# PATIENT REGISTRATION FORM

PATIENT NAME: ______________________________ DATE: ______________

STREET ADDRESS: ________________________________________

CITY: ______________________ STATE: ________ ZIP CODE: ______________

TELEPHONE: ______________________ SEX: M / F DATE OF BIRTH______________

SSN: ______________________ WORK PHONE NO: ______________________

PRIMARY CARE PHYSICIAN: ________________ REFERRED BY: ________________

EMERGENCY CONTACT NAME AND PHONE NO.: ______________________________

PREFERED PHARMACY: ________________________________________

## INSURANCE INFORMATION

**1)** PRIMARY HEALTH INSURANCE PLAN NAME: ______________________________

INSURANCE ID#: ________________ GROUP ID#: ________________

SUBSCRIBER'S NAME (if different than patient) ______________________________

SUBSCRIBER'S SS# ________________ DOB: ________________

**2)** SECONDARY INSURANCE PLAN NAME:______________________________

INSURANCE ID#:________________ GROUP ID#:________________

SUBSCRIBER'S NAME (if different than patient) ______________________________

SUBSCRIBER'S SS# ________________ DOB: ________________

**This section only needs to be filled out if patient is under the age of 18.**

MOTHER'S NAME: ________________ FATHER'S NAME: ________________

STREET ADDRESS:________________ STREET ADDRESS: ________________

City, State, ZIP: ________________ City, State, ZIP: ________________

SS#: __________ DOB:__________ SS#: __________ DOB:__________

# MAINE RECOVERY CENTER FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you, as checked and initial it.

_____ **Patient with Insurance:** You are responsible for deductibles, copays, noncovered services, coinsurance, and items considered “not medically necessary” by your insurance company. Copayment amounts will be collected at the time services are rendered. The remaining balance should be paid within 30 days of receipt of statement. If payment cannot be made at each visit, notify the front desk staff prior to visit to meet with our billing specialist.

_____ **Patient without Insurance (Private Pay):** Please make payment for your care at each patient visit upon checking in. If payment cannot be made at each visit, notify the front desk prior to visit to meet with our billing specialist.

_____ **Medicare:** Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, copays and any noncovered services.

_____ **Patient without proof of Insurance:** If you do not have evidence of health insurance at the time of visit, cash payment will be required at the time of visit. If we then receive the appropriate insurance/claim information and obtain payment, your cash payment will be refunded promptly.

_____ **Non-participating provider:** We do not participate with ___________________________ If we do not participate with your individual insurance, payment for your care should be made at each patient visit. If payment cannot be made at each visit, notify the front desk staff prior to first visit to meet with our billing specialist.

**GUARANTEE OF PAYMENT**
**Please initial each section on the line provided.**

______ I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

**NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided.**

______ I have been advised that if my health insurance carrier/HMO/Medicaid/Medicare plan claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

______ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize services that I requested and received today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

______ I authorize payment of benefits from my insurance carriers directly to Maine Recovery Center. [If I choose not to initial this item, the benefit payments will be paid to me and I will be responsible for paying Maine Recovery Center].

______ I understand three or more missed or cancelled appointments (with less than a 24 hour notice) in a twelve month period will require a $100 re-instatement fee before I can make any additional appointments. I also understand this is a one-time privilege. Any repeat offenses will make me subject to dismissal from the practice.

______ **Minor Patients only:**
The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.

**PAYMENT IS REQUIRED AT TIME OF SERVICE.**
**THERE WILL BE A $25.00 FEE FOR RETURNED CHECKS.**
**For your convenience, we also accept VISA and MasterCard.**

**I have read and understand my financial responsibilities as outlined in both pages of this Maine Recovery Center Financial Policy document.**

X________________________________________ ______________________________
Patient's signature Date

________________________________________
Patient's Printed Name

________________________________________ ______________________________
Printed name of person signing on behalf of patient Relationship to patient

**MAINE RECOVERY CENTER CONSENT FORM / PRIVACY NOTICE Please initial each section on the line provided.**

______ **Consent for Treatment:**
I consent to diagnostic procedures and medical care as necessary in the judgement of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

