COLLINS FAMILY & ADDICTION MEDICINE
collinsrefreshlife.og

WELCOME LETTER

Dear New Patient,

Welcome to our practice. We are honored that you have chosen our practice. We are committed to providing you with the best care we can. Thank you for allowing us to serve your family and addiction needs.

Our hope is that we form a partnership to keep you as healthy as possible, no matter what your current state of health; I will share my medical expertise with you. I hope you will take responsibility for working toward a healthy lifestyle that is so important for your well-being.

Here are some important steps you can take towards better health:

- ✓ Do not smoke cigarettes or use other tobacco products.
- ✓ Do not drink alcohol with medication. Never drive when you have been drinking.
- ✓ Eat a diet low in fat and high in vegetables and fruits.
- ✓ Exercise at least three times a week.
- ✓ Always let us know how we are doing and how we can improve.
- ✓ Learn about ways to deal with stress and tension.
- ✓ Discover what spirituality means to you and practice it.
- ✓ Maintain ties with your family, neighbors, co-worker, or your church community.
- ✓ A complete physical exam will be given and periodic check-ups to test for a few specific diseases.

I look forward to working with as your doctor. Please contact the office anytime with questions at 615-915-2226.

Sincerely,

Dr. Kimberly Collins

Collins Family and Addiction Medicine, PLLC
4777 Andrew Jackson Pkwy STE #102
Hermitage, TN 37076

OFFICE POLICY

1) Patients are required to call in a 72-hour notice on ALL refills on medication(s)

2) Voice messages may be left with the answering service after hours. All calls will be returned as soon as possible during normal business hours. Voice mail messages only. Please do NOT leave multiple messages – doing so will delay a call back.

*In case of emergency, please call 911 or go to the nearest emergency room.

3) All patients are expected to conduct themselves in an appropriate, respectful manner toward all staff members. Failure to do so may result in patient's appointment being rescheduled or termination from program. If a patient fails to conduct themselves in an appropriate, respectful manner toward staff, they will be asked to leave facility premises.

4) For self-pay patients: Cash for co-pays only will be accepted, credit/debit card or money orders will be accepted for all other cash pay services with Addiction Medicine.

5) Patients are expected to provide their medication bottles including prescription labels for pill counts each office visit. Failure to do so may result in no further medication prescribed.

CANCELLING & RE-SCHEDULING APPOINTMENTS

5) Patients are expected to be on time for all scheduled appointments. It is recommended patients arrive 15 mins early. If a patient is more than 10 minutes late for appointments with Dr. Collins, their appointment will be rescheduled.

6) For counseling appointments, if a patient is more than 5 minutes late, their appointment will be rescheduled, and they will not receive medication7) Same day cancellations for Dr. Collins and counseling appointments will be rescheduled for no sooner than the following week.

8) No-show appointments may result in termination from program. Readmission to program will be considered after 28 days pending availability of a slot.

______________________________ ______________________

Patient Signature Date

Collins Family and Addiction Medicine, PLLC
4777 Andrew Jackson Pkwy STE #102
Hermitage, TN 37076

Buprenorphine Patient Treatment Contract

For purposes of this contract, referrals to buprenorphine/buprenorphine products includes Suboxone, Zubsolv, and Subutex.

As a participant in the buprenorphine protocol for treatment of opioid abuse and dependence, I freely and voluntarily agree to accept this treatment agreement/contract, as follows (please initial next to each statement):

____I understand that no medication will be prescribed until I've completed the initial physical exam, lab work, urine drug screen, psychological assessment and paid my fees.

____I agree to keep, and be on time to, all my scheduled appointments with the doctor and his/her assistants. Failure to arrive in a timely manner may result in my appointment being rescheduled. Any missed or re-scheduled office visits will result in my not being able to get medication until the next scheduled visit.

____I agree not to arrive at the office intoxicated or under the influence of drugs, and to conduct myself in a courteous manner in the clinic office. If I do arrive intoxicated, the doctor will not see me, and I will not be given any medication until my next scheduled appointment.

____I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.

____I agree not to deal, steal, or conduct any other illegal or disruptive activities.

____I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place where it cannot be taken accidentally by children/pets or stolen by unauthorized users. I agree that lost medication will not be replaced regardless of the reason for such loss.

