PATIENT AGREEMENT, TREATMENT CONSENT & ASSIGNMENT OF BENEFITS FORM

Name_____ ☐Male ☐Female DOB_____/_____/_____ SS#_____-_____-_____

Home Address_____City_____State_____Zip code_____

Cell Phone_____ Home Phone_____ Work Phone_____

Email_____ Employer_____ Job title_____

Work Address_____City_____State_____Zip code_____

Emergency Contacts, Name and Phone_____

I, _____, voluntarily request, consent to, and authorize medical and health care services of Alliance MD; I consent to all treatment, physical examination, clinical or laboratory investigation, radiological imaging, electrodiagnostic testing, or any procedure pertinent to my care as determined by the office, physician or healthcare provider. I understand that no guarantee has been or can be made as to the results of treatments or examinations. I have requested medical services from Alliance MD on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment. I hereby assign, transfer, and set over to Alliance MD and the provider responsible for my treatment sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent; I understand that I am financially responsible for any charges not otherwise covered. I authorize the release of protected medical information to process claims and authorize payment of medical benefits to Alliance MD. I authorize the use of this document on all insurance submissions. Fees due to Alliance MD for patient co-payment(s), deductible(s), and treatments or fees not covered by a pre-approved medical insurance plan the office accepts are to be paid prior to treatment. I understand that the office will bill my insurance carrier where applicable as a convenience to me; however, if my carrier reimburses me, I agree to inform the office and to pay the office within 7 days. If my care is not covered by insurance, I agree to be responsible for payment of all fees in full. If I am a self-pay patient, I will pay the account in full at the time of service. I understand that should my account be turned over to an outside collection agency, I will be responsible for any and all additional fees, charges or expenses incurred by the office for collection of my outstanding account; this includes collection agency fees, state sales tax, attorney fees and/or court costs. I understand that I must cancel my appointments at least 48 hours in advance or I may have to pay a cancellation fee.

I consent to the office calling, texting, or otherwise contacting me or causing me to be called, texted, or otherwise contacted including in an automated fashion at the phone numbers or emails I have provided and may provide in the future including to leave a message regarding appointments, labs/ testing, health information or any other private health concerns that may be considered under the HIPPA guidelines.

I accept sole responsibility to follow with a primary care provider for general health maintenance and primary care needs. I understand that not following with a primary care provider may result in early death, disability, or other bad outcomes; this includes for example seeing a primary care for management of high blood pressure, a heart rate or rhythm that is not normal, infection, or other conditions. I accept sole responsibility regarding following recommendations including treatment plans, seeing a primary care provider, another provider or specialist when asked or referred to do so; I understand that not doing so may result in early disability, death, or other bad outcomes. I accept sole responsibility to make it to my appointments to review the results of blood tests and other tests and that not doing so may result in early disability, death, or other bad outcomes. For example, the results of a blood test may indicate the need for treatment where if I do not return to get the result, I will not be aware where this may lead to early disability, death, or other bad outcomes. I understand that the office will attempt to contact me if I miss an appointment including to go over such tests; regardless, I accept sole responsibility to make it back to the office in such a circumstance to review the results of tests.

A photostatted copy of this authorization shall be considered as effective and valid as the original.

I, the undersigned fully understand and agree to the above.

Patient Signature _____ Date _____/_____/_____

INSURANCE INFORMATION

Insurance Company _____ Insurance Phone _____

Policy # _____ Member ID# _____ Group# _____

Subscriber Name _____ DOB _____/_____/_____ Relationship to Patient _____

Secondary/ Additional Insurance Company _____ Insurance Phone _____

Policy # _____ Member ID# _____ Group# _____

Controlled Substance and Treatment Agreement, Informed Consent

I,_____, agree to the following:

