) Early in care patients will have blood drawn for a complete screening of liver functions, a lipid panel, Hepatitis screen, HIV screen, etc. The outside lab will bill the patient and/or their insurance company independently for those services. Contact the lab directly with any questions about that bill. These samples may be repeated periodically to monitor the body's response to the buprenorphine treatment.

6) If a patient cannot make a scheduled appointment, they must call to reschedule. If a patient misses an appointment without rescheduling, they may be dropped from the buprenorphine program. A $25.00 fee will be charged for any missed appointment without prior notification having been given. If a patient is late for an appointment (fifteen minutes), the office is under no obligation to see the Patient on that date.

7) The Patient agrees to immediately notify the office of any change of address and/or telephone number. All patients must be accessible to this office at any time when this office needs to contact them. Voice mail must be set up and checked on a daily basis. If this office cannot reach the Patient, this office has a right to discharge the Patient without further notice.

8) All copays/ payments/ and a percentage of any outstanding balances are due at each visit. If the patient cannot pay at the time of the visit, they will be rescheduled.

By signing below, the patient acknowledges understanding all the program guidelines noted above.

_____ _____ _____

Patient Signature Date Printed Name

_____

Witness Signature

Buprenorphene Treatment Guidelines

_____ I have received education concerning all available treatment options offered by the facility as well as other community resources. I have been advised that I have the opportunity to detox off of medication at any time that I may choose. I have been advised of the risks associated with medication assisted treatment.

_____ I have received education regarding neonatal abstinence syndrome (NAS) and the possible risks associated with medication assisted treatment and the potential of NAS in the event of pregnancy. I have received a referral and information for services that offer long-acting reversible contraceptive devices as well as other forms of birth control. *(Where Applicable)*

_____ I have received information and education regarding the prevention of viral illnesses, such as HIV and Hepatitis C. I have received information concerning intravenous and intranasal drug use and the possible spread of viral illnesses. I have received information where I can seek treatment for HIV and Hepatitis C.

_____ I have received education regarding the benefits and adverse of effect of medications that I may be prescribed.

_____ I have received information and understand that a risk of an overdose is present with medications that I may be prescribed. I agree to comply with the dosing instructions of my medication(s) that are prescribed by my physician. I understand that a greater risk of an overdose exists when combining medications such as Central Nervous System Depressants; Alcohol; or Benzodiazepines with my medications especially, when I have not been prescribed those medications.

_____ I have received information and education regarding prolonged abstinence from opioids and the risk of an overdose should I utilize opioids after a period of abstinence. I have received information regarding Naloxone / Narcan and their properties in reversing an overdose.

_____ I have received information about the seriousness of abstaining from any substance not prescribed for me. I realize I will have observed drug screens weekly until I have three clean screens and then observed randomly throughout my treatment.

_____ I understand that counseling is a large part of my recovery. I understand that I will be required to attend two counseling sessions monthly until I have three consistent clean drug screens. Once my screens are clean, I will be required to have counseling once per month.

_____ I understand that I will be required to return to twice monthly counseling and weekly appointments for medication prescriptions at any point during treatment if I relapse. After three consistent clean screens, I may return to once or twice monthly appointments and once monthly counseling.

By signing below, I agree that I have read each statement above and voluntarily provided my initials as an acknowledgement to each of the above statements.

_____ _____ _____

Patient Signature Print Patient Name Date

_____

Witness Signature

Important Information regarding your Treatment

1) Alternatives to medication assisted treatment (MAT) include medical withdrawal and drug-free treatment; inpatient and intensive outpatient treatment facilities; and programs utilizing alternative medications such as methadone or naltrexone. Benefits associated with more intensive treatment plans include a highly secure environment and more intense monitoring and accountability. Risks include the difficulties that may arise while trying to coordinate a normal daily schedule with the intense demands of your treatment program. It is important to understand that the goal of opioid treatment is stabilization of functioning.

2) Due to the risk of neonatal abstinence syndrome in pregnant females taking opioid medications, including buprenorphine products, it is highly advisable that women of child-bearing age consider using voluntary long-acting reversible contraception to reduce the possibility of an unplanned pregnancy while receiving MAT.

3) Chronic viral illnesses are common among individuals who suffer from the disease of addiction. It is very important that you do not inject any medication or substance into your body. Even doing so in a seemingly "clean" manner can result in contracting viruses such as hepatitis C or HIV. If you are found to already have these viruses in your body, it is important to seek care with an appropriate specialist to further evaluate and treat your infection.

4) Buprenorphine is an effective tool when used as part of a comprehensive treatment plan to facilitate recovery in an individual suffering from the disease of addiction. It helps lessen cravings and eases the withdrawal symptoms associated with the discontinuation of opioids. For some individuals, this medication can cause uncomfortable side effects, such as headache, nausea, and constipation. It is important to talk with your doctor about strategies for minimizing these effects.

5) Overdose can occur when buprenorphine is taken together with other medications such as alcohol, benzodiazepines, or other respiratory depressants. It is very important to only take the medications prescribed to you and to follow the dosing instructions provided by your doctor. It is also important to recognize the risk of overdose following relapse after periods of abstinence from opioids.