______ **Medical Release Authorization:**
With my consent, Maine Recovery Center may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

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

***To review the more comprehensive version of this notice or if you have any questions please call the office at (207) 213-4256.***

***The effective date of this notice is August 2014***

**Maine Recovery Center is required by law to protect the privacy of patient information and to provide notice to individuals of our privacy practices. We must abide by the terms of this notice. We reserve the right to change this notice. If we make changes to this notice we will provide patients with a revised notice.**

**Practice Privacy Policy**
At Maine Recovery Center your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us.

We must commit to protecting your privacy by abiding by the policies we have established. This notice outlines how we will use or disclose your protected health information.

**Patient Health Care Information Use & Disclosure**
Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. Healthcare operations may include uses and disclosures necessary to manage our practice and assure quality health care.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

**HealthInfoNet:** We participate in HealthInfoNet, the statewide health information exchange (HIE) designated by the State of Maine. The HIE is a secure computer system for health care providers to view and share your important health information to support treatment and continuity of care. For example, if you are admitted to a health care facility not affiliated with ours, health care providers there will be able to see important health information held in our electronic medical record systems.

Your record in the HIE includes medicines (prescriptions), lab and test results, imaging reports, conditions, diagnoses or health problems. To ensure your health information is entered into the correct record, also included are identifiers such as your full name, birth date and social security number. All information

contained in the HIE is kept private and used in accordance with applicable state and federal laws and regulations. The information is accessible to participating providers to support treatment and healthcare operations such as mandated disease reporting to the Maine Centers for Disease Control and Prevention.

You do not have to participate in the HIE to receive care. For more information about HealthInfoNet and your choices regarding participation, visit www.hinfonet.org or call toll-free 1-866-592-4352.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

**_______ Consent for Contact:**

With my consent, Maine Recovery Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location.

**_______ Consent for text message and/or email contact:**

With my consent, Maine Recovery Center may send lab and appointment reminder messages to my through a text message to my cellular phone or email address.

My cell phone number is: ________________________________ Email: ________________________________________

**Practice Duties – Regarding your health care information**

Maine Recovery Center is required by law to maintain the privacy of protected health information and to provide patients with notice of its legal duties and privacy practices with respect to protected health information.

Maine Recovery Center is required to abide by the terms of the notice in effect. We reserve the right to change these policies and we must inform you of these changes. We will inform you of these changes when you arrive at our practice for treatment.

If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. You will receive written notification informing you of the action taken in response to your concern.

There will be no retaliation against a patient for filing a complaint. If you feel your complaint is not resolved, you may file a complaint with the Secretary of Health and Human Services.

**Patient Rights – Regarding their health care information**

The patient has the right to request the practice to restrict use and disclosure of protected health information. Maine Recovery Center is not required to agree to the requested restrictions.

The patient has the right to receive confidential communications of protected health information.

Generally, the patient has the right to inspect and request a copy of their protected health information (additional fees may apply).

The patient has the right to request an amendment to their protected health information in the practice medical record.

The patient has the right to receive a paper copy of this notice.

**By signing this notice, I am consenting to Maine Recovery Center use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Maine Recovery Center may decline to provide treatment to me.**

X_______________________________________ ______________

Patient's signature Date

_______________________________________

Patient's Printed Name

_______________________________________ ___________________

Printed name of person signing on behalf of patient Relationship to patient

# Initial Visit Patient Questionnaire

**Name:** ____________________________________________ **Date:** ____________

**DOB:** ________________ **Primary Care Provider:** ______________________________________

**Referring Provider:** __________________________________________

**What type of dependence are you seeking treatment for?** ___________________________________

**Please tell us more about your use history.**

| What substances have you been using?<br><br>How much do you normally use? How often do you use?<br><br>When was your last use? |
|---|

**What treatment have you had for your current problem? If current treatment, please explain what it is and where you go:**

| Counseling/Therapy | NA/AA |
|---|---|
| Inpatient/Outpatient Programs | Psychiatry |
| **Methadone | Suboxone |
| Other | |

****If you have attended a Methadone clinic: Where and when?** ____________________________________
**Have you had an EKG?** ___________________________.

