valley pain relief & wellness center

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Burnsville MN 55337

p 612.444.3000 f 612.444.9000
valleypainreliefandwellness.com

Svetlana Zaydman, D.O.
Ashwin George, M.D.

IMPORTANT INFORMATION

PLEASE BRING THESE COMPLETED FORMS TO YOUR FIRST APPOINTMENT

Welcome, New Patient!

At Valley Pain Relief and Wellness Center, it is our mission to improve quality of life for those suffering from pain or afflicted with addiction. Both pain and addiction can have detrimental effects on every aspect of our lives – from our physical health, our jobs and finances, to our relationships with friends and family, and our own mental health, self worth, and pride. We work closely with patients to identify the problem, set treatment goals, and put methods into place to achieve those goals. Through individual treatment plans, we strive to improve your health and comfort, and help you get back to being your very best self.

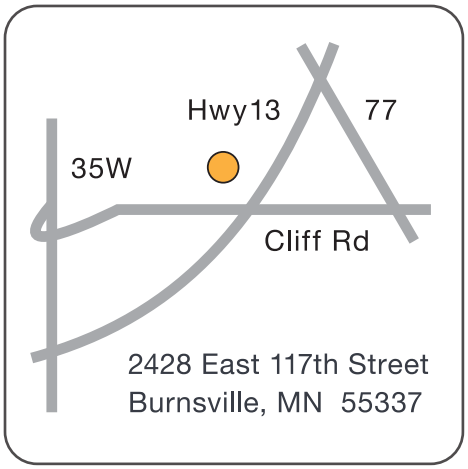
Before you arrive, collect your medical records and imaging results, such as MRI films, or X-rays. If you are not sure where these are, contact your referring physician or current PCP. If you need an interpreter, contact our office ten workings days before your appointment. We will have a few more forms for you to sign on the day of your appointment, so please remember to arrive at least 45 minutes early.

RETURN AS SOON AS POSSIBLE:

- ☐ Address/Insurance Information Form
- ☐ Medical History Form

BRING TO YOUR FIRST APPOINTMENT:

- ☐ Driver's License or other photo identification
- ☐ Insurance card or Worker's Comp/Auto Injury claim number
- ☐ Medical Records, imaging results (MRI Films, X-rays, etc)
- ☐ Any prescribed or over-the-counter medications you are currently taking
- ☐ Read forms to be signed. You will sign the forms electronically in the office.



If you have ANY questions about the forms or your appointment, call us at (612) 444-3000.
We look forward to meeting you!

OFFICE HOURS

The clinic is open from 9:00 am to 5:00 pm Monday through Friday. Receptionists answer calls during this time.

In emergencies, call 911. If you have an important question that is not an emergency, but is so urgent that it cannot wait for normal business hours, please contact our office and leave a message and it will be returned by one of our physicians.

SCHEDULING

Appointments are generally between 9:00 am and 5:00 pm. Please respect other patients who also need to see us by giving **24 hour notice** to cancel or reschedule an appointment**.** If you miss an appointment or cancel more than two appointments, we reserve the right to discontinue your care with our clinic.

YOUR APPOINTMENT

On your first visit, you will be seen by either Dr. George (Addiction Services) or Dr. Zaydman (Pain Management), depending on the care you need, and by our Medical Assistant.

INJECTIONS

Most injections—muscle, tendon, and joint—are done at our clinic. We also have a IV drip we use for intravenous treatment that you may need in conjunction with your care.

DR. SVETLANA ZAYDMAN

Dr. Svetlana Zaydman is double board certified in Physical Medicine and Rehabilitation and Pain Medicine. She graduated from NYCOM as a D.O. and completed residency in PM&R at Albert Einstein School of Medicine in New York. Throughout her medical training and 5+ years of experience with treating patients, she has developed a true passion for improving lives with pain management and wellness therapies.

Dr. Zaydman takes a comprehensive approach to pain management, utilizing therapies, medication, exercise, nutrition, and other lifestyle changes to relieve both acute and chronic pain. She works with each patient individually to develop a unique treatment plan to achieve positive, lasting results. With a keen understanding of the body's anatomy and function, she is dedicated to relieving pain and discomfort, and to renewing hope for her patients.

