Patient Registration
NOVA Addiction Specialists LLC

Patient_____

Home Address_____

_____

Home Phone #(_____)_____Cell Phone: #(_____)_____

Age_____Birth Date_____Email: _____

Patient's Social Security # _____

Male_____Female_____

Occupation_____

Primary care physician:_____Phone:_____

Counselor:_____Phone:_____

Person to call in case of emergency:

Name_____

Phone #(_____)_____

Relationship_____

How did you hear about NOVA Addiction Specialists?

_____

By signing below I authorize the physicians of NOVA Addiction Specialists, in the event of a medical or psychiatric emergency, to contact the person listed as an emergency contact. I understand that during such contact it may be necessary for the physicians to notify the emergency contact that you are under treatment for addiction and provide any additional information to them to ensure you receive appropriate emergency care.

Signed_____Date:_____

PLEASE BE SURE TO BRING YOUR PHOTO ID AND BOTTLES OF ANY OF YOUR CURRENT PRESCRIPTIONS (EVEN IF EMPTY) TO YOUR FIRST VISIT.

Authorization for communication
NOVA Addiction Specialists LLC

The purpose of this form is to obtain authorization to Leave Personal Health Information by Alternative Means. This includes Information Pertaining to Drug and Alcohol Problems and Psychological Conditions. You are not required to allow any alternative communication methods. We recommend if you do allow email communication that you do not provide an email address owned by your place of employment. **You must allow email communication to use the online patient scheduling program otherwise you can schedule your appointments by phone or in person.**

Patient Name:_____ Date of Birth:_____

(Please check all that apply)

□ May leave/share message on voicemail at your provided phone numbers

□ May leave/share detailed message via unencrypted email at provided email

□ May leave/share detailed message via unencrypted txt at provided cell phone number

□ May leave/share information with spouse(name):_____

□ May leave/share info with other family named _____

□ Check here if you do not wish to allow any means of alternative communication. We will communicate with you via phone but no message will be left if you do not answer. We also may communicate with you via mail.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Patient Signature:_____

Date:_____

NOVA Addiction Specialists LLC
Notice of privacy practices

General Information

This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Information about your treatment and care, including payment for care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Confidentiality Law. Under these laws the program may not say to a person outside of the program that you attend the program, nor may the program disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by the federal laws referenced below.

The program must obtain your written consent before it can disclose information about you for payment purposes. For example, the program must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before the program can share information for treatment purposes or for health care operations. However, federal law permits the program to disclose information in the following circumstances without your written permission:

1. To program staff for the purposes of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, record storage services, billing services);
3. For research, audit or evaluations (e.g. State licensing review, accreditation, program data reporting as required by the State and/or Federal government);
4. To report a crime committed on the program's premises or against program personnel;
5. To medical personnel in a medical/psychiatric emergency;
6. To appropriate authorities to report suspected child abuse or neglect;
7. As required by a court order.
8. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Before the program can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. (NOTE: Revoking a consent to disclose information to a court, probation department, parole office, etc. may violate an agreement that you have with that organization. Such a violation may result in legal consequences for you.)

CONFIDENTIALITY NOTICE

- Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.
- You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). The program will accommodate such requests that are reasonable and will not request an explanation from you.
- Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by the program, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.
- Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the program's records, and to request and receive an accounting of disclosures of your health related information made by the program during the six (6) years prior to your request.
- If your request to any of the above is denied, you have the right to request a review of the denial by the program Administrator.

Initial: _____ Date:_____

- To make any of the above requests, you must fill out the appropriate form that will be provided by the program.
- You also have the right to receive a paper copy of this notice.

The Use of Your Information at the program
In order to provide you with the best care, the program will use your health and treatment information in the following ways:

- Communication among program staff (including students or other interns) for the purposes of treatment needs, treatment planning, progress reporting and review, staff supervision, incident reporting, medication administration, billing operations, medical record maintenance, discharge planning, and other treatment related processes.
- Communication with Business Associates such as clinical laboratories (blood work, urinalysis), food service (special dietary needs), agencies that provide on-site services (lectures, group therapy) long term record storage.
- Reporting data to the NYS OASAS Client Data System.

The Program's Duties
The program is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The program is required by law to abide by the terms of this notice. The program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The program will provide current patients with an updated notice, and will provide affected former patients with new notices when substantive changes are made in the notice.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Christopher Sendi, M.D.
NOVA Addiction Specialists
8101 Hinson Farm Road,
Suite 201
Alexandria, VA 22306

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.
You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is: Dr. Christopher Sendi

Effective Date
This notice is effective on or after September 1, 2016.

