Hill Alcohol and Drug Treatment

Please completely fill out all requested information:

1. PATIENT INFORMATION

Patient Last Name_____ **First Name:**_____ **MI:**_____

How Were You Referred To Us?_____

Home Phone:_____ **Cell:**_____ **Email:**_____

Physical Address:_____ **Apt #**_____ **City:**_____ **Zip:**_____

Mailing Address If Different:_____

SSN: _____ **(Required)** **Birth Date:** _____ **Gender:**_____ **Age:**_____

Race: _____ **Ethnicity:** _____

Food or Drug Allergies: _____

(Required if driving to treatment) **Vehicle:**_____ **Year:** _____ **Model:**_____

Color: _____ **License Plt. #:**_____ **DL #**_____

Marital Status: _____**Married** _____**Single** _____**Separated** _____ **Divorced**

Spouse Name_____ **Spouse Cell:**_____

Primary Care Physician/ First and Last Name:_____

Address:_____ **Phone#:**_____

2. EMPLOYER INFORMATION OF INSURED

Employer Name:_____ **Phone:**_____

Address:_____ **City** _____**St.**_____ **Zip**_____

3. INSURANCE INFORMATION

Insurance Company:_____ **Policy #:**_____

Insured's Last Name:_____ **First Name:**_____

Relationship to the Patient:_____**Birth Date:**_____ **SSN:**_____

Insured Address:_____ **City:**_____ **Zip:**_____

ALTERNATIVE EMERGENCY CONTACT

I _____ **give my permission for the staff of Hill Alcohol and Drug to contact the following person, as staff deems necessary.**

1ST CONTACT NAME:_____ **Relationship:**_____

Home Phone:_____**Cell Phone:**_____ **Work:**_____

_____ _____ _____

Patient/Responsible Party Signature **Relationship to the Patient** **Date**

HILL ALCOHOL AND DRUG TREATMENT

Patient ID: _____

Referral Source: _____

Assessment Date: _____

PATIENT SELF - ASSESSMENT

TO BE COMPLETED BY
PATIENT And/or MINOR'S FAMILY

Name: _____ Nickname: _____

D.O.B. _____ Age: _____ Marital Status: _____

Number of Children: _____ Ages: _____ _____ _____ _____ _____
Who do *you* live with? _____
What language is spoken at home? _____
Where do you consider home? (Country, State, Region) _____
How would you describe your cultural background? _____
_____
What groups or organizations do you belong to? _____
_____

What do we need to understand about your beliefs, culture, or traditions to better help you in treatment? _____
_____
_____
_____

Are you afraid to talk about yourself in a group? (Choose One)
☐ Huge fear ☐ Significant fear ☐ Some anxiety ☐ Not fearful at all

How can we help you deal with your anxiety? _____

What, *specifically*, has happened that brings you here today? _____
_____
_____
_____
_____
_____
_____

1. LEGAL

Have you ever been arrested for any of the following?

a. Drinking and Driving? _____BAC ☐ N ☐ Y _____Yr
b. (BAC=Blood Alcohol Content)
   How Many DUIs? _____ When? _____ _____ _____ _____
b. Domestic Violence? ☐ N ☐ Y _____Yr
c. Alcohol or Drug Intoxication? ☐ N ☐ Y _____Yr
d. Possession of Drugs or Paraphernalia? ☐ N ☐ Y _____Yr
e. Sale of Drugs? ☐ N ☐ Y _____Yr
f. Prescription Forgery? ☐ N ☐ Y _____Yr
g. Doctor Shopping? ☐ N ☐ Y _____Yr
h. Any Offense? ☐ N ☐ Y _____Yr

Are you currently on Probation or Parole? ☐ N ☐ Y _____Yr
Officer's Name: _____
* Reminder: Release to be signed to Officer.