**Have you seen any other providers, and/or are you currently seeing other providers?** If yes, please list and explain: ___________________________________________________________________________________

**Trauma history:** Is there any underlying pain issues or injuries? If yes, please explain:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**If pain is of concern:**

Please circle the **ONE** number on the line below that describes the overall amount of pain you are experiencing today:

no pain ----------------------------------------------------------------------worst pain imaginable
**0 1 2 3 4 5 6 7 8 9 10**

Please circle the **ONE** number on the line below that describes the worst your pain has been in the last month:

no pain ----------------------------------------------------------------------worst pain imaginable
**0 1 2 3 4 5 6 7 8 9 10**

Please circle the **ONE** number on the line below that describes the least your pain has been in the last month:

no pain ----------------------------------------------------------------------worst pain imaginable
**0 1 2 3 4 5 6 7 8 9 10**

**Please circle the number on the line below that describes your ability to sleep at night:**

didn't sleep--------------------------------------------------------------------------------------------fell asleep immediately
a wink **0 1 2 3 4 5 6 7 8 9 10** and slept all night

**Check the box that best describes your emotional health (check ONE):**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Happy/cheerful | | Optimistic | | Anxious | | Worried |
| | Angry | | Depressed | | Suicidal | | Compulsive |
| | Indifferent | | Hopeless | | Frustrated | | Panicked |
| | Other (please explain): | | | | | | |

**Please look at the following Quality of Life Scale and circle ONE number between 0 and 10 that best describes your current level of function.**

| | |
|---|---|
| **0** | Stay in bed all day; feel hopeless and helpless about life |
| **1** | Stay in bed at least half the day; have no contact with outside world |
| **2** | Get out of bed but don't get dressed; stay at home all day |
| **3** | Get dressed in the morning; minimal activities at home; contact with friends via phone or email |
| **4** | Do simple chores around the house; minimal activities outside of home two days a week |
| **5** | Struggle but fulfill daily home responsibilities; no outside activity; not able to work/volunteer |
| **6** | Work/volunteer limited hours; take part in limited social activities on weekends |
| **7** | Work/volunteer for a few hours daily; can be active at least 5 hours a day; can make plans to do simple activities on weekends |
| **8** | Work/volunteer for at least 6 hours daily; have energy to make plans for one evening social activity during the week; active on weekends |
| **9** | Work/volunteer/be active 8 hours daily; take part in family life; outside social activities limited |

| 10 | Go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life |
|---|---|

**Past Medical History:** Please check any conditions you have or have had in the past:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | AIDS/HIV positive | | Alcoholism | | Anemia | | Anorexia |
| | Appendicitis | | Arthritis | | Asthma | | Bleeding disorders |
| | Blood clots | | Cancer | | Diabetes | | Drug dependency |
| | Emphysema | | Epilepsy/seizures | | Glaucoma | | Goiter |
| | Osteoporosis | | Gout | | Heart disease | | High cholesterol |
| | High blood pressure | | Kidney disease | | Liver disease/Hepatitis | | Migraines |
| | Prostate problems | | Psychiatric care | | Acid reflux (GERD) | | Stomach ulcers |
| | Stroke | | Thyroid problems | | Irritable Bowel | | Depression |

Comments: ____________________________________________
____________________________________________

**Past Surgical History:** Please list all surgeries you have had and the approximate year:

____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________

**Medications:** Please list all of the medications (with dosages if possible) you are taking. Include over-the-counter medications as well.

____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________
____________________________________________

**Allergies:** Are you allergic to any medications/substances? ☐ no ☐ yes: ______________________

**Social History:** Do you smoke or chew tobacco? ☐ no ☐ yes _____ packs per day for _____ years Did you ever smoke or chew tobacco? ☐ no ☐ yes When did you quit? ______________________

**Occupation** (current or previous): ______________________________________________________

Are you working: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled through Social Security, year: _______

☐ Not currently working because of pain

**Family History:** Have your relatives had any of the following medical problems?

| Blood Relative | Arthritis | Migraines | Cancer | Joint Problems | Osteoporosis |
|---|---|---|---|---|---|
| Mother | | | | | |
| Father | | | | | |
| Brother/Sister | | | | | |
| Children | | | | | |
| Grandparents | | | | | |