Patient Name:_____

Date of Birth: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES By signing below, I am Acknowledging that I am either the patient or the patient's personal representative and I have received a copy of the "Notice of Privacy Practices" for NOVA Addiction Services LLC.
I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____
Signature of patient

_____
Date

Insurance Attestation
NOVA Addiction Specialists LLC

I_____hereby attest **I am/am not** (circle one)covered by Medicaid, Medicare, or any other government sponsored medical insurance. I further agree to contact NOVA Addiction Specialists LLC in writing if I were to obtain any government sponsored health care insurance. If I fail to provide NOVA Addiction Specialists LLC with notification of coverage I hereby agree to pay any fines or levies imposed on NOVA Addiction Services LLC, its physicians, or staff by any government organization. If you are covered by Medicare or Medicaid, you agree that you are personally responsible for payments to NOVA Addiction Specialists LLC and will not be able to submit any statements to your insurer.

I further understand that NOVA Addiction Specialists LLC does not routinely bill any medical insurance company, entity, or organization. I hereby waive NOVA Addiction Specialists LLC and its' physicians from any requirement to bill my insurance company on my behalf.

_____
Signature

_____
Print Name

_____
Date

Treatment Contract
NOVA Addiction Specialists LLC

As a participant in the NOVA Addiction Specialists protocol for treatment of drug and alcohol abuse and dependence, I freely and voluntarily agree to accept this treatment agreement/contract, as follows:

1. I agree to keep, and be on time to, all my scheduled appointments with the doctor and his/her assistant. If I need to make or change an appointment I will contact the office at least **24 hours** prior to my scheduled appointment. If I cancel my appointment less than 12 hours in advance I agree to pay a $50 rescheduling fee. If I cancel my appointment less than 2 hours in advance or do not show for my appointment I agree to pay a $100 no show fee. I agree that payment of the above fees can be charged to my credit card on file.
2. I agree to conduct myself in a courteous manner in the physician's office.
3. I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the doctor will not see me, and I will not be given any medication until my next scheduled appointment.
4. I agree to pay for services promptly and understand that full payment is due at the time of my visit.
5. 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.
6. I agree not to deal, steal, or conduct any other illegal or disruptive activities in the doctor's office.
7. I agree that my medication (or prescriptions) can be given to me only at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
9. I agree to store medication properly. Medication may be harmful to children, household members, guests, and pets. The pills should be stored in a safe place, out of the reach of children. If anyone besides the patients ingests the medication, the patient must call the Poison Control Center or 911 immediately.
10. I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treating physician.
11. I understand that mixing buprenorphine 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).
12. 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.
13. 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.
14. I agree to abstain from alcohol, benzodiazepines, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).
15. I agree to undergo random urine or blood drug screening and understand if I do not submit a sample for testing I will not receive additional prescriptions.
16. I agree to notify the clinic in case of relapse to drug/alcohol use or abuse. An appropriate treatment plan must be developed as soon as possible. The physician should be informed of a relapse before it is revealed by random urine testing.
17. Females only. I am not pregnant and agree to inform my doctor if I attempt to get pregnant or do become pregnant. I understand that the safety of some medications such as buprenorphine, as found in Suboxone, is not known in pregnancy. Initial: _____

18. If buprenorphine is part of my treatment regimen I have been informed that buprenorphine, as found in Suboxone, is a narcotic analgesic. I know that taking buprenorphine can lead to physical dependence and addiction, and that if I were to abruptly stop taking buprenorphine after a period of regular use, I would experience symptoms of opiate withdrawal.
19. I understand that I may not be able to drive a car or operate any form of heavy machinery during the induction phase of my medication regimen because of possible psychomotor impairment that I may have during this induction phase. I will assume all responsibility for determining the method of my transportation to and from the treatment facility during my first days of taking any prescribed medication. I hereby vacate any and all responsibility for any transportation issues from the treating physician, facility and staff.
20. I agree to fill all prescriptions provided by NOVA Addiction Specialists in the state of Virginia unless express permission is given by my treating physician in writing that I may do otherwise.
21. I understand that violations of the above may be grounds for termination of treatment.

Printed Name _____

Signature _____

Date _____

NOVA Addiction Specialists LLC
Prescription Medication Understanding

I_____(patient name) understand that upon receiving prescriptions for any buprenorphine containing medication from NOVA Addiction Specialists LLC I have the following responsibilities:

1. I will email or call NOVA Addiction Specialists every Sunday to check in and inform of any issues that have arisen.
2. I will respond to any call or email from NOVA Addiction Specialists within 24 hours.
3. I will make a follow up appointment at least one week prior to the needed appointment.
4. If a drug screen is requested by NOVA Addiction Specialists before a scheduled appointment I agree to either submit a sample to the lab within 24 hours or contact NOVA Addiction Specialists to set up an in office drug screen.
5. If I have a relapse or have any issues with my prescription I will contact NOVA Addiction Specialists immediately.

I hereby understand that failure to follow the above requirements will result in immediate cancellation of all prescription refills. Further I understand failure to follow above requirements may result in more frequent appointments, drugs screens, or dismissal from the practice.