Do you have an immediate family member
that is currently incarcerated or having legal issues? ☐ N ☐ Y

2. EMPLOYER

How do you financially support yourself? _____
Job Title: _____ Length of time on job? _____
If working, what is your work schedule? _____
Who helps you financially? _____
Does your employer suspect that you have a problem
with substances? ☐ N ☐ Y
Did your Employer Mandate Treatment? ☐ N ☐ Y
If yes, please explain: _____
Does your Employer need reports from us? ☐ N ☐ Y
Have you ever been disciplined or counseled at work for:

a. Absenteeism? ☐ N ☐ Y
b. Tardiness? ☐ N ☐ Y
c. Intoxication? ☐ N ☐ Y
d. Theft? ☐ N ☐ Y
e. Positive Urinalysis? ☐ N ☐ Y
f. Other? ☐ N ☐ Y

If other, please describe? _____
If unemployed, reason for unemployment: _____
_____

Is your employer supportive of treatment? ☐ N ☐ Y

3. HEALTH

Has a Health Care Professional ever:

a. Expressed concerns over your Alcohol or Drug use? ☐ N ☐ Y
b. Recommended that you reduce or discontinue use? ☐ N ☐ Y
c. Recommended Treatment or Detox? ☐ N ☐ Y
d. If yes, please describe: _____
_____

4. FAMILY

Has a Family Member ever:

a. Expressed concerns over your Alcohol or Drug use? ☐ N ☐ Y
b. Made excuses for your behavior? ☐ N ☐ Y
c. Had to drive you because of intoxication? ☐ N ☐ Y
d. Been to Al-Anon or therapy to improve coping with a loved one's drug use? ☐ N ☐ Y
e. Who will attend Family Program?
Name: _____ Relationship _____
Phone: _____

Does anyone in your home abuse substances? ☐ N ☐ Y
Who?_____ What Substance? _____

5. GENERAL

a. Do most of your friends drink or use drugs? ☐ N ☐ Y
b. Have you ever attended AA or NA meetings? ☐ N ☐ Y
Did you find them helpful? ☐ N ☐ Y
c. Have you ever attempted to stop or cut down use? ☐ N ☐ Y
d. Has Substance Use interfered with enjoyment of leisure activities? ☐ N ☐ Y
e. Do you think about or plan for getting high frequently? ☐ N ☐ Y
f. Do you utilize community resources (support groups, social services, school-based services)? ☐ N ☐ Y

g. Last grade completed in school? _____
h. Degree, certifications, or licenses you hold? _____
i. Specialized training that you have had? _____
j. Military History: _____

6. SPIRITUALITY ASSESSMENT

a. Is religion or spirituality important in your life? ☐ N ☐ Y
b. What do you feel is your purpose in life?_____
_____
c. Do you affiliate with a particular church or religion now? ☐ N ☐ Y
If yes, which? _____

d. Were you raised in a particular belief or religion? ☐ N ☐ Y
If yes, which? _____
e. What is your perception of a "Higher Power" or "Power greater than yourself"? _____
_____
_____
f. Is Prayer or Meditation something you are comfortable with? ☐ N ☐ Y

7. DISCHARGE PLANNING

a. How motivated are you to achieve sobriety?
_____Extremely _____Very _____Fairly ____Hardly ____Not at all
b. Where do you plan on living following treatment?
_____My Home _____Friend or Relative ____Sober Living ____Unsure
Other: _____

Patient Signature Date
_____ _____

Parent/Guardian Signature Date
_____ _____

Reviewed by:_____ _____
Assessor's Signature Date

Early Termination Agreement

I, _____, acknowledge that the assessment and/or doctor visit fees (where applicable) are included when I start the Hill Alcohol and Drug Treatment program. Should I decide not to admit and attend the program, I understand that I will be charged to cover the costs of the services rendered at the rates shown below. A minimum of five days attendance is required to cover the fees.

Dr. Visit: $200
Assessment/Intake Fee: $300

Credit Card Number or ACH #	Expiration Date
Patient	Date
Responsible Party	Date
Witness	Date

.