6) It is advisable that overdose reversal kits be kept with you and in your home. These products, such as Narcan/Naloxone, can be life-saving for you as well as for others. Please ask your doctor for more information on obtaining these agents.

7) Be advised that the goal of opioid treatment is stabilization of functioning.

8) Be advised that at regular intervals the following elements of your treatment will be discussed with you: present level of functioning, course of treatment, and future goals.

9) Be advised that you may choose to withdraw from or be maintained on the medication as you desire unless medically contraindicated.

By my signature below I acknowledge that I have read and understand the items listed above, and consent to treatment.

Patient Signature: _____ Date: _____

WESTBROOK MEDICAL CENTER
930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600

BUPRENORPHINE TREATMENT AGREEMENT

Patient Name_____ **Date**_____

Please read each statement and put your initials beside each number after reading.
As a participant in buprenorphine treatment for opioid addiction, I freely and voluntarily agree and understand this treatment agreement, in its entirety, as follows:

___ 1. I agree that I have been informed that buprenorphine is a treatment designed to treat opioid addiction --- not addiction to other classes of drugs.
___ 2. I agree that medication management with buprenorphine is only one part of the treatment for my addiction and I agree to participate in a regular program of professional counseling while in treatment with buprenorphine.
___ 3. I agree that **benzodiazepines are contraindicated while taking buprenorphine and cannot be taken while in treatment with buprenorphine.**
___ 4. I agree to provide proof of counseling at every visit.
___ 5. I agree to abstain from **all** illegal drugs, alcohol, marijuana, and other addictive substances while in treatment with buprenorphine.
___ 6. I agree that I will be subject to random drug screens (observed or non-observed) and/or medication counts. I understand that I am responsible for the cost of the visit. This sample will be referred to an outside lab or tested in-house and I and/or my insurance company will receive a bill. I agree to report to this office for random medication counts or drug screens within two hours of being called. Should I be out of town when called, I understand that I must bring in proof of my whereabouts at the time of the call (a credit card receipt which is time and date stamped with my name on it or a notarized statement from an official entity).
___ 7. I agree to keep and be on time for all my scheduled appointments or be subject to discharge from the program.
___ 8. I agree to immediately notify the office of any change of address and/or telephone number. All patients must be accessible to this office at any time when this office needs to contact them.
___ 9. Voice mail MUST be set up. If this office cannot reach the Patient within two hours, this office has a right to discharge the Patient without further notice.
___ 10. I agree that a network of support and communication is an important part of my recovery. I will be asked for my authorization to allow contact, as appropriate, between my doctor and/or his staff and outside parties, including physicians, therapists, probation/parole officers, and other parties. Contact will only be made when the doctor has determined that communication is necessary for effective treatment and recovery.
___ 11. I agree to adhere to the payment policy outlined by this office.
___ 12. I agree that I have a means to store my medication(s) safely where it cannot be taken accidentally by children or stolen by others. I further agree that if my buprenorphine is ingested by anyone besides me, I will call 911 or the Poison Control Center at 1-800-288-9999.

___ 13. I agree not to sell, share, or give any of my medication(s) to another person. I understand that such mishandling is a serious violation of this contract and illegal and will result in my treatment being terminated without any recourse for appeal.

___ 14. Medication lost, stolen, or damaged ***will not*** be replaced. It is my responsibility to protect my medication. I understand that the consequence of not protecting the medication is that I may be without prescribed medication for a period of time.

___ 15. I agree that if the doctor recommends that my medication(s) should be kept in the care of a responsible member of my family or another person, I will abide by such recommendation.

___ 16. I agree not to conduct any illegal or disruptive activities in or around the doctor's office and/or pharmacy and to treat all office and pharmacy staff with respect. I understand that should such behavior occur, I will be terminated from treatment without recourse for appeal and the appropriate authorities will be notified.

___ 17. I agree that my medication/prescriptions can only be given to me at my regularly scheduled office visits. No medication will be called in to any pharmacy.

___ 18. I agree not to obtain medication(s) from any other doctors, pharmacies, or other sources without informing the doctor.

___ 19. I agree to take my medication(s) as the doctor has instructed. I understand that only the doctor can change the way I take my medication(s).

___ 20. I agree that I should not drive a motor vehicle or operate heavy or dangerous machinery during my first two weeks of treatment to ensure that I can tolerate my medications without becoming sleepy or clumsy as a side-effect.

___ 21. I agree that I will be open and honest with my doctor and treatment team about my addiction and overall health history and will inform my doctor about cravings or unhealthy situations in which I am involved, specifically about any relapse that has occurred before a drug test result confirms it.

___ 22. I understand that I may be witnessed by a staff member when giving urine samples. I also understand that attempts to alter my urine or bring in urine from others will result in termination from treatment without recourse for appeal.

___ 23. I understand that, if I am prescribed a buprenorphine product that is individually packaged, the empty packets MUST be returned to Westbrook Medical Center to be counted and destroyed. I further understand that if I fail to return these packets, I will not be seen and could possibly be discharged from the program.

___24. I understand that the recommended period of treatment in a recovery program is twelve to eighteen months. After that time I may be tapered off buprenorphine or transferred to the Vivitrol program.

