Welcome to MedPlex, Inc. We are pleased that you have chosen our clinic. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

Please review the following information:

- Your 1st visit is $225, and monthly appointments are $195 (every 28 days).
- We accept cash, Visa/Mastercard debit/credit, Discover, American Express, and ApplePay; the cardholder must be present at the visit.
- Please bring a photo ID and, if applicable, your insurance or prescription medication card so that we may assist you in medication coverage.
- You will complete new patient paperwork at your 1st visit; for your convenience, this is available online if you would like to print and complete this ahead of time.
- Please bring a list of your prescription and over-the-counter medications with you.

Welcome to our practice, and thank you for choosing MedPlex, Inc.!

Sincerely,

Emily Lazenby, MD
Diplomate, American Board of Psychiatry and Neurology
Diplomate, American Board of Addiction Medicine

I, _____ have read and understand the above fee for services and I will comply with the terms as a binding agreement.

_____ _____

Patient Signature Date Witness

Personal Information

Name: _____ Gender: _____ DOB: _____

Address: _____

City, State, Zip Code: _____

Social Security Number: _____ Marital Status: Single / Married / Divorced / Widowed

Home Phone: ( )_____ Cell: ( )_____ Work: ( )_____

Emergency Medical Contact: _____ Relationship: _____

Emergency Medical Contact Phone: ( )_____

Primary Care Physician: _____ Phone: ( )_____

Do you have Health Insurance? Yes / No

Primary Insurance: _____
Policy #: _____ Group #: ____
Subscriber Name: _____
Subscriber DOB: _____ SSN:_____
Relationship: _____

Secondary Insurance: _____
Policy #: _____ Group #: ____
Subscriber Name: _____
Subscriber DOB: _____ SSN:_____
Relationship: _____

Are you interested in receiving EMAIL reminders regarding your appointments? Yes / No

If yes, please give your email address: _____

Are you interested in receiving TEXT MESSAGE reminders regarding your appointments? Yes / No

If yes, please give your cell phone number: _____

How did you hear about our clinic? _____

_____ _____
Patient/Guardian Signature Date

Patient Treatment Contract

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

1. I agree to keep and be on time to all my scheduled appointments. I understand if I am late to my appointment, I may be rescheduled for the next available appointment.
2. I understand that I must provide current government issued photo ID to receive treatment.
3. I agree to immediately notify MedPlex Inc should any of my personal information change at any time.
4. I agree to follow the payment policy outlined in the Welcome Letter. I understand that MedPlex Inc is a cash clinic and payment is due in full at time of service, and I waive my health insurance benefits for office visit charges (i.e. evaluation, consultation).
5. I agree to conduct myself in a courteous manner in the office and over the phone.
6. I agree not to steal or conduct any illegal or disruptive activities at MedPlex, Inc and my pharmacy. I understand violation will result in termination of treatment without recourse.
7. I will not sell, share or give any of my medication to another person. I understand that this is illegal and is a violation of the treatment contract and will result in termination of treatment without recourse.
8. I understand that my prescription will be written at regular office visits with my physician. If I miss my regularly scheduled appointment, I will reschedule a visit as soon as possible to be evaluated by a physician.
9. I understand my prescription and my medication is my responsibility and I will keep it in a safe and secure place. I understand lost or stolen will not be replaced.
10. I will notify my doctor at MedPlex Inc. if I receive any prescription medication from other doctors.
11. I understand the risks of mixing buprenorphine with other medication like benzodiazepines and/or alcohol. I understand medications should be reported to my physician for proper monitoring and these medications should only be taken as directed. I agree to take my medication as prescribed and I understand that overtaking may be grounds for dismissal.
12. I will consult my doctor before I alter the amount or the method in which I take my medication.
13. I understand medication alone is not a sufficient treatment and I agree to participate in counseling.
14. I agree to abstain from alcohol, opioids, marijuana, cocaine and other illegal and addictive substances.
15. I agree to follow the compliance monitoring protocols set forth by MedPlex, Inc. including but not limited to routine and random drug and alcohol testing.
16. If I violate the substance use agreement, I agree to perform weekly drug screens and medication counts. I will pay $25 for each drug screen performed and I understand these weekly visits will not be with my doctor.
17. I understand that MedPlex Inc may send mail to my home address if needed to contact me.
18. I understand and agree that any violation of the treatment contract outlined above may be grounds for termination of my treatment.

Patient/Guardian Signature _____ Date _____

Medical and Social History

Patient Name: _____ DOB: _____

Drug Allergies: _____ Other Allergies: _____

Are you currently taking any prescribed medications? (Including vitamins and oral contraceptives)?