HILL ALCOHOL AND DRUG TREATMENT

HEALTH QUESTIONNAIRE

Name: _____DOB: _____Date: _____

Patient Height _____ Patient Weight _____

This brief questionnaire is about your health. It will assist us in determining your ability to participate in our program. **This information is confidential.**

Section 1 **Please answer Yes or No. If YES, please give dates and details.**

1. Are you currently or have you experienced or suffered any chest pains recently?
□ N □ Y
If **yes,** please give details:
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

2. Have you ever had a heart attack or any problem associated with the heart?
□ N □ Y
If **yes,** please give details:
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

3. Have you ever had a stroke?
□ N □ Y
If **yes,** please give details:
a. When did the condition occur?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

4. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you?

☐ N ☐ Y

If **yes,** please give details:

a. When did the condition start?_____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

5. Do you **currently** have any **contagious** health problems or illnesses (such as tuberculosis or active pneumonia).

☐ N ☐ Y

If **yes,** please give details:

a. When did the condition start?_____

b. Who is the treating health care provider?_____

c. What medication do you take for this condition?_____

d. What else are you doing to help this condition?_____

e. How is the medication and/or other interventions working?_____

6. Have you had had a head injury in the past 6 months that resulted in a period of loss of consciousness?

☐ N ☐ Y

If **yes,** please give details:

a. When did the condition occur?_____

b. How long were you unconscious? _____

c. Do you still have problems such as dizziness or loss of memory? _____

d. Who is the treating health care provider? _____

e. What medication do you take for this condition? _____

f. What else are you doing to help this condition? _____

g. How is the medication and/or other interventions working? _____

7. Have you ever had any form of seizures, delirium tremens or convulsions?

☐ N ☐ Y

If **yes,** please give details:

a. When did the condition start?_____

b. Who is the treating health care provider?_____

c. What medication do you take for this condition?_____

d. What else are you doing to help this condition?_____

e. How is the medication and/or other interventions working?_____

8. Have you ever had high-blood pressure or hypertension?

□ N □ Y

a. When did the condition start?_____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

9. Have you ever had blood clots in the legs or elsewhere that required medical attention?

□ N □ Y

a. When did the condition start?_____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

Section 2 **Please answer Yes or No. If YES, please give dates and details.**

1. Are you running a fever today?

□ N □ Y

If **yes,** please give details:

a. When did the condition start?_____

b. Who is the treating health care provider?_____

c. What medication do you take for this condition?_____

d. What else are you doing to help this condition?_____

e. How is the medication and/or other interventions working?_____

2. Do you have a rash, skin lesions or open wounds?

□ N □ Y

If **yes,** is the wound draining?

□ N □ Y

Please give details for the above conditions if yes:

a. When did the condition start?_____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

3. Have you ever tested positive for tuberculosis?

□ N □ Y

If yes, please give details:

a. When did the condition start?_____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

4. Have you ever been diagnosed with MRSA?

□ N □ Y

a. When did the condition start?_____

b. Who is the treating health care provider?_____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

5. Do you have a history of any other illness that may require frequent medical attention?

□ N □ Y

a. When did the condition start?_____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

6. Do you have a history of cancer?

□ N □ Y

a. When did the condition start?_____

b. Who is the treating health care provider? _____

c. What medication do you take for this condition? _____

d. What else are you doing to help this condition? _____

e. How is the medication and/or other interventions working? _____

Section 3 Please answer Yes or No. If YES, please give dates and details.

1. Do you have any allergies to medications, foods, animals, chemicals, or any other substance?

☐ N ☐ Y

a. What are you allergic to?_____
b. What is your specific allergic reaction?_____
c. Who is the treating health care provider? _____
d. What medication do you take for this condition? _____
e. What else are you doing to help this condition? _____
f. How is the medication and/or other interventions working? _____

2. Do you have food and/or fluid restrictions due to medications or medical conditions?

☐ N ☐ Y

a. What is your food or fluid restriction?

_____
b. What are you allergic to?_____
c. What is your specific allergic reaction?_____
d. Who is the treating health care provider? _____
e. What medication do you take for this condition? _____
f. What else are you doing to help this condition? _____
g. How is the medication and/or other interventions working? _____

3. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation?