___25. I have read and understand the patient's rights and responsibilities.

By signing below I attest that I have read and understand the above agreement and that I have had the opportunity to ask questions and have them answered to my understanding. I also understand that violations of this agreement may be grounds for termination of treatment without recourse for appeal.

_____

Patient name (print)

_____ _____

Patient signature Date

_____ _____

Witness signature (employee) Date

OBOT Service Recipient Rights, Confidentiality, Responsibilities and Grievance Procedures

Rights and Confidentiality

- To be fully informed/presented before the initiation of services about your rights and responsibilities in a manner/format that promotes understanding - including any limitation imposed by the rules of the licensee
- To be treated with consideration, respect and full recognition of their dignity and individuality, and have courteous, compassionate care
- To be protected by the licensee from neglect, physical, verbal and emotional abuse (including corporal punishment), and from all forms of misappropriation and/or exploitation
- To have reasonable personal privacy when you receive care
- To receive a list of available advocacy services upon admission
- To have your records kept confidential and private – to ask the facility to correct information in the records
- To be informed about your care and involved in your care planning in a language of your understanding
- To submit complaints without fear of retaliation and have them addressed timely
- To refuse services and be informed of the impact toward your care
- To be informed of any changes in your care, including the type, amount, and frequency
- To participate fully, or to refuse to participate, in community activities
- Not to be required to make public statements which acknowledge gratitude to the agency
- Not required to perform in public gatherings
- Identifiable photographs will not be used without written and signed consent by the patient or guardian
- To voice grievances to the licensee and to outside representatives of their choice with freedom from restraint, interference, coercion, discrimination or reprisal
- To be assisted in the exercise of their civil rights
- To have all applications, certificates, records, reports, and all legal documents, petitions, and records made or information received pursuant to treatment in a Facility directly or indirectly identifying a patient to be kept confidential in accordance with T.C.A. 33-3-103; Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations at 45 Code of Regulations (CFR) Parts 160 and 164, Subparts A and E; and Confidentiality of Alcohol and Drug Abuse Patient Records regulations at 42 CFR Part 2

Responsibilities – The Patient Agrees....

- To keep and be on time for scheduled appts. or make reasonable notifications; not arrive intoxicated
- That the medication is my responsibility and to keep it in a safe place; not to sell or share my medication; and to take my medication as instructed
- To notify staff of any additions/changes in meds from other providers or any conditions which affect my care
- That medication alone is not sufficient treatment; the patient agrees to participate in Relapse Prevention, Group and Individual Counseling Sessions.

Grievance Procedures

You have the right to voice grievances to the staff of the agency, to the owner of the agency, and to outside representatives of your choice with freedom from restraint, interference, coercion, discrimination or reprisal.

Any question or specific concerns regarding patient's rights or to report a complaint may be directed to any of the following:

Facility's Contact Person:_____ Phone #_____

TN Dept. of Mental Health & Substance Abuse Services Phone # 1-866-777-1250

Disability Law and Advocacy Center of TN Phone # 1-800-342-1660

TN Department of Human Services – Adult Protection Services Phone # 1-888-277-8366

I have been explained and received a copy of *Service Recipient Rights, Confidentiality, Responsibilities, and Grievance Procedures.*

Patient Signature _____ Date _____

Agency Witness Signature _____ Date _____

4/3/19

NAME_____ DATE_____

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.			
In the past 12 months...		**Circle**	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes".			**Score:**

Staff member validating score_____ Date _____

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Patient Name Date:

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

NIDA-Modified ASSIST V2.0 (Questions 1-8)

NIDA Quick Screen V1.0[1]

Patient Name: _____ DOB: ____/____/_____

Interviewer: _____ Date: ____/____/_____

STEP 1

In the past YEAR, how often have you used the following?	NEVER	ONCE or TWICE	MONTHLY	WEEKLY	DAILY or ALMOST DAILY
Alcohol • MEN: 5 or more drinks a day • FEMALE: 4 or more drinks a day					
Tobacco Products					
Prescription Drugs for NON-Medical Reasons or no prescribed					
Illegal Substances					

- If all answers are **"NEVER"** for all substances, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes"** to **use of illegal drugs or prescription drugs for non-medical reasons,** proceed to **Question 1.**

STEP 2

In your *LIFETIME*, which of the following substances have you ever used?	**Yes**	**No**
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) • Please record **nonmedical use only**: *Non-medical use refers to using a substance either not prescribed to the patient or used in ways or amounts not prescribed by their doctor.*		
j. Other – specify:		

- If **"Yes"** to any of the drugs, proceed to **Question 2.**

Name of the substances mentioned in Q1 that have been used in the past 3 months:

NIDA-Modified ASSIST V2.0 (Questions 1-8)

Patient Name: _____ DOB: ____/____/____

STEP 3

Answer the following questions based on the substances used within the ***PAST 3 MONTHS.***	NEVER	ONCE or TWICE	MONTHLY	WEEKLY	DAILY or ALMOST DAILY
Q2. ***In the past 3 months,*** how often have you used illegal substances?	0	2	3	4	6
Q3. ***In the past 3 months,*** how often have you had a strong desire to use an illegal substance?	0	3	4	5	6
Q4. ***In the past 3 months,*** how often has your use of illegal substances led to health, social, legal, or financial problems?	0	4	5	6	7
Q5. ***In the past 3 months,*** how often have you failed to do what was normally expected of you because of your use of illegal substances?	0	5	6	7	8

