Life Spring Recovery Retreat

Patient Registration Form

Patient's Name (Last, First, MI): _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Home Phone#: _____ Alternate Phone# (□ cell or □ work): _____

Email Address: _____

Date of Birth: _____ Age: _____ Sex: M or F Social Security#: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed

Employer: _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____

Employment Status: □ Full time □ Part time □ Unemployed □ Retired □ Student □ Other

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: _____

INSURANCE INFORMATION - We will request to scan your ID and insurance card

Primary Insurance: _____ Member ID#: _____

Secondary Insurance: _____ Member ID#: _____

INSURED INFORMATION (if other than patient) – We will request to scan your ID and insurance card

Subscriber/Policy Holder: _____

Relationship to Patient: _____

Address: _____

Social Security #: _____ Date of Birth: _____

His or Her Employer: _____

Work Phone#:

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): Relationship to Patient:

Life Spring Recovery reserves the right to charge a **$25** fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice
2. Are missed without calling to cancel (no show)

Patient/Parent or Guardian Signature: _____ Date: _____

Life Spring Recovery
Recover Wisely

Past Medical History

Medical History (Circle all that apply)

Blood Pressure Problems	Diabetes	Skin Issues
Heart Problems	Head Trauma	Asthma
Seizures	Kidney Problems	Abdominal Issues
Chronic Pain	Hepatitis	

Specify Other Problems

_____

_____

_____

If you are female, what is your pregnancy status? (Circle one)

Pregnant Not Pregnant Trying to Get Pregnant Not Applicable

Past Psychiatric History

Outpatient Treatment

_____

_____

_____

_____

Inpatient Psychiatric Hospitalization

_____

_____

_____

_____

Life Spring Recovery

Family Psychiatric History (Circle the family member who has been diagnosed or treated for any of the following diagnoses)

Drug Abuse	Child	Parent	Sibling	Grandparent
Alcohol Abuse	Child	Parent	Sibling	Grandparent
Domestic Violence	Child	Parent	Sibling	Grandparent
Anxiety	Child	Parent	Sibling	Grandparent
Bipolar Disorder	Child	Parent	Sibling	Grandparent
Depression	Child	Parent	Sibling	Grandparent
Post-Traumatic Stress	Child	Parent	Sibling	Grandparent
Schizophrenia	Child	Parent	Sibling	Grandparent

Past/Current Psychiatric Medications

_____

_____

_____

_____

Social History

Relationship Status (Circle one)

Single Married Divorced Separated Significant Other

Do you have children? (Circle your answer)

Yes No

Have you been married previously? (Circle your answer)

Yes No

Life Spring Recovery

Are you sexually active? (Circle your answer)

Yes No

How would you identify your sexual orientation/identity? (Circle one)

Heterosexual/Straight Bisexual Unsure Homosexual/Gay

Transgender Prefer Not to Answer

Do you have a history of trauma/abuse? If yes, circle the types

No History of Sexual, Emotional, Physical or Neglect

Sexual Emotional Physical Neglect

Highest Educational Level Completed (Circle all that apply)

Some HS Graduated HS Some College Associate Bachelor

Masters PhD

Do you work outside the home? (Circle your answer)

Yes, Full-Time Yes, Part-Time No

Have you served in the military? (Circle your answer)

Yes No

Smoking Status (Circle all that apply)

Non-Smoker	Ex-Smoker	Cigar Smoker
Chews Tobacco	Current Every Day Smoker	Current Heavy Tobacco Smoker
Current Light Tobacco Smoker	Snuff User	Pipe Smoker
Vaping		

How much do you smoke per day?

_____

Life Spring Recovery

Do you drink alcohol? (Circle your answer)

Yes No

How much and how often do you drink per week?

_____

CAGE

Have you felt the need to CUT down? Yes No

Have you ever gotten ANGRY if someone talks to you about your drinking? Yes No

Have you felt bad or GUILTY about your drinking? Yes No

Do you ever need an EYE-OPENER? Yes No

Legal History

Do you have any felony charges?

Yes No

Do you have any pending legal problems?

Yes No

Explain Below

_____

_____

_____

Spiritual Life

Do you attend a church?

Yes No

_____

CONSENT TO TREATMENT WITH BUPRENORPHINE

Patient Name: _____ Date: _____

I hereby authorize and give consent to Life Spring Recovery and it's physicians and/or any appropriately authorized assistants he/she may select to administer or prescribe buprenorphine/naloxone as an element in the treatment for my dependence on heroin, opioid, or other narcotic drugs.

The procedures to treat my condition have been explained to me. I understand that it will involve my taking the prescribed buprenorphine on the schedule determined by the physician or his/her designee. This will help control my dependence on heroin or other narcotic drugs.