____I agree that I will file a police report if any of my buprenorphine medication is missing.

____I agree that I will not drive a motor vehicle or use power tools or other dangerous machinery during my first days of taking buprenorphine, to insure that I can tolerate the medication without becoming sleepy or clumsy as a side effect.

____I agree that I will arrange transportation to and from the treatment facility during my first days of taking buprenorphine.

____I agree that I will stop taking any opiate medications 24 hours before Dr. Collins begins my buprenorphine treatment.

____I agree that a strong support system, and communication of persons within that system, is an important part of my recovery. I will be asked for my authorization, if required to allow telephone, email, or face to face contact, as appropriate, between my

treatment team and outside parties (physicians, therapists, pharmacists, probation and parole officers, and other parties) when the staff has decided that open communication about my care, on my behalf, is necessary.

____I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treating physician. I understand that mixing buprenorphine-based medications with alcohol or other medications, especially benzodiazepines (such as Valium, Ativan, Xanax, Klonopin) and other drugs of abuse, can be dangerous. I also understand that a number of deaths have been reported among individuals mixing buprenorphine-based medications with benzodiazepines.

____I agree to take my medication as the doctor has instructed and not to alter the way I take my medication without first consulting the doctor.

____I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education and relapse prevention programs, as provided, to assist me in my treatment.

____I understand that I will be expected to answer all phone calls from this clinic (or call the clinic back as soon as possible) and present to the designated location when requested for pill counts and / or random urine drug screens.

____I understand that my physician may recommend treatment at a facility providing more intensive treatment that can be provided in this outpatient setting. If recommended, I agree to proceed with said treatment.

____I agree to notify and update the clinic if I move to a new address or obtain a new phone number.

____I understand that I may be released from treatment at any time for failed urine drug screens, infractions of the above rules, and if my physician feels I'm making inadequate treatment progress.

____I understand that smoking (including e-cigarettes) is not allowed on the premises.

____I have been given a copy of clinic rules and regulations. I understand these rules and I've had my questions answered to my satisfaction.

Patient Signature____ Date______________________

Staff Signature____ Date______________________

Collins Family and Addiction Medicine, PLLC
Kimberly R. Collins, M.D.
4777 Andrew Jackson Parkway STE 102
Hermitage, TN
Phone: 615-915-2226

Buprenorphine Consent to Treatment Form

Buprenorphine is a medication approved by the Food and Drug Administration (FDA) for treatment of people with opioid dependence. Qualified physicians can treat up to 30 patients for opiate dependence. Buprenorphine can be used for detoxification for maintenance therapy. Maintenance therapy can continue as long as medically necessary.

Buprenorphine itself is an opioid, but it is not as strong an opioid as heroin or morphine. Buprenorphine treatment can result in physical dependence of the opiate type. Buprenorphine withdrawal is generally less intense than 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.

If you are dependent on opiates, you should be in as much withdrawal as possible when you take the first dose of buprenorphine. If you are not in withdrawal, buprenorphine may cause significant opioid withdrawal. For that reason, you should take the first dose in the office and remain in the office for observation. Within a few days, you will have a prescription for buprenorphine that will be filled in a pharmacy.

Some patients find that it takes several days to get used to the transition from the opioid they had been using to buprenorphine. During that time, any use of other opioids may cause an increase in symptoms. After you become stabilized on buprenorphine, it is expected that other opioids may cause an increase in symptoms. Attempts to override the buprenorphine by taking more opioids could result in an opioid overdose. You should not take any other medication without discussing it with me first.

Combining buprenorphine with alcohol or some other medications may also be hazardous. The combination of buprenorphine with medication such as Valium, Librium, Ativan has resulted in deaths.

The form of buprenorphine you may be taking is a combination of buprenorphine with a short-acting opiate blocker (naloxone). If the Suboxone tablet were dissolved and injected by someone taking heroin or another strong opioid, it could cause severe opiate withdrawal.

Buprenorphine tablets must be held under the tongue until they dissolve completely. Buprenorphine is then absorbed over the next 30 to 120 minutes from the tissue under the tongue. Buprenorphine will not be absorbed from the stomach if it is swallowed.