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Please list ALL medical problems/illnesses for which you are currently being treated: _____

_____

List any surgeries/hospitalizations you have had, the year and any complications: _____

_____

When was your last physical? _____ Are you Pregnant? Yes / No Last Menstrual Cycle? _____

If you are currently or you have experienced problems with any of the following conditions listed below, **PLEASE CIRCLE "Yes" or "No"**. **PLEASE CIRCLE "Family"** if you have a family history of the condition.

Pneumonia Yes / No / Family	**Ulcer** Yes / No / Family	**High Blood Pressure** Yes / No / Family
Cancer Yes / No / Family	**Blood Clot** Yes / No / Family	**Cysts** Yes / No / Family
HIV/AIDS Yes / No / Family	**Diabetes** Yes / No / Family	**Heart Disease** Yes / No / Family
Thyroid Disorder Yes / No / Family	**Phlebitis** Yes / No / Family	**Osteoporosis** Yes / No / Family
Rheumatic Fever Yes / No / Family	**Anxiety** Yes / No / Family	**Kidney Disease** Yes / No / Family
Epilepsy/Seizures Yes / No / Family	**Anemia** Yes / No / Family	**Liver Disease** Yes / No / Family
Tuberculosis Yes / No / Family	**Stroke** Yes / No / Family	**Emphysema** Yes / No / Family
Hepatitis Yes / No / Family	**Arthritis** Yes / No / Family	**Abnormal Breathing** Yes / No / Family
Vascular Disease Yes / No / Family	**Asthma** Yes / No / Family	**Migraine/Headache** Yes / No / Family
Alcoholism Yes / No / Family	**Addiction** Yes / No / Family	**Mental Health** Yes / No / Family

Substance Use History

Patient Name: _____ DOB: _____

Tobacco History: Cigarettes/Smokeless/Pipe How many per day? _____ How many years? _____

How long have you been abusing substances? _____

Have you been treated for substance abuse? _____

If yes, please describe when, where and for how long? _____

Substance Abuse History

	No	Yes/Past	Yes/Current	Route (i.e. oral, IV)	How much	How often	Date/Time of Last Use	Qty Last Used
Alcohol								
Caffeine (pills/drinks)								
Cocaine								
Crystal Meth								
Heroin								
Inhalants								
LSD/Hallucinogens								
Marijuana								
Methadone								
Pain Killers								
PCP								
Stimulants (pills)								
Tranquilizers								
Ecstasy								
Other								

Name: _____ Date: _____

Drug Abuse Screening Test DAST-10

(These Question Refer to the Past 12 Months)

		Please Circle	
1	Have you used drugs other than those required for medical reasons?	YES	NO
2	Do you abuse more than one drug at a time?	YES	NO
3	Are you unable to stop using drugs when you want to?	YES	NO
4	Have you ever had blackouts or flashbacks as a result of drug use?	YES	NO
5	Do you ever feel bad or guilty about your drug use?	YES	NO
6	Does your spouse, parents or children ever complain about your involvement with drugs?	YES	NO
7	Have you neglected your familty because of your drug use?	YES	NO
8	Have you engaged in illegal activities in order to obtain drugs?	YES	NO
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	YES	NO
10	Have you had medical problems as a result of your drug use? (i.e. memory loss, hepatitis, convulsions, bleeding)	YES	NO

The "CAGE" Questionnaire

		Please Circle	
1	Have you ever felt you should "cut down" on your drinking?	YES	NO
2	Have people "annoyed you" by criticizing your drinking?	YES	NO
3	Have you ever felt "bad or guilty" about your drinking?	YES	NO
4	Have you ever had a drink first thing in the morning to "steady your nerves" or to "get rid of a hangover (Eye Opener)?	YES	NO

HIPAA Disclosure and Privacy Practices Form

Your Patient Health Information (PHI) will be used in this office and you have rights concerning those records. In addition to how your PHI will be used, office policies regarding payment and collections, and consent to treat are listed below. By signing this form, you agree to all stipulations of our policies listed.

- Patient understands and agrees to allow MedPlex, Inc to use their PHI for the purposes of treatment, payment, health care operations and coordination of care.
- The patient has the right to examine and obtain a copy of his/her own health records at any time and request further restrictions on the use of their PHI. Our office in not obligated to agree to those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given to the patient in the office.
- The patient may provide a written request to revoke consent but would apply to any care given after the request has been presented.
- For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known to assure that your records are not readily available to those who do not need them for treatment.
- Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- If the patient refuses to sign this consent for the purpose of treatment, payment or health care operations, the medical physician has the right to refuse care.

Authorizations, Assignments of benefits, and consent to treat to MedPlex, Inc physician's hereafter referred to as the "Office".