In addition to pain management and pain medication, Dr. Zaydman is a firm believer in the powerful effect that daily wellness choices have on our overall quality of life. Previously, Dr. Zaydman was on the medical staff at the Atkins Center for Complementary and Alternative Medicine in NYC, where she worked under Dr. Robert Atkins, developer of the low carbohydrate diet. As part of comprehensive therapy, she provides education and guidance on diet, exercise, and alternative wellness treatments to help patients feel their very best.

PAIN MANAGEMENT

After a comprehensive patient evaluation, Valley Pain Relief and Wellness Center works with each patient to personalize their best treatment plan for pain management. Our multidisciplinary approach incorporates pain medicine with physical and interventional pain therapies for optimal results. Quite often, alternative medicine and lifestyle changes are also advised to support long-term relief.

In addition to therapy and medication, creating a healthy lifestyle will play a critical role in your pain management treatment. This includes choices that we make every day, such as proper nutrition, appropriate exercise, sufficient sleep, and healthy habits. These factors are important for everyone, but even more so for those who are ill and experiencing pain, as they affect how the body heals. Our physicians can provide guidance on making healthy lifestyle changes, to optimize your recovery and for long term benefits.

To ensure patient safety, Valley Pain Relief and Wellness Center will follow best practices in monitoring all prescriptions, and uphold patient safety and proper ethics at all times.

Our patients will be required to take regular urine tests while under our care. If test results indicate illicit medication or prescription misuse, continuation of care with our practice will be reviewed. Such patients may be discharged or referred to a substance abuse specialist as part of our protocol.

It is always best to communicate openly with your physician. Notify them of all current medications, and always discuss desired changes prior to altering medication on your own.

In some cases, we prescribe opioids. Such medications are federally regulated and carefully controlled. We strictly monitor patient compliance. **Bring all pain medications you are taking,** in their prescription bottles. Be prepared to provide a urine sample for drug testing

We require substantial medical records before prescribing medications. Therefore, we may not be able to issue a prescription at your first appointment.

DR. ASHWIN GEORGE

Dr. Ashwin V. George is double board certified in Internal Medicine and Palliative Care & Hospice, and is also a Diplomate of the American Board of Addiction Medicine. His knowledge, combined with his compassion for people, makes Dr. George an approachable and caring physician. His greatest passion is improving the quality of patients' lives by assisting them in overcoming addiction.

As Addiction Medicine Director at Valley Pain Relief and Wellness Center, Dr. George provides treatment for opioid dependency and heroin addiction, alchohol and chemical dependency, and addiction counseling services. He is one of few physicians certified in Suboxone treatment for narcotic addiction in Minnesota.

Additionally, Dr. George has 7+ years of experience working as a hospitalist, managing cancer pain for palliative care patients. Dr. George is affiliated with Health Partners and Regions Hospital.

ADDICTION SERVICES

Practice of addiction medicine is a relatively new area in medicine. It has advanced tremendously through increased understanding of the brain's chemical reaction to addiction and related psychological factors. With a physician's supervision and care, medical treatments can be used to combat withdrawal symptoms while working towards recovery.

Valley Pain Relief and Wellness Center takes a multi-disciplinary approach to addiction treatment, utilizing not only medication but additional therapies and support to help each unique patient with their specific addiction. Research shows that patients benefit most from this combined approach.

There is no need to suffer from addiction in silence and shame. Life changing opportunities exist for those who are ready to fight their addiction. Valley Pain Relief and Wellness Center is focused to help achieve that goal.

The misuse of pain pills, heroin, and other opioids is on the rise in staggering fashion, resulting in a dramatic increase in both addiction and overdose-induced deaths. The increase of opioid use and dependency has even surpassed that of marijuana.

Opioid dependency is a chronic, long-term, medical condition. Because of the way it affects the brain, opioid addiction is not something most people can overcome on their own.