_____
Patient Signature

_____
Date

Schedule of Fees
NOVA Addiction Specialists LLC

The physicians of NOVA Addiction Specialists LLC do not directly bill medical insurance for their professional services. Unless arrangements have been made prior to your office visit the fees for our services are the following:

1. Initial evaluation for opioid addiction including induction if indicated: $400
2. Initial evaluation for alcohol addiction requiring acute detoxification: $400
3. Initial evaluation for alcohol addiction not requiring detox: $250
4. Office visit for established patient: $250

The proceeding fees do not include the cost of medications or diagnostic studies.

Any cancellation or change in an appointment must be at least 24 hours prior to the scheduled appointment. Patients who change or cancel their appointment later than 24 hours prior to their appointment will be assessed the following fees:

1. Cancellation less than 12 hours prior to the scheduled appointment: $50.
2. Cancellation less than 3 hours prior to the scheduled appointment or patients who do not show for their appointment: $100.

Follow up visits should be scheduled at least 72 hours in advance of the appointment. An additional $100 may be charged if the follow up visit is scheduled less than 72 hours from the date of the appointment.

By signing below I hereby agree that payment for professional services is due at the time of the scheduled service. I further agree to pay any outstanding charges at the time of my appointment in full. I also agree to pay any late charges or missed appointment charges and agree that these charges can be charged to my credit card on file without my signature. If I contest any of the above charges with my Credit Card Company or financial institution I hereby allow NOVA Addiction Specialists LLC to release this contract to the credit card company or any other financial institution as proof the above charges were authorized.

_____
Patient Name

_____
Patient Signature

_____
Date

Pharmacy Consent Form
NOVA Addiction Specialists LLC

Description:
By signing this Pharmacy Consent Form, the patient authorizes a physician to disclose to the pharmacy that he or she is being treated for alcohol and/or drug dependence; the pharmacy is also authorized to contact the physician to discuss treatment.

NOVA Addiction Specialists LLC
8101 Hinson Farm Road, STE 201
Alexandria, VA 22306
Phone: 703-844-0184
Fax: 1 (888) 965-7708

PHARMACY CONSENT

I,_____[Patient Name- Print], do hereby authorize the physicians of NOVA Addiction Specialists at the above address to disclose my treatment for alcohol and/or drug dependence to employees of the pharmacy where I fill my prescriptions provided by the physicians of NOVA Addiction Specialists. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my prescriptions directly to the pharmacy.

I understand that I may withdraw this consent at any time in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for alcohol and/or drug dependence by NOVA Addiction Specialists 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.

Patient Name (print)_____
Patient Signature:_____
Date:_____

Prescription Monitoring Database Query
NOVA Addiction Specialists LLC

By signing below I hereby acknowledge that the physicians of NOVA Addiction Specialists will query the Virginia Prescription Monitoring database prior to providing a prescription for any controlled substances. The Virginia prescription monitoring database has partnered with multiple other state/district programs and all programs will be queried simultaneously as allowed by law.

Patient Name (printed):_____

Patient Signature:_____

Date:_____

Laboratory Consent Form
NOVA Addiction Specialists LLC

Description:
By signing this Laboratory Consent Form, the patient authorizes a physician to disclose to the laboratory that he or she is being treated for alcohol and/or drug dependence; the laboratory is also authorized to contact the physician to discuss treatment.

NOVA Addiction Specialists LLC
8101 Hinson Farm Road, STE 201
Alexandria, VA 22306
Phone: 703-844-0184
Fax: 1 (888) 965-7708

LABORATORY CONSENT

I,_____[Patient Name- Print], do hereby authorize the physicians of NOVA Addiction Specialists at the above address to disclose my treatment for alcohol and/or drug dependence to employees of the laboratory where I provide samples for testing. Treatment disclosure most often includes, but may not be limited to, discussing the reason for laboratory testing and faxing/calling in certain laboratory tests.

I understand that I may withdraw this consent at any time in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for alcohol and/or drug dependence by NOVA Addiction Specialists 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.

Patient Name (print)_____

Patient Signature:_____

Date:_____

Informed Consent and Agreement to HIV Testing

NOVA Addiction Specialists

I understand the following information, which I have read or has been read to me:

- Blood, or another body fluid or tissue sample, will be tested for human immunodeficiency virus (HIV) infection;
- Consent to be tested for HIV, the virus that causes AIDS, should be given FREELY;
- Results of this test, like all medical records, are confidential, but confidentiality cannot be guaranteed; and
- If positive test results become known, an individual may experience discrimination from family or friends and at school or work.

What a NEGATIVE Result Means:

• A negative test means that HIV infection has not been found at the time of the test.

What a POSITIVE Result Means:

- A positive HIV test means that a person is infected with HIV and can transmit the virus by having sex, sharing needles, childbearing (from mother to child), breastfeeding, or donating organs, blood, plasma, tissue, or breast milk.
- A positive HIV test DOES NOT mean a diagnosis of AIDS -- other tests are needed.