ALL illegal substances *EVER USED*	NO	YES, but not in the last 3 months	YES, in the past 3 months
Q6. Has a friend, relative, or anyone else ***ever*** expressed concern about your substance use?	0	3	6
Q7. Have you ***ever*** tried and failed to control, cut down, or stop using illegal substances?	0	3	6

ANY injectable substances, including those listed in the "other" category.			
Q8. Have you ever used any drug (including steroids) by injection? ***Non-medical use ONLY.***	No, Never	Yes, but NOT in the last 3 months	Yes, in the past 3 months

SUBSTANCE INVOLVMENT (SI) SCORE (add all numbers circled in questions) →	

High Risk	**Score >27**
Moderate Risk	**Score 4-26**
Lower Risk	**Score 0-3**

Patient Name:	DOB:	DATE:

RELAPSE PREVENTION PLAN

Preventing relapse requires a commitment to recovery. It also requires a plan of action. Relapse is not an event, but a process. Before the physical act of relapse, there are changes in feelings, thoughts, and behaviors. Cravings also play a role in relapse. By developing and following a written plan, relapse can be prevented.

Substance of choice:_____

Three (3) reasons for readiness for recovery.

-
-
-

What is a **feeling** or **thought** that may trigger a relapse?

_____

What can you do if this **feeling** or **thought** occurs?

_____

Who are (3) people you can call when tempted to use? *List phone numbers*

_____

_____

_____

What is a **place** or **person** are you mostly likely to use at or with?

_____

What is a **situation** or **event** that may trigger relapse?

_____

My short-term goal (1- 4 weeks):

_____

_____

My long-term goal (2-3 months):

_____

_____

Why is this goal really important to me?

_____

_____

How can my provider help me in meeting my goal?

_____

_____

By signing this document, I Give Westbrook Medical Center permission to collaborate with necessary providers in order to provide the utmost efficient and timely care to better my health and my recovery.

Patient (Print Name)	**Signature**	**Date**
Provider (Print Name)	**Signature**	**Date**

Kessler Psychological Distress Scale (K6)

Protected when completed.

Family name	Given Names	File No.

Address	Date of assessment (yyyy-mm-dd)	Date of birth (yyyy-mm-dd)

The Kessler Psychological Distress Scale (K6)[1] is a simple measure of psychological distress which involves 6 questions about a person's emotional state. Each question is scored from 0 (None of the time) to 4 (All of the time). Scores of the 6 questions are then summed, yielding a minimum score of 0 and a maximum score of 24. Low scores indicate low levels of psychological distress and high scores indicate high levels of psychological distress.

The following questions are about how you have been feeling during the **past 30 days**.	ALL	MOST	SOME	A LITTLE	NONE	(IF VOL) DON'T KNOW	(IF VOL) REFUSED
1. About how often during the past 30 days did you feel **nervous** - would you say **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?	O	O	O	O	O	O	O
2. During the past 30 days, about how often did you feel **hopeless** - **all** of the time, **most** of the time, **some** of the time, a **little** of the time, or **none** of the time?	O	O	O	O	O	O	O
3. During the past 30 days, about how often did you feel **restless or fidgety**? (IF NEC: **all, most, some, a little,** or **none** of the time?)	O	O	O	O	O	O	O
4. How often did you feel **so depressed that nothing could cheer you up**? (IF NEC: **all, most, some, a little,** or **none** of the time?)	O	O	O	O	O	O	O
5. During the past 30 days, about how often did you feel that **everything was an effort**? (IF NEC: **all, most, some, a little,** or **none** of the time?)	O	O	O	O	O	O	O
6. During the past 30 days, about how often did you feel **worthless**? (IF NEC: **all, most, some, a little,** or **none** of the time?)	O	O	O	O	O	O	O

[1]Source: Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J., Normand, S.L.T., Manderscheid, R.W., Walters, E.E., Zaslavsky, A.M. (2003). Screening for serious mental illness in the general population. Archives of General Psychiatry. 60(2):184-9.

Name of assessor	Professional designation	Date (yyyy-mm-dd)

New policy effective 07/01/2020

Please list below all individuals living in your household

Patient Full Name _____ **DOB** _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

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Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____Birth Date:_____
Phone #:_____Alt Phone #:_____SS#:_____
Street Address:_____
City:_____State:_____Zip Code:_____

I authorize: _____

To release information from the medical records of:_____
To: _____ - individual
_____ - organization
_____ - address
_____ - city, state, zip

For the purpose of:_____

Type of Access Requested:

___Physician/Clinic Office Notes___Lab___Counseling___Case Management___Other:_____
For the specified time period of:_____

I acknowledge and hereby consent to such, that the released information may include, but not limited to:

Diagnostic Information
Treatment History
Medications and Dosages
Lab Tests and Results
HIV/AIDS Testing and Results
Allergies
Substance Use History
Trauma History
Program Participation and Com
Employment Status
Living Situation and Social Supports

1. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
2. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires as follows:

_____

3. I understand that my care, payments, benefits or eligibility to enroll in a benefit program will not be affected by refusal to sign this authorization for release of medical information.
4. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient. This physician practice is released and discharged of any liability and the undersigned will hold the physician practice harmless for complying with "Authorization for Release of Medical Information".
5. Fees/Charges will comply with all laws and regulations applicable to release of information

_____ _____
Signature of Patient/Parent/Conservator/Guardian Date

_____
Relationship to Patient

Patient Rights and Responsibilities

All patients who receive services through Westbrook Medical Center have inherent legal and moral rights and responsibilities. These rights include confidentiality, timely information, dignified care and personal safety. Responsibilities include following the rules and regulations of the office, providing accurate information, following treatment plans and fulfilling obligations. All patients are entitled to fair, considerate care and courtesy that recognizes and respects the individual. Likewise, all staff members are entitled to courtesy from patients.

Patient Rights

Participation
You have the right to participate in the development and implementation of your plan of care. You have the right to be informed of the consequences of modifying or not complying with the agreed-upon plan of care.

Consent and Refusal
You have the right to make informed decisions regarding your care. Inherent in this right is the right to consent to treatment, the right to refuse treatment and the right to be informed about what will be occurring during the hospitalization.

Communication
You have the right to know the identity of your provider rendering your personal care. You have the right to communicate with all persons rendering care. This right includes the right to meaningful and understandable communication for patients who are sensorially deprived or have low English proficiency. You have the right to identify the person of your choice whom you wish to have notified of your care.

Privacy
You have the right to personal privacy. Inherent in this right is the right to respect, dignity and comfort. Privacy extends to privacy from view, privacy of communication and privacy in treatment consistent with the capabilities, resources and nature of treatment, as well as the location of treatment as recognized as reasonable in the Guidelines published by the Office of Civil Rights, CMS, July 6, 2001. You have the right to confidentiality of your medical information and medical record. You have the right to access the information contained in your clinical records within a reasonable time of your request.

Safety
You have the right to receive care in a safe setting. You will be kept informed of your responsibilities for personal safety and maintenance of a safe environment for your care. You have the right to be informed of the rules and regulations of the facility and to be informed of the responsibilities of patients.

Beliefs
You have the right to have your religious, spiritual and cultural beliefs respected and to have honored the outward expressions of those beliefs and values to the extent such expressions are consistent with all patient safety, comfort and law. You have the right to be free from all forms of abuse or harassment.

Charges
You have the right to obtain full access to your bill, to receive an explanation of charges upon request, and to be informed of probable charges to the extent such as may be projected.

Satisfaction
You have the right to present concerns and grievances, to be informed of the procedures relating to resolution of such concerns and grievances, and to be assured that your access to care and treatment will not be compromised solely for exercising this right.

Patient Responsibilities

Each patient seeking services has responsibilities to the staff in recognition of and compliance with policies and procedures that will protect other patients.

Information
Patients have the responsibility to provide accurate and complete information relating to their health and are responsible for following the treatment plan recommended by the practitioners responsible for their care. Patients are responsible for accepting the consequences of failing to follow the instructions for the plan. Each patient is responsible for keeping his or her care staff informed of changes in condition, changes in pain and changes in decisions with regard to care and the treatment plan.

Behavior
Each patient is responsible for behaving in a manner that respects the rights of staff and of other patients. Each patient is responsible for following the rules and regulations of the hospital, as are all hospital visitors.

Safety
Patients are responsible for reporting any circumstances that they believe create an unsafe environment or that are perceived to compromise their personal care.

Stewardship
Patients are responsible for fulfilling financial obligations for care.

Participation
Patients are responsible for assuring their own understanding of their treatment plan and should ask questions to ensure understanding. Patients are responsible for following the care, service or treatment plan developed.

The consequences of not following such plan(s) are the patient's responsibility. Participate in your care by having an updated and complete list of all medications you take. The list should include the names, dose, frequency and reason for each medication. Please give this list to your nurse and ask that you be given a revised list upon discharge.

WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600

TELEPHONE APPOINTMENT REMINDER AND CONTACT CONSENT

I, _____ give the medical providers at the above address and/or
Patient name (print)
members of his/her staff my permission to call me either for treatment purposes and prior to an appointment to remind me of the appointment date and time.

I can be contacted at the numbers (please give at least two contact numbers):

- ☐ 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

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. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

_____ _____
Patient Signature Date

_____
Patient Name (Print)

_____ _____
Witness Signature Date

WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600

CONSENT TO TREAT-BUPRENORPHINE TREATMENT

I _____ do hereby: (initial all statements)
Patient Name (print)

___ Give my willful and informed consent to Dr. Richard Poehlein or Dr. Lorin Holst and members of their staff at the above location to administer to me the treatment of Buprenorphine for opioid addiction.

___ Agree that I have had ample opportunity to discuss treatment and have all my questions answered in a manner that I understand.

___ Agree that I can withdraw this consent at any time with verbal or written notice of my intent to withdraw delivered to either the physician or his staff.

___ Understand my rights and responsibilities as a patient of the above named facility as outlined to me by the physician and his staff.