Fortunately, proven medical treatments like Suboxone, along with counseling and behavioral therapy, has helped millions of opioid-dependent people regain control over their condition. Valley Pain Relief and Wellness Center is one of few providers to offer Suboxone treatment to patients in Minnesota.

Suboxone (Buprenorphine and Naloxone) is a discreet and effective treatment that can be taken at home. By suppressing withdrawal symptoms and reducing cravings, Suboxone Film can help eliminate the use of illicit opioids, so you can focus on getting back to the life you desire and things you care about most.

ADDRESS & INSURANCE FORM

I. PATIENT:

LAST NAME FIRST MIDDLE	**MARTIAL STATUS** **MARRIED SINGLE D IVORCED WIDOWED**
DATE OF BIRTH: _____/_____/_____	**SEX: MALE FEMALE**
ADDRESS:	**SSN#**
CITY: STATE: ZIP:	**PRIMARY PHONE #**
RACE: LANGUAGE:	**SECONDARY PHONE #**
Driver's License Number:	**Referred by:**
ETHNICITY: HISPANIC OR LATINO/NON HISPANICE OR LATINO	**EMAIL:**
PHARMACY NAME & PHONE:	**EDUCATION: 12th GRADE COLLEGE AND/OR ABOVE**
Primary Care Physician:	**Clinic: Phone:**
Occupation:	**EMPLOYER NAME/ADDRESS/PHONE:**

II. GUARANTOR OF ACCOUNT (if different than above):

LAST NAME FIRST MIDDLE	**MARTIAL STATUS: MARRIED SINGLE D IVORCED WIDOWED**
DATE OF BIRTH: _____/_____/_____	**SEX: MALE FEMALE**
ADDRESS:	**SSN#**
CITY: STATE: ZIP:	**PRIMARY PHONE #**
RELATIONSHIP TO PATIENT:	**SECONDARY PHONE #**

III. PATIENT PRIMARY INSURANCE: (present insurance card)

INSURANCE COMPANY: EFFECTIVE DATE:	**POLICY HOLDER NAME/DOB:**
POLICY/ID NUMBER:	**GROUP #/GROUP NAME:**
ADDRESS: PAYER ID:	**ADJUSTER NAME/PHONE #:**
CIRCLE IF APPLICABLE: WORKER'S COMP AUTO INJURY	**DATE OF INJURY:**

III. PATIENT PRIMARY INSURANCE: (present insurance card)

INSURANCE COMPANY: **EFFECTIVE DATE:**	**POLICY HOLDER NAME/DOB:**
POLICY/ID NUMBER:	**GROUP #/GROUP NAME:**
ADDRESS: **PAYER ID:**	**ADJUSTER NAME/PHONE #:**
CIRCLE IF APPLICABLE: **WORKER'S COMP** **AUTO INJURY**	**DATE OF INJURY:**

IV. PATIENT SECONDARY INSURANCE: (present insurance card)

INSURANCE COMPANY: **EFFECTIVE DATE:**	**POLICY HOLDER NAME/DOB:**
POLICY/ID NUMBER:	**GROUP #/GROUP NAME:**
ADDRESS: **PAYER ID:**	**ADJUSTER NAME/PHONE #:**

V. NOTIFY IN CASE OF EMERGENCY:

NAME(LAST,FIRST):	**PHONE #:**	**RELATIONSHIP TO PATIENT:**
NAME(LAST/FIRST):	**PHONE #:**	**RELATIONSHIP TO PATIENT:**

Assignment of Benefits Clause: I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any profession services. I authorize direct payment of medical benefits to Valley Pain Relief and Wellness Center for services rendered. I also authorize release of any information concerning my past medical care to my insurance companies, referring physician, or legal guardian.

_____	_____
PATIENT SIGNATURE **DATE:**_____	**GUARANTOR SIGNATURE** **DATE:**_____

FINANCIAL POLICY

You are responsible for all charges you incur at Valley Pain Relief and Wellness Center. We accept cash and credit/debit cards. We know that both cost and quality of care are important to you. Ask if you have questions about fees.