What Will Happen if the Test Is Positive:

- A copy of the Department of Health and Mental Hygiene's publication "Information for HIV Infected Persons" will be provided;
- The health department or my doctor will offer advice about services that are available;
- Women who are pregnant or may become pregnant will be told of treatment options which may reduce the risk of transmitting HIV to the unborn child;
- Information will be provided on how to keep from transmitting HIV infection;
- My name will be reported to the health department for tests that indicate HIV infection. This includes, but is not limited to: HIV Antibody (Western blot), HIV Viral Load (RNA or DNA quantification), HIV viral sequencing or HIV p24 antigen tests;
- My name will be reported to the health department if my doctor finds that I have AIDS;
- I will be offered assistance in notifying and referring my partners for services. If I refuse to notify my partners, a doctor may notify them or have a representative of the local health department do so. If a representative of the local health department notifies my partners, my name will not be used. Maryland law requires that when a local health department knows of my partners, it must refer them for care, support, and treatment.

I have been given a chance to have my questions about this test answered.

I hereby agree to be tested for HIV infection.

Print name of individual to be tested in the boxes below:

Printed Name:_____

Patient Signature:_____ Date:_____

Addiction Therapists and Counselors
NOVA Addiction Specialists

Michele Cole, LCSW
Founder/Psychotherapist
PhD Candidate
Moving Forward, PLC
117 S. St. Asaph St.
Old Town/Alexandria, VA 22314
571.483.0306 cell 703.819.3357
Fax 571.483.0356
Website: www.movingforwardplc.com

Robyn E. Brickel, M.A., LMFT
Director, Brickel and Associates, LLC
300 N. Washington Street, Suite #305
Alexandria, VA 22314
Telephone: (703) 518-8883
Fax: (301) 215-7530
Website: http://brickelandassociates.com

Sunstone Counselors
George Coyne, LCSW
112 S. Pitt St
Alexandria, VA
22314
703-534-5100
Website: www.sunstonecounselors.com

Meg Simmons LCSW
600 Cameron St. Suite 304
Alexandria, VA 22314
703-951-3428
Website: www.megsimmons.com

Lisa Kruger
Stepping Stone Psychotherapy, LLC
601 King St
Office 303
Alexandria, Virginia 22314
(202) 517-0285

Bonnie Martin
Alexandria, Virginia 22314
(240) 204-6400

Moving Forward, PLC
117 S St Asaph St
Alexandria, Virginia 22314
(240) 204-6400

Psychological counseling acknowledgement
NOVA Addiction Specialists LLC

I hereby acknowledge that NOVA Addiction Specialists does not provide psychological counseling for narcotic or alcohol addiction. NOVA Addiction Specialists provides only medical therapy for narcotic and alcohol addiction.

The physicians of NOVA Addiction Specialists highly recommend ongoing psychological counseling in conjunction with medical therapy for treatment of both alcohol and narcotic addiction. In many cases we will require proof of continuous psychological therapy to obtain ongoing prescriptions.

By signing below I acknowledge I understand the above statement AND that I have received a list of area counselors that provide psychological counseling for addiction.

_____
Patient Signature

_____
Printed Name

_____
Date

Consent for Buprenorphine Maintenance Treatment

NOVA Addiction Specialists LLC

Buprenorphine is an FDA approved medication for treatment of people with heroin or other opioid addiction. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opiate addiction, including methadone, naltrexone, and some treatments without medications that include counseling, groups and meetings.

If you are dependent on opiates – any opiates - you should be in as much withdrawal as possible when you take the first dose of buprenorphine. It you are not in withdrawal, buprenorphine can cause severe opiate withdrawal. For that reason, you should take the first dose in the office and remain in the office for at least 1 hour. We recommend that you arrange not to drive after your first dose, because some patients get drowsy until the correct dose is determined for them.

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

Combining buprenorphine with alcohol or other sedating medications is dangerous. The combination of buprenorphine with benzodiazepines (such as Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) has resulted in deaths.

In very rare instances buprenorphine may cause liver damage, your doctor will monitor your liver tests while you are taking buprenorphine (This is a blood test).

Females only. I am not pregnant and agree to inform my doctor if I attempt to get pregnant or do become pregnant. I understand that the safety of buprenorphine, as found in Suboxone, is not known in pregnancy.

The form of buprenorphine you may be taking may be in a combination with a short acting opiate blocker (Naloxone). Buprenorphine will maintain physical dependence, and if you discontinue buprenorphine, you will likely experience withdrawal. If you are not already dependent, you should not take buprenorphine, it could eventually cause physical dependence. Though some people can stop taking buprenorphine there is a very high rate of relapses for people who attempt to stop using buprenorphine.

Buprenorphine sublingual films/tablets or buccal film must be held/left in place until they dissolve completely. You will be given your first dose at the clinic, and you will have to wait as it dissolves, and for at least one hour after it dissolves, to see how you react. It is important not to talk or swallow until the film/tablet dissolves. This takes up to ten minutes. 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.