- I understand that Van Wadlington, MD and Michael Chandler, MD are PMD (Preferred Medical Doctors) with Blue Cross Blue Shield, and that BCBS will not be filed within the office of MedPlex Inc. for physician consultation, evaluation and treatment. I understand I will be responsible for all office fees at the time of service. You are free to see a provider at a different clinic who accepts insurance and that physician may submit claims to BCBS for your care.
- I authorize, assign and direct my insurance carrier to pay directly to said office such sums as may be due and owing the Office of services rendered to me, now and hereafter, which are payable under my insurance contractor contractual agreement.
- I understand that my insurance will be billed for my urine drug screen confirmations. I will be responsible for the amount not covered by my insurance.
- I understand that email and/or text messages may be used to remind me of appointments. You may opt out of this by simply notifying the front desk in writing. A form will be available for you to fill out if you do not wish to be reminded by email and/or text messages.
- I agree that in the event I receive checks, drafts or other payments subject to this agreement, I agree to act as fiduciary agent to the Office. The Office agrees to apply any proceeds to the patient's debt for services rendered.
- I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I may be responsible for expenses not paid by insurance. I understand and agree to pay the customary charges of the Office and agree that if my health insurance does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that I will pay for my treatment in full; I will be responsible for any remaining balance. I understand and agree that I may be charged for missed appointments.
- I agree the Office has the right to call my home, place of employment, and cell phone regarding my appointment times and other issues, requests and notifications.
- I have read the above consent. I have also had an opportunity to ask questions about course of treatment for my present condition and future condition for which I seek treatment. A photocopy of this form shall be as valid as the original.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical/protected health information about you may be used, disclosed, and how you can get access to this information. Please review it carefully.

As a patient, you have the following rights:

1. The right to inspect a copy of your information
2. The right to request corrections to your information
3. The right to request your information be restricted
4. The right to request confidential communication
5. The right to a report of disclosures of your information
6. The right to a paper copy of this notice

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

I have read and understand how my patient health information will be used, as well as the Privacy Practice of MedPlex, Inc. I further authorize MedPlex Inc to use my private health information for the purposes stated in this agreement in the manner stated in the agreement. Also, I hereby acknowledge that I have received a copy of this practice's Privacy Practices and HIPAA disclosure. I understand that if I have questions or complaints regarding my rights that I may contact MedPlex Inc at the number listed above. I further understand that the practice will offer me updates to these practices should it be amended, modified, or changed in any way.

Patient/Guardian Signature _____ Date _____

HIPAA Privacy Authorization Form *Authorization for Use or Disclosure of Protected Health Information*

I, _____ (Patient), hereby authorize MedPlex Inc to use and disclose the protected health information to the following person(s) listed below:

	Full Name	Relationship	Expiration Date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I understand that my treatment, payment, enrollment or eligibility for care will not be conditioned on whether I sign this authorization. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization and that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient Signature Date

_____ _____

Printed Name of Patient Employee Witness Signature

APPOINTED PHARMACY CONSENT

- I authorize MedPlex, Inc to disclose my treatment for opioid dependency to employees of the pharmacy specified below. Treatment disclosure may not be limited to, discussing my medications with the pharmacist and faxing/calling in my buprenorphine prescription directly to the pharmacy.
- I agree to allow pharmacist to contact MedPlex, Inc to discuss my treatment so that my prescription can be filled.
- I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician group specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician group specified above is otherwise notified by me.
- I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.
- I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Appointed Pharmacy: _____ Phone: ( ) _____

Pharmacy Address: _____

_____ _____

Patient/Guardian Signature Date

TO REQUEST **RELEASE OF MEDICAL INFORMATION** PLEASE COMPLETE AND SIGN THIS FORM (This form will be kept on file for future use if needed)

I, _____ hereby voluntarily authorize the disclosure of information from my health record.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

INFORMATION REQUESTED

All Medical Records _____ or Date of Service (or range) _____ to _____

PURPOSE OF RELEASE

To receive my medical history information from the following physicians and/or healthcare facilities:

_____

_____

INFORMATION IS TO BE PROVIDED TO

2124 4th Avenue South Birmingham, AL 35233 | Phone: 205-731-9090 | Fax: 205-731-0760

1901-A 4th Avenue South Jasper, AL 35501 | Phone: 205-295-5234 | Fax: 205-295-5237

_____ _____

Patient Signature or Patient's Representative Signature Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS.

Under HIPAA with a patient's written request, records must be provided within 30 days of a request. Under House Bill 300 Texas Law with a patient's written request, records must be provided within 15 days of a request.

HIPAA Authorization for Release of Medical Records
This form does not constitute legal advice and covers federal, not state law