☐ N ☐ Y

a. What is the specific condition? _____
b. When did the condition occur?_____
c. Who is the treating health care provider? _____
d. What medication do you take for this condition? _____
e. What else are you doing to help this condition? _____
f. How is the medication and/or other interventions working? _____

4. Have you ever been diagnosed with diabetes?

☐ N ☐ Y

a. When was the condition diagnosed?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition?

☐ Insulin ☐ Oral Medication ☐ Special Diet

Dosage: _____ Strength: _____ Frequency: _____
Dosage: _____ Strength: _____ Frequency: _____

Special Diet:

_____

d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

Section 4 **Please answer Yes or No. If YES, please give dates and details.**

1. Have you ever been diagnosed with any type of hepatitis or other liver illness?
□ N □ Y
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

2. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for any type of glandular disease?
□ N □ Y
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

3. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis?
□ N □ Y
a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. Do you use a CPAP? □ N □ Y
If **yes,** please explain:

_____

e. Are you dependent on oxygen? □ N □ Y
If **yes,** please explain: _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

4. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with kidneys or bladder?

□ N □ Y

a. When did the condition start?_____
b. Who is the treating health care provider? _____
c. What medication do you take for this condition? _____
d. What else are you doing to help this condition? _____
e. How is the medication and/or other interventions working? _____

Section 5 Please answer Yes or No. If YES, please give dates and details.

1. Do you have any of the following:

Arthritis □ N □ Y Are you experiencing any pain? □ N □ Y
When did the condition start?_____
a. Who is the treating health care provider? _____
b. What medication(s) do you take for the condition(s)? _____
c. What else are you doing to help the condition(s)? _____
d. How is the medication and/or other interventions working? _____
e. Additional info: _____

2. Back Problems □ N □ Y Are you experiencing any pain? □ N □ Y
When did the condition start?_____
a. Who is the treating health care provider? _____
b. What medication(s) do you take for the condition(s)? _____
c. What else are you doing to help the condition(s)? _____
d. How is the medication and/or other interventions working? _____
e. Additional info: _____

3. Bone Injuries □ N □ Y Are you experiencing any pain? □ N □ Y
When did the condition start?_____
a. Who is the treating health care provider? _____
b. What medication(s) do you take for the condition(s)? _____
c. What else are you doing to help the condition(s)? _____
d. How is the medication and/or other interventions working? _____
e. Additional info: _____

4. Muscle Injuries ☐ N ☐ Y Are you experiencing any pain? ☐ N ☐ Y
When did the condition start?_____
a. Who is the treating health care provider? _____
b. What medication(s) do you take for the condition(s)? _____
c. What else are you doing to help the condition(s)? _____
d. How is the medication and/or other interventions working? _____
e. Additional info: _____

5. Joint Injuries ☐ N ☐ Y Are you experiencing any pain? ☐ N ☐ Y
When did the condition start?_____
a. Who is the treating health care provider? _____
b. What medication(s) do you take for the condition(s)? _____
c. What else are you doing to help the condition(s)? _____
d. How is the medication and/or other interventions working? _____
e. Additional info: _____

6. Have you had any surgeries or hospitalizations due to illness or injury?
☐ N ☐ Y

Date of incident: _____Please describe:_____

_____

_____

Date of incident: _____Please describe:_____

_____

_____

Date of incident: _____Please describe:_____

_____

_____

Date of incident: _____Please describe:_____

_____

_____

Section 6 Please answer Yes or No. If YES, please give dates and details.

1. When was the last time you saw a physician including a psychiatrist?_____

_____

What was the purpose of the visit? _____

_____

_____

_____

_____

_____

_____

2. Do you take any prescription psychiatric medications?

□ N □ Y

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

3. Do you take any over the counter (OTC) medications? (Aspirin, Tylenol, Ibuprofen, etc.)

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

4. Do you take any over the counter (OTC) digestive medications? (Tums, Maalox, etc.)

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Type:_____ Dosage: _____
Frequency: _____ Is it helping? _____

Section 7 Please answer Yes or No. If YES, please give dates and details.