If you swallow the film/tablet, you will not have the important benefits of the medication, and it may not relieve your withdrawal. Most patients end up at a daily dose of 16 mg to 24 mg of buprenorphine (Suboxone, other formulation doses differ a little) (this is roughly equivalent to 60mg of methadone maintenance). Beyond that dose, the effects of buprenorphine plateau, so there may not be any more benefit to increase in dose. It may take several weeks to determine just the right dose for you. The first dose of the most common formulation (Suboxone) is usually 4 mg

If you are transferring to buprenorphine from methadone maintenance, your dose has to be tapered until you have been below 30 mg methadone for at least a week. There must be at least 24 hours (preferably longer) between the time you take your last methadone dose and the time you are given your first dose of buprenorphine. Your doctor will examine you for clear signs of withdrawal, and you will not be given buprenorphine until you are in withdrawal.

Patient Name_____

Signed _____Date _____

Consent to Release Confidential Information
NOVA Addiction Specialists LLC

I_____(patient name) hereby authorize and request,
_____(doctor/hospital/agency name)

Doctor/Hospital/Agency Address:

_____

_____

Doctor/Hospital/Agency Phone:

_____

to release confidential information, including personal, psychological, psychiatric, drug/alcohol, medical records and opinions, resulting from my contacts with the above to:
Name: NOVA Addiction Specialists LLC
Address:
8101 Hinson Farm Rd, STE 201
Alexandria, VA 22306
Phone: 703-844-0184
Fax: 1 (888) 965-7708

Disclosure shall be limited to the following specific types of information:

1. Laboratory Results including drug screens
2. History and Physical/progress notes/discharge summaries
3. Counseling records

Use of this information shall be limited to the following purpose(s):

1. Medical follow up/ongoing care

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

This authorization shall remain valid until revoked in writing.

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information

Patient Signature_____Date _____

NOVA Addiction Specialists L.L.C. (NAS)
Vivitrol Treatment Consent and Agreement

I. Vivitrol Medication Guide:

VIVITROL® (viv-i-trol) (naltrexone for extended-release injectable suspension)

Read this Medication Guide before you start receiving Vivitrol injections and each time you receive an injection. There may be new information. This information does not take the place of talking to your healthcare provider about your medical condition or your treatment.

What is the most important information I should know about Vivitrol?

Vivitrol can cause serious side effects, including:

1. Risk of opioid overdose. You can accidentally overdose in two ways.

•Vivitrol blocks the effects of opioids, such as heroin or opioid pain medicines. Do not take opioids, including opioid-containing medicines, such as heroin or prescription pain pills, to try to overcome the opioid blocking effects of Vivitrol. This can lead to serious injury, coma, or death.

•After you receive a dose of Vivitrol, its blocking effect slowly decreases and completely goes away over time. If you have used opioid street drugs or opioid-containing medicines in the past, using opioids in amounts that you used before treatment with Vivitrol can lead to overdose and death. You may also be more sensitive to the effects of lower amounts of opioids: ◦ after you have gone through detoxification

- when your next Vivitrol dose is due
- if you miss a dose of Vivitrol
- after you stop Vivitrol treatment

It is important that you tell your family and the people closest to you of this increased sensitivity to opioids and the risk of overdose. You or someone close to you should get emergency medical help right away if you:

•have trouble breathing •become very drowsy with slowed breathing

•have slow, shallow breathing (little chest movement with breathing)

•feel faint, very dizzy, confused, or have unusual symptoms

2. Severe reactions at the site of the injection (injection site reactions).

Some people on Vivitrol have had severe injection site reactions, including tissue death (necrosis). Some of these injection site reactions have required surgery. Call your healthcare provider right away if you notice any of the following at any of your injection sites: • intense pain • blisters • a dark scab • the area feels hard • an open wound • lumps • large area of swelling

Tell your healthcare provider about any reaction at an injection site that concerns you, gets worse over time, or does not get better by two weeks after the injection.

3. Sudden opioid withdrawal.

Anyone who receives a Vivitrol injection must not use any type of opioid (must be opioid-free) including street drugs, prescription pain medicines, cough, cold, or diarrhea medicines that contain opioids, or opioid dependence treatments, buprenorphine or methadone, for at least 7 to 14 days before starting Vivitrol. Using opioids in the 7 to 14 days before you start receiving Vivitrol may cause you to suddenly have symptoms of opioid withdrawal when you get the Vivitrol injection. **Sudden opioid withdrawal can be severe, and you may need to go to the hospital.** You must be opioid-free before receiving Vivitrol unless your healthcare provider decides that you don't need to go through detox first. Instead, your doctor may decide to give your Vivitrol injection in a medical facility that can treat you for sudden opioid withdrawal.