It has been explained to me that buprenorphine itself is an opiate, but for some individuals, it may not be as strong an opiate as heroin or morphine. Buprenorphine treatment can result in physical dependence. Buprenorphine withdrawal is generally less intense than that with heroin or methadone. If buprenorphine is suddenly discontinued, some patients have no withdrawal symptoms; others have symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opiate withdrawal, buprenorphine should be discontinued gradually, usually over several weeks or more.

For my first dose, I should be in withdrawal as much as possible. If I am not already in withdrawal, buprenorphine can bring on sever opiate withdrawal. For that reason, for the first few days, I will be asked to be seen more regularly, at the beginning of treatment, for observed dosing. I will comply with the correct dosing method for buprenorphine – holding it under the tongue until it fully dissolves, without swallowing it. Swallowing the buprenorphine will lessen its effectiveness.

I understand that it may take several days to get used to the transition from the opiate I had been using. I understand that using any other opiates will complicate the process of stabilization on buprenorphine. I also understand that other opiates will have less effect once I become stabilized on buprenorphine. Taking more opiates to try to override the effect of buprenorphine can result in an opiate overdose. In addition, I understand that intravenous use of buprenorphine can produce serious problems including severe withdrawal, overdose and even death.

I understand that I will not take any other medication without first discussing it with my primary physician because combing buprenorphine with other medications may be hazardous. The combination of alcohol and buprenorphine may also be hazardous. The combination of buprenorphine with Valium, Librium, or Ativan has resulted in death.

I understand that, upon the clinic's request, I will need to provide urine samples.

I understand that during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me.

I will not allow any other individual to use my buprenorphine. It is dangerous for an individual not on buprenorphine to ingest the medication. Doing so may result in serious injury or even death for that individual.

Women who are pregnant or trying to become pregnant must let the physician know immediately. To the best of my knowledge:

_____ I am pregnant at this time

_____ I am not pregnant at this time

Date of last menstrual period: _____

Method of birth control used: _____

Alternative methods of treatment, the potential benefits of treatment, possible risks involved, and the possibility of complications have been explained to me. I certify that no guarantee or assurance has been made as to the results that may be obtained from narcotic addiction treatment. I consent to buprenorphine treatment since I realize that I would otherwise continue to be dependent on heroin, opioids, or other narcotic drugs. I will receive a copy of this consent form.

Printed Name	DOB
Patient Signature	Date

Mandated Pill Count & Counseling

I have agreed to & signed Life Spring Recovery (LSR) patient registration documents. I further agree to the policies set forth by my insurance company. I understand that my treatment here is voluntary and should I decide not to comply with LSR policies, I can seek treatment elsewhere.

In accordance with Federal guidelines for medicated assisted treatment programs, **I WILL ATTEND ALL COUNSELING SESSIONS AS WELL AS COMPLY WITH A PILL COUNT OF ALL MEDICATIONS THAT ARE BEING PRESCRIBED TO ME BY LIFE SRPING RECOVERY PHYSICIANS.**

I understand it is ***MY RESPONSIBILITY*** to attend all scheduled doctor & counseling appointments. ***NO EXCEPTIONS, NO EXCUSES***. If I cannot attend a scheduled appointment, I will contact the LSR office management to discuss an alternative option.

Should I fail to comply with my scheduled counseling appointments and/or my mandated pill counts, I may be discharged from the Life Spring Recovery program.

Patient's Signature

Date

NOTICE OF CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, Life Spring Recovery, may not say to a person outside the program that a patient attends the program, or discloses any information identifying a patient as an alcohol or drug abuser unless:

1) The patient consents in writing;
2) The disclosure is allowed by a court order;
3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at Life Spring Recovery or against any person who works for Life Spring Recovery or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect form being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. § 290dd-3 and 42 U.S.C. § 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations)

By signing below, I acknowledge that I have received a copy of the above information as required by 42 CFR § 2.22.

_____ Date: _____

(Patient Signature)

_____

(Signature of parent, guardian, or authorized representative)

Life Spring
Recover wisely

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing LSR as your healthcare provider. We ask that you read and sign this form to acknowledge your understanding of our patient financial responsibility policies.

Life Spring Recovery ("LSR") provides healthcare services to our patients which consists of treatment and counseling for the dependency/addiction to opiate based drugs ("Services"). The Services may consist of medication assisted therapy (MAT) programs resulting in a prescription for buprenorphine/naloxone or other medication, as medically indicated.

In addition to the cost of the Services, LSR also charges for costs associated with the completion of medically related forms, such as FMLA or disability forms, at a rate of $5 for each form and for any missed appointments at a rate of **$25** ("Fees"). In order to avoid a missed appointment fee, cancellation of your appointment must be communicated to LSR at least ***24 hours*** in advance of your appointment.