____

Signature | Print Name | DOB | Date

Collins Family and Addiction Medicine, PLLC

4777 Andrew Jackson Pkwy STE #102

Hermitage, TN 37076

Insurance/Payment Policy

- If you have a health insurance policy, it is important to know if we are in network with your insurance company. If we are out of network (OON), you will be responsible for paying the balance of charges that your insurance company does not pay.
- For patients whose insurance company covers their visits to our practice, you may have a co-pay, deductible or co-insurance charge. These charges reset and may change at the beginning of each calendar year. You are expected to pay the required payment at each visit, before you begin the appointment, **no exception.** If you are unable to make the payment, we will not be able to see you on that date. In addition, if we cannot confirm that your insurance is active, you will be required to pay the practice cash price prior to seeing the physician or counselor.
- I understand if I do not provide this practice with up-to-date insurance information or notify us of insurance policy changes, I will be responsible for any and all uncovered charges.
- Unpaid bills will be subject to a compounding 10% interest rate (APR).
- I understand as a patient of Dr. Collins if I do not pay any fees not covered by insurance, I will be subject to actions that may include small claims court, collections actions and notification of credit agencies with negative impacts upon credit scores.
- I understand I will be responsible for fees associated with attempts to collect past due monies. These fees include court fees, attorney fees and any other fees that are associated with these actions.

I have read and understand the above policy. Any questions that I have were answered by office staff. I agree to the above policy.

______________________________	______________________________
Signed	Date
______________________________	______________________________
Printed Name	Witnessed

Collins Family & Addiction Medicine
4777 Andrew Jackson Parkway, Suite 102, Hermitage TN 37076
Phone#615-915-2226 Fax#629-202-7956

Authorization for Release of Information

Name:______________________________ DOB:_____________ Social Security: ________________

I hereby authorize the release of the following specific information ___Yes ___No

Yes No

___ ___ 1) Medical history, examinations, laboratory tests and treatment reports.
___ ___ 2) Psychological test/psychiatric evaluation/neurological workup.
___ ___ 3) Social history, including family, education, employment, arrest and drug use information.
___ ___ 4) Summary of previous mental health treatment.
___ ___ 5) Periodic reports of current treatment progress including attendance, participation and urine surveillance results.
___ ____ 6) Other (specify)____

Treatment dates to release: Circle (any or all records)

Specific dates

Date of service: ______/______/______ to ______/______/______

Date of service: ______/______/______ to ______/______/______

Date of service: ______/______/______ to ______/______/______

I understand that this information will be used for the following specific purposes ___ Yes ___No

Yes No

___ ___ 1) To develop a diagnosis, treatment and rehabilitation plan.
___ ___ 2) To coordinate medical, psychological and social rehabilitative process.

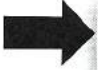
I understand this information will not be disclosed to any other agency or individual without my written consent/authorization, except as allowed by law. I also understand my protected health information, which is disclosed with this release, may be subject to re-disclosure by the recipient and no longer protected by law. Collins Family & Addiction Medicine is not responsible for any alterations made on its medical record copies that have been released to any party. I understand I have the right to a copy of this authorization after I sign it. This authorization automatically expires one year after the date I have signed it. I understand this authorization may be revoked at any time with my written statement.

This authorization for release of information is given freely, voluntarily and without coercion.

______________________	______________	________________	________________
Signature of Patient	Date	Witness	Date

Financial Agreement/Responsibility

I acknowledge financial responsibility for services provided by Dr. Collins. I understand that the clinic will file my insurance as a courtesy and that I am responsible for any amounts including but not limited to: co-payments, co-insurance, deductibles, FMLA/Disability paperwork, copies of x-rays and/or medical records. I understand that co-pays and prior balances are due at time of service. Deductibles and co-insurance carries made on my behalf will be directed to KRC for services provided.



Signed ______________________________ Date ____________________

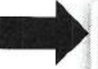
Consent of Treatment/Payment/HIPAA Consent

I authorize Dr. Collins physician and staff to provide medical treatment as needed. I authorize the order and use of x-rays, injections, casting and/or diagnostic tests to diagnose and treat my illness or injuries. I hereby consent for KRC to use or disclose, for the purpose of carrying out treatment, payment, and/or healthcare operations at any time by giving a written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information.