1. I understand what opioid, benzodiazepine, and amphetamine-like medications are.
2. I will not obtain opioid medications from other sources including other healthcare providers, family, or friends. In an emergency, I will inform the treating provider of my controlled substance and treatment agreement and inform the office AS SOON AS POSSIBLE before my next appointment.
3. I will take medications as directed and make sure that they last until my next planned appointment.
4. I understand that medications I get from providers elsewhere may affect the treatment options my provider offers me here; for example, the provider will recommend against certain combinations of medicines such as benzodiazepines or amphetamine-like medications with opioids. I will inform the office of all medications I take and am prescribed.
5. I understand that the office will access prescription reports about me that show controlled substances I obtain from the pharmacy. I give the office permission to look up additional prescription histories on me.
6. I understand that treatment with an opioid medication results in physical dependence.
7. I understand that opioid medications carry many risks not limited to addiction and drug abuse, withdrawal symptoms, constipation, sedation and sleepiness, dizziness, problems urinating, sleep disturbance, increased sensitivity to pain, coma, respiratory depression (decreased or ineffective breathing that can result in organ damage including the brain and death), decreased blood pressure, itching, decreased testosterone and sex drive, osteoporosis, depression, nausea, sweating, and death.
8. *FOR WOMEN*: I understand that opioid medications do present risks to pregnancy such as fetal opioid dependency, neonatal abstinence syndrome, and unknown potential harm to pregnancy/ baby. All medications may present risks to pregnancy/ baby, **the responsibility to avoid pregnancy is mine.** I will take measures to avoid pregnancy. I will inform the provider if I plan to or become pregnant.
9. I will keep my office appointments.
10. I understand that my provider may not prescribe medications during evenings and weekends. In case of an emergency I will go to the emergency room or call 911 and inform my provider as soon as possible before my next appointment. Although the provider will be available, I will not expect my provider to call in medications for me.
11. **UNDER NO CIRCUMSTANCES will I expect a new prescription if my medications are lost, stolen, destroyed or I run out early**.
12. I will avoid illegal drugs such as cocaine, heroin, and methamphetamines. I will avoid alcohol while taking my medications. If I ever drink alcohol while taking medications I will inform my provider.
13. If I am tired or feel impaired, I will not drive, operate machinery, or partake in tasks that may harm me or others; I will not partake in such tasks until I am absolutely sure that my medication does not impair my ability to perform such tasks.
14. My provider may receive information from or contact my other health care providers or pharmacists about use or possible misuse of drugs. The office may send a copy of this agreement to my other healthcare providers or to the pharmacy. This permission shall expire upon my written cancellation of this agreement
15. Upon request, I will bring all my unused medication to the office for pill counts within 24 hours.
16. I will choose one pharmacy to get my prescriptions from.
17. I will ensure my medications are not accessible to anyone except me or my caretaker. A safe may be used.

18. If I feel my medications are bad for me, causing side effects, or there are any other issues, I will inform my provider immediately; I understand this is my responsibility.
19. I understand goals and benefits of my treatment include increasing function and participation in regular activities, improving quality of life, and enabling normal day to day function; however, there are no guarantees.
20. I will refrain from disrespectful and violent language and behavior, threats, and intimidation towards staff members and other patients.
21. I understand that I do not have to continue treatment at this location; if I disagree with my treatment, I am free to seek care elsewhere as long as the provider is aware of such a decision.
22. I will submit a urine sample upon request for drug testing; I may be observed by staff or the provider. The provider will act on urine drug test results even if results contradict what I say. I understand that if I am unable to provide a urine sample the provider may decline providing any treatment including prescriptions.
23. I understand that prescribed medications may be stopped if:
    - I fail a urine drug test including my urine not showing my prescribed medication as expected
    - I fail a urine drug test including my urine showing controlled substances not recently prescribed
    - I fail a urine drug test including my urine showing illegal drugs
    - I fail a urine drug test including my urine showing inconsistencies with the treatment program
    - My provider feels the medication is causing harm, not helping me reach treatment goals, or not providing adequate benefits
    - I misuse my medication (this includes selling or sharing medication and not taking medication as directed)
    - I obtain opioids or other controlled substances from other sources including other healthcare providers
    - I repeatedly request increases or early refills
    - I lie to the office or my provider (which demonstrates I cannot be trusted)
    - I engage in illegal activity
    - I violate any part of this agreement
24. I understand that my provider may immediately terminate my care if I violate this agreement.