INSURANCE

As your medical provider, our relationship is with you. Your insurance is a contract between you and your insurer, which may not cover all of your care. We will file your claim as a courtesy. You must pay any charges that are not reimbursed.

To prevent fraud, you must present a valid insurance card or claim, photo ID, and any applicable co-payment or past-dur balance at each visit.

If your insurance has changed, you may need to pay the full cost of your visit. We understand your frustration and will assist in obtaining reimbursement or credit from your insurer.

If you do not have insurance, we require you to pay the entire amount of the charges at the time of service. If additional services are required during the appointment and a balance remains, we will provide you with the option of a payment plan to help give you the time between appointments to pay your remaining balance.

REFERRALS

Some insurers require a referral from your primary doctor; refer to your medical policy. Please bring the referral to your appointments. Without a referral, insurers may require you to pay for your visit in full.

FORMS/PRIOR AUTHORIZATION/APPEALS

Insurance covers only your medical care. It does not cover submitting forms that may assist you in collecting disability benefits, maintaining employment, or prior authorization for certain medications. **There are fees for these service which reflect the resources diverted to the effort.**

Your insurance may not cover all treatments or medications. You may pay cash, forego treatment, or appeal with your insurer. If you ask us to appeal, we will bill you an hourly rate as this is not medical care.

ASSIGNMENT OF BENEFITS

I authorize all insurance benefits to be paid directly to Valley Pain Relief and Wellness Center. I authorize the release of all necessary information to file and complete all insurance claims.

UNPAID BILLS _____

Accounts that are 10 days past due will be assessed a $15.00 late fee. You may also be responsible for collection costs including court and attorney fees.

Valley Pain Relief and Wellness Center has the right to refuse ongoing treatment to any patient that has not paid for previous treatments provided. In addition, we have the right to refuse future referrals made to our clinic on your behalf.

MISSED AND CANCELLED APPOINTMENTS _____

Be respectful to other patients. If you cannot keep an appointment, please give us at least 24 hours notice, so that we can make this time available for other patients. We will charge $100 fee if sufficient notice is not given (weekends not included). If you arrive ten minutes or later to an appointment you may be asked to reschedule**. This type of missed appointment also requires a charge.**

LATE ARRIVALS

We are working hard to maintain scheduled appointments. In order to do this, we have to ensure that all patients are on time for their scheduled appointment.

For your new patient intake, we ask that you are an hour early for your appointment. If you are more than a half hour late for this intake process, you will be charged $50 before the doctor can see you, as it pushes back all other appointments for the day.

For your follow up appointments, if you are more than 15 minutes late you will be assessed a $50 fee and asked to reschedule your appointment.

EMERGENCY APPOINTMENTS _____

Valley Pain Relief and Wellness Center does not have appointments that are only for same day requests. Same day appointments are at the discretion of the provider and are based on medical necessity. If, for any reason, you need to be seen by the doctor on the same day that you call and this request is granted, we may charge you an additional $100.00 fee for hours that are outside of our normal operating hours. We will charge this fee at time of service.

DISABILITY PAPERWORK _____

Here at Valley Pain Relief and Wellness Center, it is our job to provide you with the best care possible to manage your pain so you can work and go on with your daily living. When it comes to patients who are applying for disability benefits, we need at minimum 4 –5 visits to access your individual situation to see if you qualify for disability or not. When it comes time to determine this, the time it takes to fill out the paperwork and the detail required takes our physicians a elongated amount of time to complete. The charge for this service is $250. This fee will need to be paid before any paper work is filled out or given to the doctor for review. Thank you for your compliance on this.

I HAVE READ AND UNDERSTAND ALL THE INFORMATION ON THIS FINANCIAL POLICY. I AGREE TO ITS TERMS AND TO THE ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION DESCRIBED ABOVE. WITH MY SIGNATURE I AM ALSO AUTHORIZING MEDICAL TREATMENT TO BE PERFORMED BY VALLEY PAIN RELIEF AND WELLNESS CENTER

_____

PATIENT/GUARDIAN SIGNATURE

_____

PRINT PATIENT/GUARDIAN NAME

_____

DATE

INTAKE FORM

CHIEF COMPLAINT:

What brought you in today?_____

If for pain—Where is the pain and how long have you had it?_____

If for substance abuse—How long have you been addicted and to what?_____

Are you currently in treatment for any of the following conditions?