Signed ______________________________ Date ____________________

Consent of Communication Method

I acknowledge and agree that Dr. Collins and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided and any other telephone number associated with my account, including wireless and/or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as ATDS (Automated Telephone Dialing System) or pre-recorded message. I also agree that I will notify Dr. Collins if I have given up ownership or control of any such telephone numbers.



Signed ______________________________ Date ____________________

ePrescribing

A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an internet connection. ePrescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription to a pharmacy from the point of care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribing program.
These include:

- Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Dr. Collins can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Signed ______________________________ Date ____________________

I have received a copy of the Notice of Privacy Practices of Collins Family and Addiction Medicine.

Signed ______________________________ Date ____________________

Collins Family & Addiction Medicine

HIPAA Disclosure Form

Consent for release of information to an individual

I, ______________________________, hereby authorize Collins Family & Addiction Medicine to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, text, or email to the following family members:

Name: ____________________ DOB: ______________ Relationship: ______________

Name: ____________________ DOB: ______________ Relationship: ______________

Name: ____________________ DOB: ______________ Relationship: ______________

Name: ____________________ DOB: ______________ Relationship: ______________

Name: ____________________ DOB: ______________ Relationship: ______________

I, ______________________________, hereby authorize Collins Family & Addiction Medicine to Contact the below named individual/individuals in case of emergency. I authorize Collins Family & Addiction Medicine representative to discuss the emergency with the individual/individuals listed below.

Name: ______________________________ Relationship: ______________

Name: ______________________________ Relationship: ______________

Print Name: ______________________________

Signature: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________

Collins Family & Addiction Medicine
HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The patient understands that:
Protected health information may be disclosed or used for treatment, payment, or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The Practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: ______________________________

Printed Name-Patient or Responsible Party

____

Patient Signature or Responsible Party **Date**

____

Relationship to Patient (if other than patient)

Witness: ______________________________

Printed Name-Practice Representative

______________________________ ____/____/______

Signature **Date**

Collins Family & Addiction Medicine
4777 Andrew Jackson Parkway, Suite 102, Hermitage TN 37076
Phone#615-915-2226 Fax#629-202-7956

Patient acknowledgement and consent

______I understand that using opiate-based medication including but not limited to morphine, hydrocodone, oxycodone, fentanyl, methadone and buprenorphine, etc. has been associated with neonatal abstinence syndrome. Neonatal abstinence syndrome is a condition were newborn babies go through withdrawals from drugs including opiates. The symptoms including skin mottling, high pitch prolonged crying, excessive suckling, irritability, seizures in severe cases, poor weight gain, vomiting, diarrhea, tremors, stuffy nose or sneezing. Buprenorphine based products such as (subutex, suboxone, zubsolv) used to treat your addiction are associated with neonatal abstinence syndrome. Children born to mothers being treated with methadone or buprenorphine-based medication normally expedience a less severe case of neonatal abstinence syndrome and do not require hospitalization for as long as babies exposed to other shorter acting opiate like oxycodone, fentanyl, hydrocodone, codeine and morphine.

_____My provider has discussed with me the risk of neonatal abstinence syndrome as listed above and recommended the use of a voluntary long acting reversible contraception for all females patient of childbearing age or the potential to bear children. My provider discussed with me my options like an IUD, Nexplanon, BTL, depo shot, birth control pills or condoms.

_____My provider has discussed with me that they will be doing blood work to evaluate for chronic viral illnesses such as HIV and Hepatitis C. If I am found to be positive, I will work with the provider regarding treatment options. My provider has also discussed with me on how to prevent the transmission of chronic viral illnesses.

_____My provider has discussed overdosed prevention and has educated me about naloxone nasal or injection and has offered to send in a prescription for me to the pharmacy.