By signing this agreement, I acknowledge that I have reviewed the entire agreement and have had the opportunity to ask any and all questions about this agreement and that I FULLY UNDERSTAND THIS ENTIRE AGREEMENT.

Patient Signature _____ Date _____

Witness _____

Name _____

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 non-medical use of drugs. Please answer every question.

In the past 12 months…			
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)?	Yes	No

Opioid Use Disorder Criteria

Please check all of the boxes that apply to you

☐ Opioids are often taken in larger amounts or over a longer period of time than was intended.

☐ There is a persistent desire or unsuccessful efforts to cut down or control opioid use.

☐ A lot of time is spent in activities to obtain the opioid, use the opioid, or recover from its effects.

☐ Craving, or a strong desire or urge to use opioids.

☐ Continued opioid use resulting in a failure to fulfill major role obligations at work, school, or home.

☐ Continued opioid use despite having ongoing social problems caused or worsened by the effects of opioids.

☐ Important social, occupational, or recreational activities are given up or reduced because of opioid use.

☐ Continued opioid use in situations in which it is physically hazardous.

☐ Continued opioid use despite knowledge of having an ongoing physical or psychological problem caused or worsened by the substance.

☐ Tolerance, either a need for greatly increased amounts of opioids to achieve intoxication or desired effect or a significantly decreased effect with continued use of the same amount of an opioid.

☐ Withdrawal.

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	

Name:_____ **Signature**_____ **Date**_____

☐ I have received and/ or read a copy of this office's Notice of Privacy Practices

☐ I understand that care in this program may be terminated without any recourse or appeal if the treatment agreement is violated.

☐ I will undergo drug tests and medication counts as requested.

☐ I have been informed of the necessity of safe storage of prescribed medications.

☐ I have been informed that misuse of prescribed medication and the combination of alcohol and/ or benzodiazepines can be fatal.

☐ If prescribed **a Buprenorphine-based medication**, I understand this **is an opioid medication** and a controlled substance, use results in physical dependence. Buprenorphine-based medications include but are not necessarily limited to Suboxone, Zubsolv, Bunavail, Sublocade, Subutex, Buprenorphine, and Buprenorphine-Naloxone.

☐ I understand Buprenorphine-based medication information including side effects, risks, and strategies to minimize risks.

☐ I understand the risks and benefits of other treatments for opioid use disorder including Methadone, Naltrexone, and non-medication treatments.

☐ I have been given information on how to contact the office after hours and during weekends.

☐ Female patients: I understand reviewed information on the risks of taking Buprenorphine/Naloxone while pregnant or if I should become pregnant during treatment. I agree to take measures to prevent pregnancy.

☐ I understand that medication alone is not considered sufficient treatment and have been informed that counseling (psychosocial services) is a recommended requirement of this program. I have been given but am not limited to the following information regarding counseling services:

Choices - 2424 Franklin St Michigan City, IN 46360 (219) 548-8727, (219) 326-5922

Fresh Start Counseling 7108 Calumet Ave Hammond, IN 46324 (219) 933-7990, (219) 736-5990

Front-Line Counseling Services – 605 Michigan Ave LaPorte, IN 46350 (219)728-1638

Keys Counseling - 424 Perry St LaPorte, IN 46350 (219) 809-0333

Swanson Center - 7224 W 400 North Michigan City, IN 46360 (219)879-0676

Patiene Name (Print): _____ Patient Signature: _____

Date: _____ Witness: _____

Alliance MD

Patient Questionnaire

Patient Name: _____ Birth Date _____/_____/_____
Last First Middle

1. Job title & description: _____

2. □ Married □ Separated □ Divorced □ Never married □ Live with Partner □ Other _____

3. □ No children □ Children, how many_____ □ Pets (dogs or cats), how many dogs _____ cats _____

4. Primary Care Physician: _____

5. Primary Care Physician Address: _____

6. Referring Physician: _____

7. How did you hear about this office? _____

8. Primary reason for visit: ☐ Addiction/ opioid dependence ☐ Pain _____ ☐ Other _____

9. What year did this problem start? _____ What caused the problem? _____

_____

10. How has this problem affected you day to day? _____

_____

11. What are your treatment goals? _____

_____

12. What treatments have you had in the past (some examples include PT, chiropractic therapy, medications, counseling, group therapy, rehab, injections, surgery, dieting, exercise program)? Please describe, include dates and locations:

_____

_____

_____

_____

Alliance MD

Patient Questionnaire

13. ☐ I do not need treatment for dependence. **SKIP THIS PAGE**

14. ☐ I do need treatment for dependence. **PLEASE COMPLETE THIS PAGE**

15. Drugs or drugs of choice _____ _____ _____

☐ Snort	☐ Snort	☐ Snort
☐ Inject	☐ Inject	☐ Inject
☐ Smoke	☐ Smoke	☐ Smoke
☐ Oral	☐ Oral	☐ Oral
Age first taken _____	Age first taken _____	Age first taken _____
Amount _____	Amount _____	Amount _____

16. Have you ever been in treatment before? ☐ No ☐ Yes When _____ Where _____

17. Have you ever been in counseling? ☐ No ☐ Yes When _____ Where _____

18. Have you ever been charged or convicted of a drug related crime? ☐ No ☐ Yes, explain _____

_____

19. Are you currently on: ☐ Parole ☐ Probation ☐ Work Release ☐ Court Ordered Program

20. Do you have family members with history of substance abuse? ☐ No ☐ Yes

21. Have you been tested for:

Hepatitis C ☐ No ☐ Yes, when _____ Results _____

Hepatitis B ☐ No ☐ Yes, when _____ Results _____

HIV ☐ No ☐ Yes, when _____ Results _____

22. Have you ever taken medications for any of the following conditions?

Anxiety ☐ No ☐ Yes, medication(s) _____ still taking? ☐ No ☐ Yes

ADHD ☐ No ☐ Yes, medication(s) _____ still taking? ☐ No ☐ Yes

Sleep ☐ No ☐ Yes, medication(s) _____ still taking? ☐ No ☐ Yes

Antidepressants ☐ No ☐ Yes, medication(s) _____ still taking? ☐ No ☐ Yes

Opioid addiction ☐ No ☐ Yes, medication(s) _____ still taking? ☐ No ☐ Yes

23. Have you ever overdosed? ☐ No ☐ Yes, when _____ Explain _____

24. Are you living with family, in your own home, or other situation? _____

25. What substances and/or medications are in your system now? _____

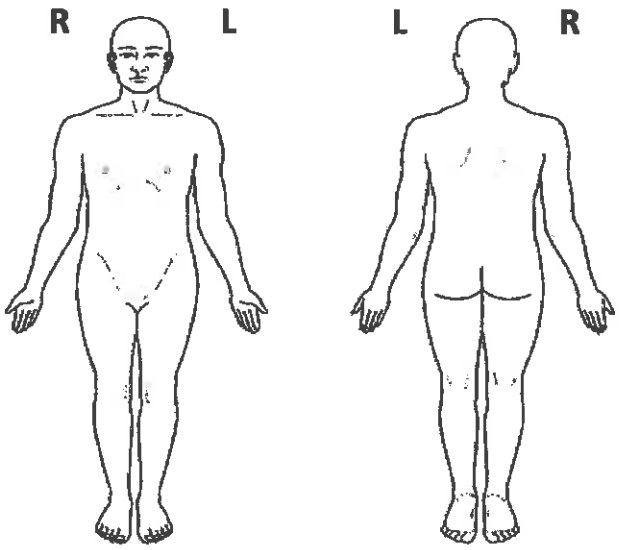
Alliance MD

Patient Questionnaire

26. □ I do not presently have any pain complaints. **SKIP THIS PAGE**

27. □ I do have pain. **PLEASE COMPLETE THIS PAGE**

28. Where is your pain located? Please mark the drawing where you have pain at and where it travels to if it radiates. Also, please check boxes to indicate where your pain is located.