___ Agree I have been given copies of relevant information relating to the treatment to which I am consenting.

___ Understand the risks and benefits to me of the Buprenorphine Treatment and agree to follow the program as outlined in my treatment plan and treatment contract

_____ _____
Patient Name (print) Date

_____
Patient Signature

_____ _____
Witness Name (print) Date

_____
Witness Signature

WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Dr. Richard Poehlein, or Dr. Lorin Holst, and members of their staff at the above address to:

Check all that apply

___ Receive my medical history information from the following physicians:
Primary Care Physician _____
(name, address) _____

___ Receive my treatment records from the following therapist, counselor, sponsor, etc.
(name, address) _____

___ Release my treatment information/records to the following healthcare professional, family member, etc
(name, address) _____

___ Release my treatment information to the health insurance company listed below for billing purposes:
Insurance Provider _____ Address _____
_____

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. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

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

_____ _____ _____
Witness Signature Witness Name (Print) Date

WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600

PATIENT INTAKE: MEDICAL HISTORY

Please print legibly.

Name _____

Address _____ City _____ State _____ Zip _____

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

DOB _____ Age _____ SS# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

Date of last physical _____ Have you ever had an EKG? ( ) N ( ) Y Date _____

Patient current or past medical conditions (check all that apply)

( ) Asthma/respiratory	( ) Cardiovascular (heart attack, high cholesterol, angina)	
( ) Hypertension	( ) Epilepsy or seizure disorder	( ) GI disease
( ) Head trauma	( ) HIV/AIDS	( ) Diabetes
( ) Liver problems	( ) Pancreatic problems	( ) Thyroid disease
( ) STDs	( ) Abnormal Pap smear	( ) Nutritional deficiency

Other (Please describe) _____

_____

_____

_____

MD NOTES: _____

_____

_____

_____

_____

Immediate family members current or past medical conditions (check all that apply)

( ) Asthma/respiratory
( ) Cardiovascular (heart attack, high cholesterol, angina)
( ) Hypertension
( ) Epilepsy or seizure disorder
( ) GI disease
( ) Head trauma
( ) HIV/AIDS
( ) Diabetes
( ) Liver problems
( ) Pancreatic problems
( ) Thyroid disease
( ) STDs
( ) Abnormal Pap smear
( ) Nutritional deficiency

Other (Please describe) _____

_____

_____

MD NOTES: _____

_____

_____

Have you ever had surgery or been hospitalized? (Please describe) _____

_____

_____

MD NOTES: _____

_____

Childhood Illnesses: Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

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 ( ) Y

Medication(s) and dates of use _____ Why stopped _____

Please list all current prescription medications and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) _____

_____

_____

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

_____

_____

Please list any allergies you have to foods, drugs, seasonal, pets, and etc. _____

_____

MD NOTES: _____

Tobacco History

Cigarettes: Now? ( )N ( )Y In the past? ( )N ( )Y

How many per day on average? _____ For how many years? _____

Other Tobacco: Now? ( )N ( )Y In the past? ( )N ( )Y

How often per day on average? _____ For how many years? _____

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

_____

_____

How long have you been using substances? _____

Substance Use History

	No	Yes/Past or Yes/Now	How Taken (Route)	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
Anxiety Meds							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers Please Specify all:							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

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

What was your longest period of abstinence?

MD NOTES:

Have you ever been a victim of abuse? If so, describe when and circumstances

Are you receiving or have you ever received counseling support? _____ if so, please describe when and for how long.

MD Notes:

Staff Signature _____ Date _____

WESTBROOK MEDICAL CENTER
930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name _____ Date _____

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

Years married/ in long-term relationship _____ Times Married _____ Times Divorced _____

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 ( ) Y(Please describe)

Education (check most recent degree):

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

( ) High School Grade _____

Are you currently employed? ( ) N ( ) Y 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 ( ) Y

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

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

( ) Physically ( ) Sexually (including rape or attempted rape) ( ) verbally ( ) emotionally

Have you ever attended:

AA ( ) Current ( ) Past NA ( ) Current ( ) Past CA ( ) Current ( ) Past

ACOA ( ) Current ( ) Past OA ( ) Current ( ) Past

If you are not currently attending meetings but did in the past, what factors led you to stop? _____

_____

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

REGISTRATION FORM

Date_____

Patient Name_____
Last First Middle Suffix
Sex: Male_____ Female_____ Patient's Social Security Number_____
Birth date _____Single ___ Divorced ___ Married ___ Widowed ___ Separated ___

Home Street Address_____
City_____State_____Zip_____
Home Phone (_____)_____ Cell Phone (_____)_____
Cell Phone Company_____ email address _____
Name of Primary Care Physician_____ Phone #_____
Referral Source_____ Patient's Driver's License Number_____
PHARMACY Pharmacy Name, Address, and Phone Number _____
_____

EMPLOYER OF PATIENT (or Guardian if patient is minor)
Company Name_____
Address_____
City _____State _____Zip_____
Occupation _____ Phone Number (_____)_____

Circle appropriate answer:
Race: American Indian Asian Black Caucasian Other Declined
Ethnicity: Hispanic Non-hispanic Declined

Primary Language Spoken_____

Name of Parent or Guardian (if patient is a minor)_____
Date of birth of Guardian_____ SSN of Guardian _____
Driver's License # of Guardian_____