1. Do you wear or need to wear glasses, contact lenses, or hearing aids?
☐ N ☐ Y Details: _____

_____

2. Do you have difficulty hearing?
☐ N ☐ Y Details: _____

_____

3. Do you have difficulty reading?
☐ N ☐ Y Details: _____

_____

4. When was your last dental exam? Date: _____

5. Are you in need of dental care?
☐ N ☐ Y Details: _____

_____

a. What has prevented you from getting care? _____

_____

_____

6. Do you wear or need to wear dentures or other dental appliances that may require dental care?
☐ N ☐ Y Details: _____

_____

7. Are you pregnant? ☐ N ☐ Y
If **yes,** which trimester: ☐1st Trimester ☐2nd Trimester ☐3rd Trimester
Are you receiving pre-natal care? ☐ N ☐ Y
Any complications? ☐ N ☐ Y
If **yes,** please explain:

_____

_____

_____

8. Are you breastfeeding? ☐ N ☐ Y

Section 8 FAMILY MEDICAL HISTORY

1. Has a 1st degree relative had the following:

- ☐ N ☐ Y Addiction
- ☐ N ☐ Y Asthma
- ☐ N ☐ Y Cancer
- ☐ N ☐ Y Diabetes
- ☐ N ☐ Y Stroke
- ☐ N ☐ Y Rheumatoid Arthritis
- ☐ N ☐ Y Depression
- ☐ N ☐ Y Bi-Polar Disorder
- ☐ N ☐ Y Heart Disease
- ☐ N ☐ Y Lupus
- ☐ N ☐ Y Blood clots

If yes to any of the above, please complete the following:

Condition	Family Member	Type of Medication Prescribed/Used	Response to Medication
Example- Depression	Mom	Prozac	Good

Section 9 SUBSTANCE USE HISTORY

1. Do you use nicotine?

☐ N ☐ Y

a. _____packs/day for _____years.

2. Do you vape nicotine?

☐ N ☐ Y

a. Do you desire to quit? ☐ N ☐ Y

b. Have you quit before? ☐ N ☐ Y

c. How long did you quit for? _____

d. What method did you use to quit? _____

3. In the past seven days what types of drugs, including alcohol, have you used?

Type of Drug	Amount	Route of Administration

4. In the past year what types of drugs, including alcohol, have you used?

Type of Drug	Amount	Route of Administration

Section 10 HIV/AIDS/STD ASSESSMENT

1. Have you ever used IV drugs? ☐ N ☐ Y

2. If you are currently using IV drugs…
   a. Is the injection area infected or abscessed? ☐ N ☐ Y

3. Have you ever participated in unsafe or unprotected sex? ☐ N ☐ Y

4. Have you had a blood transfusion? ☐ N ☐ Y

5. Have you been sexually active with an IV drug user? ☐ N ☐ Y

6. Have you been tested for STDS? ☐ N ☐ Y
   When: _____ Results: _____

7. Have you been tested for HIV/AIDS?
   ☐ N ☐ Y
   When: _____ Results: _____

Referral for HIV Test to: _____

8. Have you ever been treated for HIV or AIDS? ☐ N ☐ Y
If **yes,** please give details:
a. When did the condition start? _____
b. Who is the treating health care provider? _____
c. What medication(s) do you take for the condition(s)? _____
d. What else are you doing to help the condition(s)? _____
e. How is the medication and/or other interventions working? _____
f. Additional info: _____

9. Do you identify self as part of LBGT Community?
   ☐ N ☐ Y

Section 11 MENTAL / EMOTIONAL ASSESSMENT

1. Are you currently feeling down, depressed, anxious or hopeless?
   □ N □ Y
   If **yes,** please describe: _____

   _____

2. Are you currently receiving treatment services for an emotional/psychiatric diagnosis?
   □ N □ Y
   If **yes,** for what are you being treated for?

a. Who is the treating health care provider? _____
b. What medication(s) do you take for the condition(s)? _____
c. What else are you doing to help the condition(s)? _____
d. How is the medication and/or other interventions working? _____
e. Additional info: _____