**Review of Systems:** Please check any problems you are **now having** or have had **repeatedly** in the last month

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Fatigue | | Fever | | Weight Change | | Weakness |
| | Headaches | | Dizziness | | Head injury | | Confusion |
| | Vision changes | | Hearing Loss | | Ear aches | | Sinus trouble |
| | Trouble swallowing | | Jaw pain | | Chest pain/pressure | | Shortness of breath |
| | Rapid heart beat | | Irregular heart beat | | Calf pain with walking | | Swelling of ankles |
| | Blood clots | | Chronic cough | | Coughing up blood | | Wheezing |
| | Poor appetite | | Heartburn/Indigestion | | Belly pain | | Diarrhea |
| | Constipation | | Rectal bleeding | | Nausea/vomiting | | Poor bowel control |
| | Painful urination | | Poor bladder control | | Difficulty urinating | | Rash/Hives |
| | Painful/swollen joints | | Back pain | | Arm or leg pain | | Difficulty walking |
| | Convulsions/seizures | | Numbness/tingling | | Weakness arms/legs | | Difficulty sleeping |
| | Depression | | Anxiety | | Excess thirst/urination | | Easy bruising/bleeding |
| | Other (please describe): | | | | | | |

Comments:______________________________________________________________________

**What is your goal for today's visit?** _________________________________________________

**You authorize the release of office notes to your primary care physician and referring physician by signing here:**

_____________________________________________

Patient Signature

Reviewed by: ______________________________________ Date: __________________

# PATIENT HEALTH QUESTIONNAIRE – 9
# (PHQ – 9)

| **Over the <u>last two weeks</u>, how often have you been bothered by any of the following problems?** *(Circle the number 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? O 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 in some way | 0 | 1 | 2 | 3 |

*For office coding* ____0_____+________+_________+________

**=Total Score:** _________

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

| **Not difficult at all** | **Somewhat difficult** | **Very difficult** | **Extremely difficult** |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute

MAINE RECOVERY CENTER

CONSENT FOR IMMUNODEFICIENCY VIRUS (HIV) TESTING

FOLLOWING AN ACCIDENTAL EXPOSURE

***(To be completed at the MRC office or after communication with provider)***

After discussion with my Provider, I have voluntarily decided to have a sample of my blood drawn for the purpose of having the blood sample tested for the presence of antibodies to the Human Immunodeficiency Virus (HIV). The reason for this testing is that I may have been accidentally exposed to HIV.

I have been informed that HIV has been identified as the causative agent in Acquires Immunodeficiency Syndrome (AIDS), and that person infected with HIV may transmit the virus to others. I have also been informed that evidence to date suggests that transmission of the virus takes place only through sexual contact with an affected person, exposure to blood or other bodily fluids (such as through use of contaminated needles), or from an infected mother to her infant or fetus during pregnancy or birth. However, I have also been informed that there is much that is not known about HIV and about its potential for transmitting or for causing AIDS.

I have been informed that the test for HIV is generally accurate. Even so, I understand that a small percentage of individuals tested will have a "false positive" test result, more likely in the early stages of the infection. For that reason, a negative HIV antibody test result does not guarantee that I am not infected with HIV.

Maine Recovery Center has informed me of the risks and benefits associated with the performance of this test. Importantly, a true positive test will indicate that I am at risk for developing AIDS in the future. Among the risks that are generally associated with obtaining a blood specimen are minor bleeding, swelling, or discomfort at the site from which the blood specimen is obtained.

Understanding all this information, I hereby agree to this test in an entirely voluntary fashion. I have not been coerced or induced in any way to have this test performed. There will be no charge to me for this test. I will be informed of my test results. My test results will be maintained in strict confidence in accordance with Maine Law.

BOTH THE FACT AND THE RESULTS OF THIS TEST WILL APPEAR IN MY MEDICAL RECORD

DATE:___________________ PATIENT SIGNATURE:____________________________________________

WITNESS:_____________________________________________________