SPOUSE OF PATIENT (or Guardian if patient is minor)
Name_____
Birthdate _____Social Security Number_____
Employer Name_____
Address_____
City_____State_____Zip_____Phone_____

REASON FOR VISIT
Condition related to: Illness_____ Well visit_____Accident_____
Other_____ Date of Accident, if applicable_____

INSURANCE INFORMATION
Insurance Company_____
Insured Name _____Relationship to Patient_____
Group or Policy Number_____ ID #_____

Westbrook Medical Center
7328 Middlebrook Pike
Knoxville, TN 37909

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ DOB_____

Review of Systems: (Check all that apply)

Head & Neck
___ Eye Disease
___ Double vision
___ Blurred vision
___ Prior-Ear Surgery
___ Ear Ache
___ Hearing loss
___ Dizziness
___ Ringing in ears
___ Nasal Obstruction
___ Nosebleeds
___ Nasal Discharge
___ Altered sense of smell
___ Sinusitis
___ [illegible]
___ Snoring
___ Excessive sleepiness
___ Facial pain
___ Pain with chewing
___ Recent dental work
___ Mouth sores
___ Lumps in the neck
___ Allergies

Respiratory System
___ Hoarseness
___ Chronic cough
___ Throat clearing
___ Heart Burn
___ Regurgitation
___ Spitting up blood
___ Shortness of breath
___ Wheezing
___ Asthma
___ Chronic bronchitis
___ Chest Pain
___ Emphysema
___ Tuberculosis
___ [illegible]

Neurologic
___ Headaches
___ Head injury
___ Numbness or tingling
___ Transient black-outs
___ Transient vision loss
___ Seizures
___ Strokes

General
___ Night Sweats
___ Fevers
___ Skin diseases
___ Arthritis
___ Bleeding Disorder
___ Easy Bruisability
___ HIV infection or AIDS
___ Psychiatric Diseases

Gastrointestinal
___ Difficult swallowing
___ Pain on swallowing
___ Diarrhea
___ [illegible]
___ Jaundice
___ Liver disease
___ Hepatitis
___ Kidney Disease
___ Bloody stools
___ Diverticulosis
___ Gall bladder disease
___ Heartburn or ulcers

Cardiovascular
___ Hypertension
___ Heart disease
___ Angina
___ Swelling of the ankles
___ Heart surgery
___ Angioplasty
___ Pacemaker
___ Anemia

Endocrine
___ Diabetes
___ Heat/cold intolerance
___ Thyroid imbalance
___ [illegible]

Urologic
___ Difficulty on urination
___ Frequent urination
___ Blood in the urine
___ Prostate problems

Other
_____

Past and present medical problems:

_____
_____
_____
_____
_____
_____
_____

Previous surgeries and dates (month/year)

_____
_____
_____
_____
_____
_____
_____

List all current medications and dosages (including OTC):

_____
_____
_____
_____
_____
_____
_____

Do you smoke?
___Yes ___No
If yes, how much ?_____

Do you drink alcohol?
___Yes ___No
If yes, how much ?_____

Please list all allergies: (medications, inhalants, foods, contact allergies) _____
_____

Patient Signature_____ Date_____

ASSIGNMENT – AUTHORIZATION & LIEN

I hereby irrevocably authorize and direct my insurance company, my attorney, and/or any third party payers to pay directly to the provider, Westbrook Medical Center, PLLC, all sums of money due for any and all services rendered to me (or a minor child for which I m responsible) by reason of accident, illness or any and all reasons. I further direct said insurance company, attorney, or third party payer to withhold such sums from any payment, including but not limited to health and accident benefits, disability benefits, workers' compensation benefits, medical payment benefits, no fault benefits, foundation grants, government or agency benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignees.

I further agree that this agreement acts as an assignment of my rights and benefits to the extent this office rendered services; therefore if my insurance company and/or attorney obligated to make payment to me for the charges incurred at this office refuse to make such payment, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or in the assignee's name. This office is also authorized to settle or otherwise resolve said claim or cause of action as they see fit. I understand that this does not relieve me of my personal responsibilities for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges. I hereby agree to give a full lien to said office against any and all insurance benefits named herein, or any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injuries or illness for which I have been treated by said office and assignees. I further agree that the assignee's right for payment shall not be bound by a statute of limitations until a reasonable time has lapsed after either negotiations or litigation between third parties and myself are resolved. A photocopy of this assignment shall be considered as effective and valid as the original. I voluntarily waive the statute of limitations regarding my doctors and/or this office's rights to recover and, and I agree to be held fully responsible for all debts I incur in this office.

It is further agreed that I shall remain personally responsible for the total amount due this office and assignee for its services. I further understand and agree that this Assignment, Authorization, and Lien does not constitute any consideration for the office to wait for payment(s) and that they may demand full payment from me immediately and at any time upon rendering service at their option. Such option requires that I pay for all sums due and owing in full within ten (10) days of demand. I further understand that a monthly service charge is computed by a periodic rate of 1% per month which is an annual percentage rate of 12% applied to the previous balance after deducting current payments and that the service charge may change without notice. I understand that all money due this office will be paid in a timely manner with no amount of money due past 90 days from the date of service, regardless of attorney liens, representations of any attorney, pending settlement(s) or other matters unless approved in writing by this office in advance of the 90 day limit. I further agree and understand that, if the need arises, accounts delinquent may be placed for collection and that I am fully responsible for all court costs, filing fees, attorney costs, and all associated collection costs.