3. Over the last 2 weeks, have you felt nervous, anxious, or on edge?
   □ N □ Y
   If **yes**, please describe: _____

   _____

   a. Did you feel like you were unable to stop or control your worrying?
      □ N □ Y

      If **yes**, please describe: _____

_____

_____

4. Over the last 2 weeks, have you had thoughts of suicide or through that you would be better off dead?
   □ N □ Y
   If **yes**, please describe: _____

   _____

5. Have you attempted suicide in the past 2 years?
   □ N □ Y
   If **yes**, please describe: _____

   _____

6. Have you ever harmed yourself/others or thought about harming yourself/others?
   □ N □ Y

   If yes, please describe: _____
_____

7. Are you currently feeling that you're hearing voices or seeing things?
   □ N □ Y
   If yes, please describe: _____
_____

8. Have you ever been in a relationship where your partner has pushed or slapped you?
   □ N □ Y
   If yes, please describe: _____
_____

Section 12 PREVIOUS DRUG AND/OR ALCOHOL TREATMENT SERVICES

1. Have you received alcoholism or drug abuse recovery treatment services in the past?
   If **yes,** please give details:

Type of Previous Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Previous Treatment Facility	Dates of Previous Treatment	Treatment Completed (Yes or No)

2. Have you ever been treated for withdrawal symptoms?
   If **yes,** please provide dates you were treated:

Date: _____ to Date: _____ Date: _____ to Date:_____
Date: _____ to Date: _____ Date: _____ to Date:_____

Please list any medications you were prescribed during your treatment stays:

Type:_____ Dosage: _____
Frequency: _____ Still taking? _____

Type:_____ Dosage: _____
Frequency: _____ Still taking? _____

Type:_____ Dosage: _____
Frequency: _____ Still taking? _____

Type:_____ Dosage: _____
Frequency: _____ Still taking? _____

Type:_____ Dosage: _____
Frequency: _____ Still taking? _____

Type:_____ Dosage: _____
Frequency: _____ Still taking? _____

Section 13 DETOX RISK ASSESSMENT

1. State of General Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Have withdrawal symptoms occurred when you have become abstinent in the past?
☐ N ☐ Y Details: _____
How many withdrawal episodes have you experienced?_____

3. Have you ever had a seizure or DT's?
☐ N ☐ Y Date: _____
a. Cause of seizure: _____

4. Last date that substance was used?
Alcohol: _____ Tranquilizers:_____
Painkillers: _____ Sleeping Medications: _____

5. Are you currently experiencing any of the following?

1. Extreme Anxiety	☐ N	☐ Y	7. Visual Distortions	☐ N	☐ Y
2. Tremors	☐ N	☐ Y	8. Auditory Hallucinations	☐ N	☐ Y
3. Diaphoresis (sweating)	☐ N	☐ Y	9. Tactile Hallucinations	☐ N	☐ Y
4. Nausea/Vomiting	☐ N	☐ Y	10. Insomnia	☐ N	☐ Y
5. Diarrhea	☐ N	☐ Y	11. Loss of appetite	☐ N	☐ Y
6. Muscle Cramps	☐ N	☐ Y	12. Cravings	☐ N	☐ Y

1. The patient has been informed of the risks and benefits of Medications for Addiction Treatment (MAT) also known as Medicated Assisted Treatment. Additionally, the provider described the availability of MAT at the program, if applicable, or the referral process for MAT.

_____ _____

Patient Signature Program Nurse Signature

2. The patient has been screened for use of all tobacco products utilizing questions recommended in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders under tobacco use disorder, or similar evidence-based guidance, for determining that an individual has a tobacco use disorder.