4. Liver damage or hepatitis. Naltrexone, the active ingredient in Vivitrol, can cause liver damage or hepatitis. Tell your healthcare provider if you have any of the following symptoms of liver problems during treatment with Vivitrol:

- yellowing of the whites of your eyes
- dark urine
- stomach area pain lasting more than a few days
- tiredness

Your healthcare provider may need to stop treating you with Vivitrol if you get signs or symptoms of a serious liver problem. **What is Vivitrol?** Vivitrol is a prescription injectable medicine used to:

- treat alcohol dependence. You should stop drinking before starting Vivitrol.
- prevent relapse to opioid dependence, after opioid detoxification. This means that if you take opioids or opioid-containing medicines, you must stop taking them before you start receiving Vivitrol.

To be effective, treatment with Vivitrol must be used with other alcohol or drug recovery programs such as counseling. Vivitrol may not work for everyone.

Who should <u>not</u> receive Vivitrol? Do **not** receive Vivitrol if you:

- **are using or have a physical dependence on opioid-containing medicines or opioid street drugs**. To see whether you have a physical dependence on opioid-containing medicines or opioid street drugs, your healthcare

provider may give you a small injection of a medicine called naloxone. This is called a naloxone challenge test. If you get symptoms of opioid withdrawal after the naloxone challenge test, do not start treatment with Vivitrol at that time. Your provider may repeat the test after you have stopped using opioids to see whether it is safe to start Vivitrol.

• **are having opioid withdrawal symptoms.** Opioid withdrawal symptoms may happen when you have been taking opioid-containing medicines or opioid street drugs regularly and then stop. **Symptoms of opioid withdrawal may include:** anxiety, sleeplessness, yawning, fever, sweating, teary eyes, runny nose, goose bumps, shakiness, hot or cold flushes, muscle aches, muscle twitches, restlessness, nausea and vomiting, diarrhea, or stomach cramps. Tell your healthcare provider if you have any of these symptoms before taking Vivitrol.

• are allergic to naltrexone or any of the ingredients in Vivitrol or the liquid used to mix Vivitrol (diluent).

What should I tell my healthcare provider before receiving Vivitrol?

Before you receive Vivitrol, tell your provider if you:

• have liver problems • have kidney problems • use or abuse street (illegal) drugs

• have hemophilia or other bleeding problems • have any other medical conditions

1. are pregnant or plan to become pregnant. It is not known if Vivitrol will harm your unborn baby.
2. are breastfeeding. It is not known if Vivitrol passes into your milk, and if it can harm your baby.

Naltrexone, the active ingredient in Vivitrol, is the same active ingredient in tablets taken by mouth that contain naltrexone. Naltrexone from tablets passes into breast milk. Talk to your doctor about whether you will breastfeed or take Vivitrol. You should not do both.

Tell your healthcare provider about all the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. Especially tell your healthcare provider if you take any opioid-containing medicines for pain, cough or colds, or diarrhea. If you are being treated for alcohol dependence but also use or are addicted to opioid-containing medicines or opioid street drugs, it is important that you tell your healthcare provider before starting Vivitrol to avoid having sudden opioid withdrawal symptoms when you start Vivitrol treatment. Know the medicines you take. Keep a list of them to show your healthcare provider and pharmacist when you get a new medicine.

How will I receive Vivitrol?

• Vivitrol is injected by a healthcare provider, about 1 time each month.

• Vivitrol is given as an injection into a muscle in your buttocks using a special needle that comes with Vivitrol.

• After Vivitrol is injected, it lasts for a month and it cannot be removed from the body.

• If you miss your appointment for your Vivitrol injection, schedule another appointment as soon as possible.

• Whenever you need medical treatment, be sure to tell the treating healthcare provider that you are receiving Vivitrol injections and mention when you got your last dose. This is important because Vivitrol can also block the effects of opioid-containing medicines that might be prescribed for you for pain, cough or colds, or diarrhea.

• Carry written information with you at all times to alert healthcare providers that you are taking Vivitrol, so that they can treat you properly in an emergency. Ask your healthcare provider how you can get a wallet card to carry with you.

What should I avoid while receiving Vivitrol? Do not drive a car, operate machinery, or do other dangerous activities until you know how Vivitrol affects you. Vivitrol may make you feel dizzy and sleepy.

What are the possible side effects of Vivitrol?

Vivitrol can cause serious side effects, including:

• **Depressed mood.** Sometimes this leads to suicide, or suicidal thoughts, and suicidal behavior. Tell your family members and people closest to you that you are taking Vivitrol. You, a family member, or the people closest to you should call your healthcare provider right away if you become depressed or have any of the following symptoms of depression, especially if they are new, worse, or worry you:

• You feel sad or have crying spells. • You feel hopeless or helpless.

• You have trouble paying attention • You feel tired or sleepy all the time

You are more irritable, angry, or aggressive than usual.

You are no longer interested in seeing your friends or doing things you used to enjoy.

You are sleeping a lot more or a lot less than usual.

You are more or less hungry than usual or notice a big change in your body weight.

You have thoughts about hurting yourself or ending your life.