□ Low back	□ Foot □ left □ right
□ Neck	□ Groin
□ Upper/ mid back	□ Hand □ left □ right
□ Abdomen	□ Head
□ Ankle □ left □ right	□ Hip pain □ left □ right
□ Arm □ left □ right	□ Knee □ left □ right
□ Buttock □ left □ right	□ Leg □ left □ right
□ Chest □ left □ right	□ Mouth
□ Elbow □ left □ right	□ Shoulder □ left □ right
□ Face □left □right	□ Wrist □left □right
□ Flank □ left □ right	□ Other_____

29. My pain radiates from _____ to _____.

30. Since it began, my pain has: □ gotten better □ gotten worse □ stayed the same

31. Check all the boxes that apply to your pain.

□ Constant	□ Intermittent (comes and goes)	□ Sharp	□ Dull	□ Achy
□ Throbbing	□ Numbness/ tingling	□ Pins/needles	□ Burning	□ Shooting
□ Muscle tightness	□ Muscles spasms			

Circle number:	No pain							Severe pain			Worst pain possible
32. What is your usual pain score?	0	1	2	3	4	5	6	7	8	9	10
	No pain							Severe pain			Worst pain possible
33. What is your pain score at its worst?	0	1	2	3	4	5	6	7	8	9	10

34. What makes your pain and function better? _____

35. What makes your pain and function worse? _____

36. Is there any legal action ongoing or planned? □ No □ Yes, explain_____

37. Is your pain related to a motor vehicle accident, personal injury, or work injury?

□ No □ Yes, please expiain. _____

38. What medications are you currently taking?

Name	Strength	# per day	Name	Strength	# per day

39. What medications have you taken in the past?

Name	Strength	# per day	Name	Strength	# per day

40. List any medication allergies or side effects or ☐ NO KNOWN ALLERGIES/ leave blank :

Medication allergies, list	Reaction	Medication side effects, list	Reaction

41. What previous studies have you had performed if any (some examples include X-ray, CT scan, MRI, and EMG)? Please list what kind of study you had done, the date, and where the study was performed.

_____

_____

_____

Alliance MD

Patient Questionnaire

42. Past Medical History: Please list any medical history including psychiatric for yourself such as any health issues or things a doctor has told you (examples: high blood pressure or cholesterol, diabetes, asthma, COPD, seizures, stomach ulcer, blood clots, depression, anxiety, hepatitis, kidney disease, HIV, bipolar disorder):

_____

_____

43. Family History: Please list any medical history for family members, include relationship to you:

_____

44. Surgery History: List any surgeries you have had: _____

_____

45. Do you smoke or chew tobacco? □ No □ Yes, for _____ years. How many cigarettes do you smoke a day? _____

46. Do you drink alcohol? □ Never □ Rarely □ Occasionally □ Often □ Every day

□ Wine □ Beer □ Liquor □ Other _____

47. Review of systems: Please mark any problems or symptoms you have from the list below.

CONSTITUTIONAL: □ weight loss or weight gain □ insomnia

SKIN: □ rash

HENT: □ headache □ hearing loss □ nasal polyps □ vocal cord lesion

EYES: □ vision loss □ glaucoma

CARDIOVASCULAR: □ racing heart beat □ swelling in the legs

RESPIRATORY: □ shortness of breath □ sleep apnea

GASTROINTESTINAL: □ heart burn □ loss of bowel control □ diarrhea □ constipation

GENITOURINARY: □ loss of bladder control

MUSCULOSKELETAL: □ back pain □ neck pain

ENDO/HEME/I.D. □ bleeding disorder □ thyroid disease □ diabetes □ infection

NEUROLOGICAL: □ numbness/tingling

PSYCHIATRIC: □ depression □ anxiety

SIGNATURE _____ **DATE**_____

Alliance MD

REFERRAL FORM

Referral To: Formal Counseling

Patient Information: Name: _____

Phone: _____ Birth date: _____

Diagnosis: □ Opioid Use Disorder

□ Other _____

Remarks: _____

_____

Please fax or provide patient with documentation reflecting patient participation

Dr. Olusola Olowe, MD

_____ Date: _____

□ 10176 West 400 North Suite C
Michigan City, IN 46360
Phone: 219-873-1777
Fax: 219-873-0001

□ 8220 Calumet Ave
Munster, IN 46321
Phone: 219-595-0300
Fax: 219-595-0308