Yes No Depression When were you diagnosed? _____ Medications?_____

Yes No Anxiety When were you

Yes Mo Joint Pain Where is the pain?_____ How long?_____ Meds?_____

Treatment?_____

Yes No Myalgia How long?_____ Treatments:_____

Were the treatments effective: _____

What is your current pain level? (1 = Least 10 = Greatest)

1 2 3 4 5 6 7 8 9 10

What is your activity level?_____

Has it increased or decreased since the onset of your chief complaint?_____

Have you tried any alternative therapies besides medication?_____

If so, what therapies? _____

Has your quality of life improved or worsened or been unchanged since the onset of your chief complaint?

_____

Has your sleep improved, worsened, or been unchanged since the onset of your chief complaint?

_____

PMH

Surgeries? Yes No

What:_____ Year:_____ What:_____ Year:_____

What:_____ Year:_____ What:_____ Year:_____

Do you have any other Medical Issues/Diagnosis?

_____

_____

CURRENT MEDICATIONS

Name/mg:_____ Dosage:_____ Date started:_____

Name/mg:_____ Dosage:_____ Date started:_____

Name/mg:_____ Dosage:_____ Date started:_____

Name/mg:_____ Dosage:_____ Date started:_____

FAMILY HISTORY

Paternal History (father):

Deceased? Living? Healthy? Illness?_____

Yes No Substance Abuse How old?_____ What drug?_____

Maternal History (mother):

Deceased? Living? Healthy? Illness?_____

Yes No Substance Abuse How old?_____ What drug?_____

Children: Do you have any children? Yes No

Child 1 Name:_____ Age:_____ Illnesses?_____

Child 2 Name:_____ Age:_____ Illnesses?_____

Child 3 Name:_____ Age:_____ Illnesses?_____

SOCIAL HISTORY

Yes No Do you smoke?

How much per day? _____ How Long?_____

Yes No Do you drink coffee/tea/soda?

How much per day?_____ Per week?_____

Yes No Do you exercise? What kind and how often?_____

Yes No Are you able to perform activities of daily living on your own?

If not, please clarify:_____

Employment Status: Employed Unemployed Disabled Retired

Martial Status: Married Single Divorced Separated

How many people are in your household?_____ Relation?_____

How many times a day do you eat?_____

ROS

What does your pain interfere with?

_____

_____

How is your sleep quality? Poor Fair Good Excellent

Mood? Poor Fair Good Excellent

Activity? Poor Fair Good Excellent

Concentration? Poor Fair Good Excellent

RELEASE OF INFORMATION & CONSENT FORM

It is important that health care providers work together. As such, Valley Pain Relief and Wellness Center, would like your permission to communicate, when necessary, with your medical providers.

This release form is enforceable from _____(today) to _____(1 year from today)

Patient Name:		DOB:	
SSN:		Phone:	
Address:		City, State, Zip:	

Organization Name:	
Clinic Name:	
Address:	
Phone/Fax:	

I, _____(patient name), hereby authorize the release and exchange of information specified below between the above listed organization and:

Valley Pain Relief and Wellness Center
2428 E 117th St – Burnsville, MN 55337
P: 612-444-3000 – F: 612-444-9000

This release of information shall be limited to the following specific types of information:

__Assessment
__Diagnosis
__Treatment Plan or Summary
__Current Treatment Update
__Medication Management Information
__Presence/Participation in Treatment
__Nursing/Medical Information
__Toxicological Reports/Drug Screens
__Educational Information
__Psychiatric/Psychological Evaluations
__Toxicological Reports/Drug Screens
__Education Information
__Discharge/Transfer Summary
__Continuing Care Plan
__Demographic Information
__Progress in Treatment/Notes
__Imaging_____
__Lab Results
__Other_____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to Valley Pain Relief and Wellness Center in writing. However, a revocation is not valid to the extent that parties have acted in reliance on such authorization. The information is confidential and any redisclosure by the recipient is prohibited, unless authorization authorizes the release of all medical records including Psychiatric, alcohol, drug abuse, pain management, etc.