You are also responsible for the full cost of any prescription or laboratory work that is ordered for you as part of the Services. Third party laboratories and pharmacies are not affiliated with LSR. Any questions you may have regarding those costs should be directed to the laboratories and pharmacies.

Patients at LSR have two (2) payment options: CASH OR CREDIT CARD

Cash Program
The Cash Program cost for the initial visit is $400. Each follow up appointment is $375 per month. Payment to LSR is required at the time of the Services. Cash will only be accepted for patients who do not have insurance.

Insurance Program
LSR accepts multiple insurance providers, managed care plans, state-funded insurance plans, commercial plans, and Medicaid or Medicare for this program. LSR will bill your insurance provider.

Patient Authorization

As a patient of LSR, I, _____, understand and acknowledge the information in this form and agree to pay LSR for the Services and any Fees I incur. I understand that there are 2 payment options and have chosen an option that fits my financial means.

I understand that even if I choose the insurance option, I am still financially responsible for the payment of the Services that I receive. I understand that the drug evaluation and treatment services provided by LSR are services covered by other providers, and service centers enrolled in Job and Family Services may render the service at no cost to me.

By signing below I acknowledge, understand, and agree to all of the above information and that I will be responsible for payment to LSR for the cost of the Services and any Fess I incur.

_____ Date: _____
(Patient Signature)

NOTE: This form must be "stapled" to all disclosures/releases of information concerning substance abuse patients.

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING SUBSTANCE ABUSE PATIENTS

(To accompany disclosure of information made with consent of substance abuse patient)

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such patient. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2 and HIPAA). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2 and/or HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Life Spring
Recover Wisely

Smoking, Litter, Waiting Room, Parking Policies

I have read and agreed to abide by the following policies:

1. I will not smoke within 50 feet from the building entrance.
2. I will smoke in the designated area approved by the management staff.
3. I will not litter on the property (e.g. paper, plastic, cigarettes, soda cans/drinks, urine, etc.).
4. I understand that if the waiting room is full, I will not stand in the hallway, but be directed to another waiting area as designated by the management staff.
5. I will not immediately enter the building after smoking and wait 5-10 minutes until the smoke smell dissipates so as to not bring that odor into the medical facility.
6. I will only park in designated spaces.
7. I understand that if I arrive earlier than 15 minutes of my appointment, I can sign in early, but will not loiter in the parking lot or in the front of the building.

I understand that if I violate any of these statements, I may not be able to attend my scheduled appointment. **I also understand that if I am found littering, I will be charged $75 for the cleanup of the property.**

Patient's Signature _____ Date _____

Life Spring

Patient Last Name: _____

Patient First Name: _____

DOB: ___/___/___ **DATE:** ___/___/___

PRESCRIBED MEDICATION LIST			
ALPRAZALAM (XANAX)	☐	METHADONE	☐
AMITRIPTYLINE (ELAVIL)	☐	METHYLPHENIDATE	☐
AMPHETAMINE (ADDERALL)	☐	MORPHINE	☐
BUPRENORPHINE (ONLY)	☐	NALOXONE	☐
BUTALBITAL	☐	NALTREXONE	☐
CARISPRODOL (SOMA)	☐	OXYCODONE	☐
CITALOPRAM (CELEXA)	☐	OXYMORPHONE	☐
CLONAZEPAM (KLONOPIN)	☐	PHENOBARBIATL	☐
CODEINE	☐	PREGABALIN (LYRICA)	☐
DIAZEPAM (VALIUM)	☐	SUBOXONE	☐
FENTANYL	☐	TAPENTADOL (NUCYNTA)	☐
GABAPENTIN (NEURONTIN)	☐	TEMAZEPAM	☐
HYDROCODONE (NORCO)	☐	TRAMADOL (ULTRAM)	☐
HYDROMORPHONE	☐	VENLAFAXINE (EFFEXOR)	☐
KETAMINE (KETALAR)	☐	ZOLPIDEM (AMBIEN)	☐
LORAZEPAM (ATIVAN)	☐		

OTHER MEDICATION:

OTHER MEDICATION TO ADD TO CURRENT LIST:

Date:		Med:		Date:		Med:	
Date:		Med:		Date:		Med:	
Date:		Med:		Date:		Med:	

Life Spring

Patient's Name:	Date: _____/_____/_____

Drug Abuse Screening Test (DAST)

These questions refer to the past 12 months only.

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 always able to stop using drugs when you want to?	Yes	No
4	Have you 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 parent) 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, etc…)?	Yes	No

Guidelines for Interpretation of DAST-10

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

The statements made in this form are true to the best of my ability.

Patient Signature

Date