Corebella Health & Wellness

www.corebellawellness.com

2600 E Southern Ave Suite E-1 Tempe, Arizona 85282 (480) 409-0322

5700 W Olive Ave Suite 107 Glendale, Arizona 85302 (602) 492-9595

PATIENT INTAKE: DEMOGRAPHICS & REGISTRATION

(PLEASE PRINT LEGIBLY)

Date of Birth: _____ ☐Male ☐Female Marital Status: _____

LAST Name:_____ FIRST Name:_____ MI_____

Current Address: _____ City: _____ State: ____ Zip Code: _____

Phone (H): _____ (C)_____ (W)_____

Email: _____ Ethnicity/Race: _____

EMERGENCY CONTACTS

(1): Name- _____ Phone-_____ Relationship to Patient_____

(2): Name- _____ Phone-_____ Relationship to Patient_____

I give permission for my emergency contacts to have access to ☐**Medical Information** ☐**Financial Information** ☐**None**

PRIMARY MEDICAL INSURANCE

Insurance Carrier: _____ Patient Relationship to Policy Holder: _____

Policy #/Subscriber ID: _____ Group Name/Number: _____

Policy Holder Name (Last, First): _____

Policy Holder DOB: _____ Policy Holder Social Security #: _____

SECONDARY MEDICAL INSURANCE

Insurance Carrier: _____ Patient Relationship to Policy Holder: _____

Policy Holder Name (Last, First): _____

Policy Holder DOB: _____ Policy Holder Social Security #: _____

PRIMARY CARE PHYSICAIN:

Name:_____ Phone:_____

Address:_____ City:_____ Zip Code:_____

PREFERRED PHARMACY:

Name:_____ Phone:_____

Address:_____ City:_____ Zip Code:_____

Patient/ Responsible Party Signature :_____

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PATIENT INTAKE: MEDICAL HISTORY

(PLEASE PRINT LEGIBLY)

****Note- This is a confidential record. This record will be kept by Corebella Health and Wellness. Information contained here will NOT be released to anyone without your authorization. Please help us help you receive the best treatment possible by being HONEST****

Known Allergies: _____ _____ _____
_____ _____ _____
_____ _____ _____

Check all symptoms that apply (can be seasonal or in reaction to a trigger)-

☐ Cough	☐ Wheezing	☐ Runny Nose	☐ Sneezing
☐ Shortness of Breath	☐ Hives &/or Swelling	☐ Fatigue	☐ Eczema/skin reactions
☐ Chest Tightness	☐ Itchy/Watery Eyes	☐ Ear Infections	☐ Headaches
☐ Nasal Congestion	☐ Phlegm/Sputum	☐ Sinus Infections	☐Other: _____

History of Abuse: ☐Yes ☐No Circle Applicable: Physical Mental/Emotional Sexual Other: _____

Age of abuse: _____

Current or Past Medical Conditions (ex. Abnormal Test Results, Asthma, Diabetes, Heart Attack, Depression):

_____ _____
_____ _____
_____ _____

Past Injuries / Conditions requiring hospitalization and/or surgery:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Current Medications & Dosage

_____
_____
_____
_____
_____

Current or Past Treatment:

☐Detox ☐In-Patient ☐IOP ☐AA/NA Meetings ☐Out-Patient ☐Other: _____

Patient/ Responsible Party Signature :_____

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PATIENT INTAKE: FAMILY MEDICAL HISTORY

Mother: _____ ☐N/A ☐Unknown

☐ Deceased / Cause of Death: _____☐Unknown

Father: _____ ☐N/A ☐Unknown

☐ Deceased / Cause of Death: _____☐Unknown

Siblings: _____ ☐N/A ☐Unknown

☐ Deceased / Cause of Death: _____☐Unknown

Extended Family: _____ ☐N/A ☐Unknown

☐ Deceased / Cause of Death: _____☐Unknown

PATIENT INTAKE: SOCIAL HISTORY

Current/Past Occupation: _____

Field of Work: _____

Currently Employed: ☐Yes ☐No Circle Applicable: Full Time / Part Time

☐Retired ☐Disabled ☐Sick/Maternity Leave

Legal Problems: ☐Yes ☐No

Please Explain: _____

_____

_____

_____

_____

Patient/ Responsible Party Signature :_____

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PATIENT INTAKE: SUBSTANCE ABUSE HISTORY