• **Pneumonia.** Some people receiving Vivitrol treatment have had a certain type of pneumonia that is caused by an allergic reaction. If this happens to you, you may need to be treated in the hospital. Tell your healthcare provider right away if you have any of these symptoms during treatment with Vivitrol:

• shortness of breath or wheezing • coughing that does not go away

• **Serious allergic reactions.** Serious allergic reactions can happen during or soon after an injection of Vivitrol. Tell your NAS provider or get medical help right away if you have any of these symptoms of a serious allergic reaction.

• skin rash • chest pain • trouble breathing or wheezing

• feeling dizzy or faint • swelling of your face, eyes, mouth, or tongue

Common side effects of Vivitrol may include:

- nausea. Nausea may happen after your first Vivitrol injection and usually improves within a few days. Nausea is less likely with future injections of Vivitrol.
- sleepiness • headache • dizziness • trouble sleeping • decreased appetite
- toothache • painful joints • muscle cramps • cold symptoms • vomiting

Tell your healthcare provider if you have any side effect that bothers you or that does not go away. These are not all the side effects of Vivitrol. For more information, ask your NAS provider or pharmacist. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088. **General information about Vivitrol:** For more information about Vivitrol, call 1-800-848-4876, Option #1 or go to **www.vivitrol.com.**

What are the ingredients in Vivitrol? Active ingredient: naltrexone Inactive ingredient: polylactide-co-glycolide (PLG) Diluent ingredients: carboxymethylcellulose sodium salt, polysorbate 20, sodium chloride, and water for injection.

II. Vivitrol Patient Treatment Counseling and Treatment Agreement:

Patient Initial Each Item:

_____1. I understand the frequency of **visits** will be weekly at first and then biweekly. As my recovery progresses, with the completion of group therapy/IOP and maintenance of individual psychotherapy, my visits may extend out to 4 weeks. I understand that if I relapse or miss appointments then I will return to weekly visits until assurance in my recovery is reestablished. I must call 24 hours prior to canceling an appointment. If I miss an appointment without contacting my provider (NAS provider): I may be asked to return to more frequent visits, may not have my medication refilled until I am seen again, and I may be discharged. I understand that if I am not seen in the office as prescribed by my provider, I will be unable to obtain my prescription since the injection is coordinated with monthly visits.

_____2. I agree to have my Vivitrol Rx mailed directly to the NAS facility or to bring it directly from the pharmacy after picking it up, in its original packaging, without signs of tampering. It will be injected or stored for my future use due to storage and refrigeration requirements.

_____3. I agree not to take any **other medications** with Vivitrol without prior permission from my NAS provider.

_____4. I understand that **goal of treatment** for alcohol and opioid dependency is to learn to live without abusing alcohol and drugs. Vivitrol injections should continue as long as necessary to prevent relapse and then stopped

_____5. I will submit a **urine specimen** (my own urine) for drug screen (narcotic, pot, cocaine, amphetamine, PCP, alcohol, benzodiazepine, and others) upon my providers request as often as directed. My provider may ask that a clinical staff member observe me providing the appropriate specimen. If my drug screen indicates the presence of illegal/inappropriate substances, I may be discharged.

_____6. I understand that if I have previously used opioids, I may be more **sensitive to lower doses of opioids** and at risk of accidental overdose if I use opioids when my next dose is due, if I miss a dose, or after Vivitrol treatment is discontinued. It is important that I inform family members and people close to me of this increased sensitivity to opioids and the risk of overdose. I understand that because Vivitrol can block the effects of opioids, I may not perceive any effect if I self-administer heroin or any other opioid drug in small does while on Vivitrol. Further, I understand that administration of doses of heroin or any other opioid to try to bypass the blockade and get high while on Vivitrol may lead to serious injury, coma, or death. I understand that overdose deaths have occurred in the cases where opioid tolerant patients have tried to "over ride" the blocking action of Vivitrol with larger doses of opioids (even at doses previously tolerated).

_____7. I understand that I may not experience the expected effect from **opioid-containing** analgesic, antidiarrheal, or other antitussive (anti-cough) medications.

_____8. I understand that a **reaction at the site of Vivitrol injection** may occur. Reactions include pain, tenderness, induration, swelling, redness, bruising and itching. Serious injection site reactions including tissue death may occur. Some of these injection site reactions have required surgery. I should seek medical attention for worsening skin reactions.

_____9. I understand that I need to be off all opioids, including opioid-containing medicines, for at least 7-14 days before starting Vivitrol in order to avoid precipitation of **opioid withdrawal**. If I am transitioning from buprenorphine or methadone, I may be at risk for withdrawal for as long as two weeks. I understand that withdrawal caused by an opioid antagonist (Vivitrol) may be severe enough to require hospitalization if I have not been opioid-free for a sufficient number of days, and the withdrawal is different from the experience of spontaneous withdrawal that occurs with discontinuation of opioid in a dependent individual. I am not to take Vivitrol if I have any symptoms of opioid withdrawal. I understand that it is absolutely imperative that I notify my healthcare provider of any ALCOHOL dependence or of any recent use of opioids, or any history of opioid dependence before starting Vivitrol in order to avoid precipitation of opioid withdrawal.