_____My provider has discussed with me today about my different options for treatment and the risk and benefits of each one listed below:

Inpatient rehab
Inpatient detox
Methadone treatment
Sublocade treatment
Vivitrol treatment
Buprenorpine treatment

I, ___________________________ acknowledges that the above has been discussed with me and I understand my options associated with the items listed above with my initials next to them. All of my questions have been answered. I agree to move forward with treatment at **Collins Family & Addiction Medicine.**

Signature_________________________________ Date______________________

Provider_________________________________ Date______________________

Collins Family & Addiction Medicine
4777 Andrew Jackson Parkway, Suite 102, Hermitage TN 37076
Phone#615-915-2226 Fax#629-202-7956

Appointment Reminders and Healthcare Authorization

Your physician, and members of the practice may need to **use your name, address, phone number, clinical records, email, or text to contact you** about appointment reminders, treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or left on voicemail. By signing this form, you are giving us authorization to contact you with the information you have provided.

You may restrict the individuals or organizations to which your health care information is released, or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, other health related information, or marketing at any time.

This notice is effective as of ____________________. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use and disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient printed name ______________________________ Date ______________________________

Patient Signature ______________________________ Date ______________________________

Personal Rep printed ____________________________ Personal Rep Signature ____________________

Collins Family & Addiction Medicine
4777 Andrew Jackson Parkway, Suite 102, Hermitage TN 37076
Phone#615-915-2226 Fax#629-202-7956

Informed Consent for Telehealth Services

Patient name: ______________________________ Date of birth: ________________

I understand that I have the following rights with respect to telehealth/telemedicine:

1.**Definition of telehealth/telemedicine**. Telehealth/telemedicine services involve the use of secure interactive videoconferencing equipment and devices or platforms that enable health care providers to deliver healthcare services to patients when located at different sites.

2. **Right to care**. I understand that the same standard of care that applies to an in-person visit will apply to a video visit. I understand that I have the right not to participate or decide to stop participating in a video visit and that my refusal will not affect my right to future care or treatment.

3. **Patient information & confidentiality**. I understand that the laws that protect the privacy and the confidentiality of health care information also apply to telehealth/telemedicine services. I understand that video, audio, or photographs may be stored with my consent, and that I have a right to access my medical information in accordance with federal and state law. I understand that my insurance carrier will have access to my medical information for quality review and/or audit purposes. I understand that I will not be physically in the same room as my clinician, and I will be notified of and my consent obtained for anyone other than my clinician present. I understand that the release of my medical information, to include audio and/or video, may be by electronic transmission.

4. **Communication risk & consent**. I understand that there are potential risks with using telehealth and video technology, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, interception, interruption, or distortion due to technical failures. If it is determined, that the electronic connection is not adequate, I understand that my health care provider or I may discontinue use and make other arrangements to continue the visit by other methods. I understand that my consent will be obtained to receive SMS (text) messages to my mobile device.

5**. Insurance & Billing**. I agree and understand that I am responsible for any out-of-pocket costs, including deductibles, copayments, or coinsurances, that apply to my video visit. I understand that health plan payment policies for video visits may differ from in-person visits.

6. **Group therapy**. I will not record or photograph any part of the group or the group members, or allow anyone into my room while the group is in session. I understand that I may learn the full names of group members due to their name being listed on the video. I agree not to seek out any information about group members (e.g., using a search engine or social media), nor contact them outside of group if this is against the specific group agreements. By joining the group, you are agreeing that you are in an environment where others cannot overhear the group's dialogue or see your screen. If the group facilitator notices that nonmembers are visible or audible during the session, they will ask you to secure your environment and/or leave the group until privacy can be attained. The group facilitator reserves the right to remove you from the group, if you do not do so yourself. If you are removed, the group facilitator will check in with you after the session ends.

By my signature below, I hereby state that I have read, understand, and agree to the terms of this document.

Print Name: ______________________________ Date of Birth: _________________________

Patient's signature: __________________________________ Date: ______________________

I have been offered a copy of this consent form (patient's initials) ________

Staff Signature: _____________________________ Date: ______________________________

Pregnant Buprenorphine Consent to Treat

I, (Name) ______________________________________, born on (Birthday) ______________

Understand that using opiate-based medications (including, but not limited to, morphine, hydrocodone, oxycodone, fentanyl, codeine, methadone, buprenorphine, etc.) has been associated with Neonatal Abstinence Syndrome (NAS). NAS is a condition where newborn babies go through withdrawal from drugs (including opiates). The symptoms include skin mottling, high pitched / prolonged crying, excessive sucking, irritability, seizures (in severe cases), poor weight gain, vomiting, diarrhea, tremors, stuff nose, or sneezing. Buprenorphine based products (Subutex, Suboxone, Bunavail, Zubsolv), used to treat your addiction, are associated with NAS. Children born to mothers being treated with methadone or buprenorphine-based medications normally experience a less severe case of NAS and do not require hospitalization for as long as babies exposed to other, shorter acting opiates (oxycodone, fentanyl, hydrocodone, codeine, morphine, etc.).