How did you hear about this treatment center? _____

	Used Y/N	Age of first use	Method of Use	How Much & How Often	Last Use	Longest time without using
Alcohol						
Tobacco						
Cannabis, Marijuana, Hashish, Hash Oil, Etc.						
Benzodiazepines/ Tranquilizers						
Heroin						
Street Methadone						
Street Suboxone						
Painkillers						
Cocaine						
Meth/amphetamine(s)						
Other						

Please List any inpatient/detox facilities you have been treated at:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Patient/ Responsible Party Signature :_____

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EXPLANATION OF TREATMENT

Office Visit

You will be given a comprehensive substance dependence assessment, as well as all necessary diagnostic and laboratory testing. At this time all relevant paperwork will be filled out by you and your treatment partner. You will be expected to pay any fees that are required as outlined during your telephone or in office interview. Treatment expectations, your expectations, as well as issues involved with buprenorphine treatment will be discussed.

Induction

At this time the doctor will talk with you and your treatment partner to answer any remaining questions that you may have. You will be asked to sign a form giving your permission to the doctor to treat you with buprenorphine. In addition, a treatment plan will be developed addressing your specific needs as related to your addiction. You will be switched from your current opioid (heroin, methadone or prescription painkillers) on to SUBOXONE. You must arrive for this visit experiencing mild to moderate opioid withdrawal symptoms. When the doctor examines you and determines you are in sufficient withdrawal, you will then take your first dose of SUBOXONE. Your response to the initial dose will be monitored. You may receive additional medication, if necessary, to reduce withdrawal symptoms. Since an individual's tolerance and reactions to SUBOXONE vary, daily appointments may be scheduled, and medications will be adjusted until you no longer experience withdrawal symptoms or cravings. Urine drug screening is required for all patients at every visit during this phase.

Stabilization

Once the appropriate dose of SUBOXONE is established, you will stay at this dose until steady blood levels are achieved. You and your doctor will discuss your treatment options from this point forward.

Maintenance

Treatment compliance and progress will be monitored. Participation in some form of behavioral counseling is prescribed to ensure best chance of treatment success. You are likely to have scheduled appointments on a weekly basis; however, if treatment progress is good and goals are met, monthly visits will eventually be considered sufficient. The Maintenance phase can last from weeks to years—the length of treatment will be determined by you and your doctor, and, possibly, your counselor. Your length of treatment may vary depending on your individual needs.

Medically Supervised Withdrawal

As your treatment progresses, you and your doctor eventually decide that medically supervised withdrawal is an appropriate option for you. In this phase, your doctor will gradually taper your SUBOXONE dose over time, taking care to see that you do not experience any withdrawal symptoms or cravings.

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BUPRENORPHINE TREATMENT CONTRACT

Patient Name_____ Date_____

By initialing all statements, I as a participant in buprenorphine treatment for opioid addiction, freely and voluntarily agree and understand this treatment contract, in its entirety, as follows:

_____1. I agree that I have been informed that buprenorphine is a treatment designed to treat opioid addiction not addiction to other classes of drugs.

- If I am actively addicted to other substances, I will need to be treated by other methods for those addictions.

_____2. I agree to take my medication(s) as the doctor has instructed. I understand that only the doctor can change the way I take my medication(s).

_____3. I agree that medication management with buprenorphine is only one part of the treatment for my addiction and I agree to participate in a regular program of professional counseling while in treatment with buprenorphine.

- I agree to provide proof of counseling at every visit.