_____10. I understand that Vivitrol may cause **liver injury** and I need to notify my healthcare provider if I develop symptoms and or signs of liver disease.

_____11. I understand that I may experience **depression** while taking Vivitrol. It is important that I inform family members and people close to me that I am taking Vivitrol and that they should call a doctor right away if I become depressed or experience symptoms of depression.

_____12. I understand that Vivitrol may cause an allergic **pneumonia**. I should immediately notify my physician if I develop signs and symptoms of pneumonia, including shortness of breath, coughing or wheezing.

_____13. I understand that I may experience **nausea/vomiting** following the initial injection of Vivitrol. These episodes of nausea tend to be mild and subside within a few days post-injection. Nausea is less likely with subsequent injections. I may also experience tiredness, headache, vomiting, decreased appetite, painful joints and muscle cramps.

_____14. I understand that **dizziness or fainting** may occur with Vivitrol treatment and I should avoid driving or operating heavy machinery until I have determined how Vivitrol affects me.

_____15. I understand **other side effects** include muscle cramps, somnolence or sedation, anorexia, decreased appetite or other appetite disorder, an elevation in eosinophils which resolves over time (and in rare instances eosinophilic pneumonia), inflammation of my nose and throat, insomnia, and toothache.

_____16. I understand that Vivitrol is **contraindicated** in individuals with acute hepatitis or liver failure, fulminent AIDS, opioid positive drug screens and any individual who have previously exhibited hypersensitivity to naltrexone, PLG (polylactide-co-glycolide), carboxymethylcellulose or any other component of the diluent.

_____17. I understand that once Vivitrol is injected, it is **not possible to remove it from my body**.

_____18. I understand that the use of Vivitrol is a form of **Medication Assisted Therapy** (MAT) helping me stay sober while I receive the appropriate psychotherapy needed for long term recovery. Vivitrol has been shown to treat alcohol and opioid dependence only when used as part of a treatment program that includes counseling and support. I will be required to attend AA meetings (with proof of attendance) and group therapy or IOP here at NAS.

_____19. I understand that I am to notify my NAS provider if I am **breast-feeding**, if I **become pregnant**, if I think I might be pregnant, or if I am thinking about becoming pregnant.

_____20. I allow my provider to **communicate with other providers** regarding my medical care, consistent with HIPAA guidelines. Treatment disclosure may include, but is not limited to, discussing my medications with the pharmacist. I understand that records released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may contain confidential information about communicable diseases including Hepatitis, HIV(AIDS) or related illnesses.

_____21. I will **never alter a prescription** in ANY way. I understand this is a felony, punishable by incarceration.

_____22. I authorize NAS and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including New Hampshire's Board of Pharmacy and the DEA, in the investigation of any possible misuse, prescription forgery, sale or any other diversion of my medication.

_____23. I allow NAS to receive information from any pharmacy I have used.

_____24. I understand that **rude or disrespectful treatment of staff** is not tolerated and may result in my discharge. (Ex: using profanity, raising my voice, making vulgar or inappropriate comments).

_____25. I understand that I must provide a viable **contact** number at all times (and will update the office of any changes) or my provider may not prescribe medications.

_____26. I understand the **commitment** to the program and the many appointments, therefore transportation cannot be an issue or a reason for short notice cancellations or no show appointments.

_____27. Regarding **alcohol**: I understand that I am required to not have used alcohol or alcohol containing products for the past 4 days and that I am not having any signs of Delerium Tremens (DT's). I understand that DT's may be life threatening and if any signs occur I will call 911.

_____28. Regarding **opioids**: I understand that **I must be opioid drug free (detoxed) for 7 days and for 14 days detoxed from Methadone and Buprenorphine.** If I am not detoxed than the Vivitrol injection **will** precipitate immediate and sometimes severe opioid withdrawal (to include but not limited to nausea, vomiting, muscle cramps, tremors, headache and sweating).

_____29. I understand that I need to **carry documentation** to alert medical personnel to the fact that I am taking Vivitrol (naltrexone for extended-release injectable suspension). This is important information if I need to obtain medical treatment in an emergency and am unable to tell other health care providers that I am on Vivitrol.. I agree to wear a medical alert (card, bracelet, dog tags).

I have read and understand all the information about Vivitrol treatment. I have received answers to any questions I have. I agree that I am responsible to abide by these instructions. I wish to be treated with Vivitrol.

Name_____ Date of Birth _____

Pharmacy_____ Town_____ Phone _____

Primary Care Provider_____ Town_____ Phone _____

Patient Signature_____ Patient Initials:_____ Date _____

I, the Provider, have reviewed Vivitrol risks and side effects with the patient.

Provider Signature_____ Date _____

One copy of this form is given to the patient after signing.