_____ _____

3. Patient Signature Program Nurse Signature

I declare that the above information is true and correct to the best of my knowledge:

Patient Name (printed) _____

Patient Signature: _____ Date: _____

Program Nurse Name (printed) _____

Program Nurse Signature: _____ Date: _____

Facility Name: _____

Additional Comments:

Substance Use History Form

Client Name: _____
Date: _____
Clinician: _____

Substance	Quantity / Typical Amount	Frequency & Duration of Use	Date of Last Use	Current Withdrawal Symptoms

Additional Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Hill Alcohol and Drug Treatment – Reported Medications Sheet

Patient Name: _____DOB: _____ Admission Date: _____

Medication Name (Brand/Generic)	Dosage	How do you take this med? (Oral, cream, etc.)	Prescriber / Pharmacy	Notes / Reason

Patient Signature: _____ Date: _____

Rume Health Consent

DOB: MRN: Patient Name:

Date: **Time:**

Consent to Telemedicine

I hereby consent to the use of telemedicine by Rume Health and contracted medical groups including "Elevated Health" and "Rume Medical Group". I understand that telemedicine involves the communication of my medical information, both orally and visually, to providers involved in my treatment who are located at a different site than me. I understand I have all of the following rights with respect to telemedicine.

Patient Choice

I have the right to withhold or withdraw my consent to telemedicine at any time without affecting my right to future treatment. Access to Information. I have the right to inspect and receive copies of all medical information transmitted during a telemedicine consultation. I understand that my telemedicine provider will communicate my relevant health information to physicians and other health care practitioners involved in my treatment who are located in different offices or clinics in the state, such as my primary care physician or therapist.

Confidentiality

I understand that the laws which protect the confidentiality of medical information apply to telemedicine, that I will not be recorded, and that no information from my telemedicine consultations that identifies me will be disclosed to third parties without my consent. Potential Risks. I understand that there are potential risks associated with telemedicine, including disruption or distortion in the transmission of medical information and unauthorized access to medical information generated, transmitted, and stored pursuant to the telemedicine consultation. I understand that telemedicine is an alternative to in-person treatment and my Elevated Health/Rume Medical Group provider may recommend I discontinue telemedicine and receive in-person treatment in certain circumstances. I understand that telemedicine does not negate or minimize the risks that may be inherent to my illness or condition and that there may be other risks associated with telemedicine that are not listed here. Benefits. I understand that I can expect benefits from telemedicine, but that no particular results can be guaranteed.

Statement of Financial Responsibility

Thank you for choosing Rume Health as your provider. We are committed to providing you with the best possible care. Your clear understanding of our practices' financial policy is important to

our professional relationship. We make every effort to keep our fees reasonable while at the same time covering the cost of the services we provide. Payment of your bill is considered part of your overall treatment and responsibility. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

Fees and Payments

Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, personal check, money order, Visa, MasterCard, or Discover. While filing insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date services are rendered. Rume Health will file claims to insurances provided (primary & secondary) during registration. Your insurance is a contract between you and/or your employer, and the insurance company, we are not party to that contract. In order for us to file a claim on your behalf, you must present a CURRENT copy of your insurance card(s) at each visit and communicate any changes in your personal information. Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover, therefore we can't guarantee payment of all claims by your insurance compay. Some common examples of non covered services are labs, radiology, pharmacy, dental supplies and/or labs, contact lenses, mental health, and chiropractic, etc. Rejection of your claim does not relieve you of your financial responsibility to Rume Health "Elevated Recovery / Rume Medical Group Inc."

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnosis are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Medicare and Medi-Cal

We gladly accept Medicare patients and will bill our services at the allowed rates. Medicare regulations require that you sign an Advanced Beneficiary Notice (ABN) at every visit where your procedure may not be covered. This form helps to explain which services Medicare may not cover and may be your responsibility. Non-Covered services include, but are not limited to, Chiropractic and Vision.

Co-Payments

Your insurance company requires us to collect copayments at the time of service. Waiver of copayments may constitute a fraud under state and federal law. If you do not have your co-payment, your appointment may be rescheduled. Medical Records. All Rume Health patients may request a copy of their medical records via email. This can be done at no charge to the patient and received electronically within 30 (thirty) business days.

Uses and Disclosure of Health Information

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

REVIEW IT CAREFULLY. This notice is effective as of April 15, 2023.