Patient Signature:_____Date:_____

New patient consent to the Use and Disclosure of Health Information for Treatment, payment, or Health Care Operations

I understand that as a part of my health care, Valley Pain Relief and Wellness Center, PLLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment.

A means of communication among many health professionals who contribute to my care.

A source of information for applying my diagnosis and surgical information to my bill.

A means by which a third party payer can verify that services billed were actually provided.

A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent

The right to object the use of my health information for directory purposes.

The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Valley Pain Relief and Wellness Center, PLLC reserves the right to change their notice and practices and prior to implementation, In accordance with Section 164.520 of the Code of Federal Regulations. Should Valley Pain Relief and Wellness Center, PLLC change their notices, they will send a copy of my revised notice to the address I have provided (US mail or EMAIL).

I wish to have the following limitations to the use or disclosure of my health information:

I understand that as a part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and (Patient's Initials): _____ ACCEPT _____ DECLINE, terms of this consent.

Patient's Name (Printed): _____ Relationship to Patient: _____

Patient Signature: _____ Date: _____

For Office Use Only:

Consent received by: _____ on _____

Consent refused by patient, and treatment refused as permitted.

Consent added to the patient's medical records on _____

PATIENT TREATMENT CONTRACT

Patient Name: _____ Date: _____

As a participant in medication treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1) I agree to keep, and be on time to, all my scheduled appointments.
2) I agree to adhere to the payment policy outlined by this office.
3) I agree to conduct myself in a courteous manner in the doctor's office.
4) I agree to report my history and symptoms honestly to my doctor and the office staff. I will inform my doctor about any medications (prescription and non-prescription) that I am taking. I will report any changes in my medical history, such as becoming pregnant.
5) I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
6) I understand that my medication must be stored safely, where it cannot be taken accidentally by children or pets, or stolen. If anyone else, including a child, takes my medication, I will call 911 or Poison Control at 1-800-222-1222 immediately.
7) I agree not to deal drugs, steal, or conduct any illegal or disruptive activities in or around the doctor's office.
8) I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
9) I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
10) I will be careful with my take-home prescription supplies of my medication. If I report that my supplies have been lost or stolen, my doctor may not provide me with a make-up supply.
11) I understand that at every visit, my doctor may ask me to bring my unused supply of medication for a medication count and that I may not get a refill if I do not bring my medication with me.
12) I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
13) I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
14) I understand that mixing this medicine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
15) I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events.
16) I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
17) I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
18) I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).
19) I agree to provide random urine samples and have my doctor test my blood alcohol level.
20) I understand that violations of the above may be grounds for termination of treatment.
21) I agree to pay office visits in cash or credit card at the time of visit. If I have insurance coverage I agree to pay any required office co-pays at the time of my visit. My account balance will be kept current at all times.
22) I understand I will receive 'pass' for violating the terms I have agreed to. Further problems will be grounds for immediate and permanent dismissal from the practice. Should the final option of discharge occur I will be provided a 30 day supply of my most recent dose of medication in order to allow me time to locate another provider if possible. It is not the responsibility of this clinic to locate another provider.

This treatment contract is between Valley Pain Relief and Wellness Center and _____.
Patient's Name

Patient Signature:_____Date:_____

Physician Signature:_____Date:_____

APPOINTED PHARMACY CONSENT

SUBOXONE® (buprenorphine and naloxone) Sublingual Film (CIII)

I_____ do hereby,

Patient Name (Print)

Authorize **Dr. Ashwin George** to disclose information about my treatment for opioid dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy.

_____ Agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary so that my buprenorphine prescription can be filled and either delivered to the office address given above or picked-up by employees of the same office.

_____ **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 these rights.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____

Parent/Guardian Name (Print):_____ Date: _____

Witness Signature:_____ Witness Name (Print):_____

Date:_____

Appointed Pharmacy Name:_____

Phone Number: _____

Address:_____