I understand that the use of any opiate medication (including buprenorphine-based medications) can result in NAS.

I understand that my doctor is recommending the use of buprenorphine-based medications to treat my addiction / substance abuse disorder.

I understand that my doctor feels the buprenorphine based medications are safer than using other, shorter acting narcotics in my treatment.

I understand that the use of buprenorphine based medications can make pain management more difficult during pregnancy. My doctor will help to find other methods to help me cope with pain that I may experience during and soon after pregnancy.

I understand that ideally, I would not have to use any opiate-based medications, but given my addiction, buprenorphine-based medications are believed to be one of the safest forms of treatment.

I understand that stopping any opiate-based medications "cold turkey" or abruptly during pregnancy can result in addiction relapse and increased risk of pregnancy miscarriage or other pregnancy complications.

I've had my questions answered. I understand that if I have any new questions that arise, I may contact my doctor for clarification and further discussion.

I agree to not hold liable Dr. Collins, M.D., or any doctors, nurses, counselors, or employees of these companies for complications that arise and affect me or my unborn baby.

Signature: ____________________________ Printed Name: ______________________________

Date: ______________ DOB: _________________

Collins Family and Addiction Medicine, PLLC
4777 Andrew Jackson Pkwy STE #102
Hermitage, TN 37076

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been Bothered by the following problems?	Not at All sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+		+	+
Total Score (*add your column scores*) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ____________

Somewhat difficult ___________

Very difficult ________________

Extremely difficult____________

Collins Family and Addiction Medicine, PLLC
4777 Andrew Jackson Pkwy STE #102
Hermitage, TN 37076

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:________________________ DOB:__________ DATE:__________

Over the last 2 weeks, how often have you been
Bothered by any of the following problems
(use "√" to indicate your answer)

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	Add columns	+	+	

TOTAL:__________

(Healthcare professional: For interpretation of TOTAL,
please refer to accompanying scoring card).

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	**(0) Not difficult at all** ______ **(1) Somewhat difficult** ______ **(2) Very difficult** ______ **(3) Extremely difficult** ______

UR:
Name:
DOB:

THE SUBJECTIVE OPIATE WITHDRAWAL SCALE (SOWS)

In the column below in today's date and time, and in the column underneath, write in a number from 0-4 corresponding to how you feel about each symptom RIGHT NOW.

Scale: 0 = not at all 1 = a little 2 = moderately 3 = Quite a bit 4 = extremely

DATE					
TIME					

	SYMPTOM	SCORE	SCORE	SCORE	SCORE	SCORE
1	I feel anxious					
2	I feel like yawning					
3	I am perspiring					
4	My eyes are teary					
5	My nose is running					
6	I have goosebumps					
7	I am shaking					
8	I have hot flushes					
9	I have cold flushes					
10	My bones and muscles ache					
11	I feel restless					
12	I feel nauseous					
13	I feel like vomiting					
14	My muscles twitch					
15	I have stomach cramps					
16	I feel like using now					
	TOTAL					

Collins Family and Addiction Medicine, PLLC
4777 Andrew Jackson Parkway Suite 102
Hermitage TN 37076
Phone: 615-915-2226

Patient Rights

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatments: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as : making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever and arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health

related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, or any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury, or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable

product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcements: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6)medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health of safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are

Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: WE may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorizations: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing you the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use of disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care of Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify, or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general conditions or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practices use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in , a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. IN some circumstances, you may have a right to have this decision reviewed. Please contact or Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health

information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handles or specifications of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny or request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for the purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You May contact your doctor if you have any other questions about privacy practices.

Signature:-

____Date:_____________________