I further understand and agree that, as necessary, this office and its staff may submit, prepare or complete medical records, consultations, depositions and/or court appearances on my behalf which I understand must be paid in full in advance and are not considered part of my account. I authorize this office to release any information pertinent to my case to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. I agree that Westbrook Medical Center, PLLC is given full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office and assignee. I understand that this office, the doctors and the staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However, as with any doctor's treatment, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I do agree that I am fully obligated to pay for all charges for all services rendered to me.

Print Name_____

Signature _____ Date _____

Westbrook Medical Center

"Consent for Purposes of Treatment, Payment & Healthcare Operations"

(In this document, "I" and "my" refer to the patient, and "facility" refers to Westbrook Medical.)

I consent to the use or disclosure of my protected health information by Westbrook Medical Center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Westbrook Medical Center. I understand that analysis, diagnosis or treatment of me by this facility may be conditioned upon my consent which is evidenced by my signature below. Diagnostic testing may be required so a thorough analysis can be completed.

I understand that payment is due at the time services are rendered unless other arrangements have been approved in advance by the staff. I understand that Westbrook Medical Center may accept insurance assignments when the insurance coverage is through a group with whom they participate. If applicable, my consent for an assignment of my benefits to Westbrook Medical Center is designated by my signature below. Deductibles and co-payments must be honored at the time services are rendered. A finance charge will be added to outstanding balances. I understand that Westbrook Medical Center accepts cash, Visa, and MasterCard.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Westbrook Medical Center is not required to agree to the restrictions that I may request. However, If Westbrook Medical Center agrees to a restriction that I request, the restriction is binding to the facility.

I have the right to revoke this consent, in writing, at any time, except to the extent that Westbrook Medical Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition.

_____
Signature of Patient or Representative

_____
Print Name of Patient or Representative

_____
Date of Signing

_____
Description of Representative's Authority

CONSENT FOR PATIENT TESTING AFTER HEALTHCARE WORKER EXPOSURE

Westbrook Medical Center health care workers handle blood and other body fluids for many reasons such as when performing lab tests and cleaning equipment. It is the policy of Westbrook Health Center to test a patient for Hepatitis B, Hepatitis C and HIV (the virus that causes AIDS) if any employee or health care worker is exposed to a patient's blood or other body fluid in such a way that transmission of these infections could occur. Should an accidental exposure occur, the tests would be conducted at no cost to you. We are requesting that you consent to these tests prior to treatment. My signature below indicates my consent to test my blood or body fluid for Hepatitis B. Hepatitis C, or HIV.

_____
Signature of Patient or Representative

_____
Date

I decline to authorize the above testing:

_____
Signature of Patient or Representative

_____
Date

WESTBROOK MEDICAL CENTER
930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600
865/769-2616 FAX

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Westbrook Medical Center located at the address above to receive my medical history information or treatment records from any source needed to enhance my care with their facility.

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 by providers at this facility unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the facility specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to 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 redisclosure 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.

Unless otherwise specified, please release ALL records related to my care.

_____ _____ _____
Printed name of Patient | Patient Date of Birth | Patient Social Security Number

_____ _____
Patient Signature | Patient Signature Date

If you have received this form in error, please notify the above office immediately.

Please fax records as soon as possible unless noted otherwise.

Note: Faxed to _____ *at fax #* _____
FACILITY/PROVIDER | *NUMBER*

WESTBROOK MEDICAL CENTER

Authorization for Medical Care

COMPLETE THIS SECTION IF PATIENT IS BELOW 18 YEARS OF AGE:

I _____authorize the following people to bring my child_____ Birthdate_____in for, and consent to, treatment, or to receive medical advice over the phone if they are taking care of my child in my absence. I understand telephone triage and advice services regarding direct patient care will be extended to the above persons only when the child is in their care. This does not allow them to have access to confidential health information that is not relevant for that particular visit. In the event of an emergency or other illness, I understand that the physicians and staff of Westbrook Medical Center will deliver any medical care deemed necessary regardless of the accompanying adult.

1) Name:_____

Relationship to patient:_____ Phone #:_____

2) Name:_____

Relationship to patient:_____ Phone #:_____

3) Name:_____

Relationship to patient:_____ Phone #:_____

If a document is to be picked up by a non-legal guardian, Westbrook must have written consent from the legal guardian. This authorization serves as consent for any medical treatment Westbrook deems medically necessary and appropriate. This will remain in effect until revoked by written consent.

_____ _____

Legal guardian signature Print Name

Date _____

_____

Relationship to patient

COMPLETE THIS SECTION, IF APPLICABLE, IF PATIENT IS 18 OR OLDER:

I _____ Birthdate_____authorize the following people to have access to my treatment information and appointment dates. This will remain in effect until revoked by written consent.

1) Name:_____

Relationship to patient_____Phone #_____

2) Name:_____

Relationship to patient_____Phone #_____