USES AND DISCLOSURE OF HEALTH INFORMATION

Rume Health is committed to protecting the privacy of the personal and health information we collect or create as part of providing health care services to our clients, known as "Protected Health Information" or "PHI". PHI typically includes your name, address, date of birth, billing arrangements, care, and other information that relates to your health, health care provided to you, or payment for health care provided to you. PHI DOES NOT include information that is de-identified or cannot be linked to you. This notice of Health Information Privacy Practices (the "Notice") describes Rume Health's duties with respect to the privacy of PHI, Rume Health's use of and disclosure of PHI, client rights and contact information for comments, questions, and complaints.

Rume Health's PRIVACY PROCEDURES AND LEGAL OBLIGATIONS

Rume Health obtains most of its PHI directly from you, through care applications, assessments, and direct questions. We may collect additional personal information depending upon the nature of your needs and consent to make additional referrals and inquiries. We may also obtain PHI from community health care agencies, other governmental agencies, or health care providers as we set up your service arrangements. Rume Health is required by law to provide you with this notice and to abide by the terms of the Notice currently in effect. Rume Health reserves the right to amend this Notice at any time to reflect changes in our privacy practices. Any such changes will be applicable to and effective for all PHI that we maintain including PHI we created or received prior to the effective date of the revised notice. Any revised notice will be mailed to you or provided upon request. Rume Health is erquired by law to maintain the privacy of PHI. Rume Health will comply with federal law and will not comply with any state law that further limits or restricts the uses and disclosures discussed below. In order to comply with these state and federal laws, Rume Health has adopted policies and procedures that require its employees to obtain, maintain, use and disclose PHI in a manner that protects client privacy.

USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as outlined below, Rume Health will not use or disclose your PHI without your written authorization. The authorization form is available from Rume Health. You have the right to revoke your authorization at any time, except to the extent that Rume Medical Group Inc has taken action in reliance on the authorization. The law permits Rume Health to use and disclose your PHI for the following reasons without your authorization: For Your Treatment. We may disclose your PHI to physicians, psychologists, nurses and other authorized healthcare professionals who need your PHI in order to conduct an examination, prescribe medication or otherwise provide health care services to you.

To Obtain Payment: We may use or disclose your PHI to insurance companies, government agencies or health plans to assist us in getting paid for our services. For example, we may

release information such as dates of treatment ro an insurance company in order to obtain treatment.

For Our Health Care Operations: We may use or disclose your PHI in the course of activities necessary to support our health care operations such as performing quality checks on your employee services. We may also disclose PHI to other persons not in Rume Health's workforce or to companies who help us perform our health services (referred to as "Business Associates") we require these business associates to appropriately protect the priacy of your information.

As Permitted or Required By The Law: In some cases we are required by law to disclose PHI. Such disclosures may be required by statute, regulation court order, or government agency, we reasonably believe an individual to be a victim of abuse, neglect or domestic violence: for judicial and administrative proceedings and enforcement purposes.

For Public Health Activities:

We may disclose your PHI for public health purposes such as reporting communicable disease results to public health departments as required by law or when required for law enforcement purposes. By signing below, I acknowledge my understanding and agreement with the above statements

Release of Medical Records Authorization for Use and Disclosure of Health Information

I Andy Esparva authorize Rume Health to disclose of medical records to

Name of Facility

and any referring providers needed for my medical care.

FOR: ALL DATES OF TREATMENT OR FROM one year of the day signed for

PURPOSE: FOR ONGOING MEDICAL CARE/TREATMENT AT THE REQUEST OF THE INDIVIDUAL YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

1. I understand that if I sign this authorization, I will be provided with a copy of this authorization.

2. I understand that I am under no obligation to sign this form and that Rume Health, Inc providers may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding health plan enrollment or eligibility, or the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

3. I understand that I have the right to withdraw this authorization at any time providing a written statement of withdrawal to Rume Health. I am aware that my withdrawal will not be effective until received by Rume Health, Inc and will not be effective regarding the uses and/or disclosures of my health information that Rume Health has made prior to receipt of my withdrawal statement.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

THIS AUTHORIZATION IS VALID FOR ONE YEAR (12 MONTHS) FROM DATE OF SIGNATURE

☐ Client Refuses to Sign

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