_____4. I agree to abstain from illegal drugs, alcohol and other addictive substances while in treatment with buprenorphine.

- I agree to random drug screens and/or pill counts.
- I agree to report to this office for random pill counts or drug screens.
- I understand that I am responsible for the cost of a nurse visit to obtain this sample.
- This sample will be referred to an outside lab from whom I and/or my insurance company will receive a bill.
- I agree to keep and be on time for all my scheduled appointments.

_____5. I understand that I may be witnessed by a staff member when giving urine samples.

- I also understand that **ANY** attempts to alter my urine or bring in urine from others will result in termination from treatment without recourse for appeal.

_____6. **I agree that I have been informed that it can be dangerous to mix buprenorphine with alcohol or other sedative drugs such as Valium, Ativan Xanax, Klonopin or any other benzodiazepine drug so dangerous that it can result in accidental overdose, over sedation, coma or death.**

_____7. I agree that I will be open and honest with my doctor and treatment team about my addiction and overall health history and

- I agree to inform my doctor about cravings or unhealthy situations in which I am involved, **specifically about any relapse that has occurred before a drug test result confirms it.**

_____8. I agree to immediately notify the office of any change of address and/or telephone number, as all patients must be accessible to this office at **any time** for office contact.

- Voice mail MUST be set up.

- If this office cannot reach the Patient within two hours, this office has a right to discharge the Patient without further notice.

_____9. I agree that a network of support and communication is an important part of my recovery.

- I will be asked for my authorization to allow contact, as appropriate, between my doctor and/or his staff and outside parties, including physicians, therapists, probation/parole officers, and other parties.
- Contact will only be made when the doctor (network of support) has determined that communication is necessary for effective treatment and recovery.

_____10. I agree to adhere to the payment policy outlined by this office.

_____11. I agree not to sell, share, or give any of my medication(s) to another person.

- I understand that such mishandling is a serious violation of this contract and will result in my treatment being terminated without any recourse for appeal.

_____12. Medication lost, stolen, or damaged will not be replaced. It is my responsibility to protect my medication.

- I understand that the consequence of not protecting the medication is that **I may be without prescribed medication for a period of time.**

_____13. I agree that I have a means to store my medication(s) safely where it cannot be taken accidentally by children or stolen by others.

- if my buprenorphine is swallowed by anyone besides me, I will call 911 or the Poison Control Center at 1-800-222-1222.

_____14. I agree that if the doctor recommends that my medication(s) should be kept in the care of a responsible member of my family or another person, I will abide by such recommendation.

_____15. I agree not to obtain medication(s) from any other doctors, pharmacies, or other sources without informing the doctor.

_____16. I agree that I will not drive a motor vehicle or operate heavy or dangerous machinery during my first two weeks of treatment to ensure that I can tolerate my medications without becoming sleepy or clumsy as a side-effect.

_____17. **I agree to treat all office and pharmacy staff with respect**

- not to conduct any illegal or deceptive activities in or around the doctor's office and/or pharmacy
- I understand that should such behavior occur, I will be terminated from treatment without recourse for appeal and the appropriate authorities will be notified.

_____ 18. Corebella Health & Wellness's Monthly Addiction/Pain Program:

- I understand, as a new patient during the initial four (4) weeks of entering the program; I will be required to be seen in office weekly by the provider.
- Each month following, I understand that I will be required to be seen in office every two (2) weeks by the provider.
- I understand Corebella Health and Wellness reserves the right to make changes at any time to the monthly program, when necessary or by the provider's medical recommendation after 1st month of program is completed.

By signing below, I attest that I have read and understand the above contract and that I have had the opportunity to ask questions and have them answered to my understanding. also understand that violations of this contract may be grounds for termination of treatment without recourse for appeal.

Patient/Responsible Party Signature_____ Date _____

Witness (Corebella Medical Staff) Signature _____ Date _____

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CONSENT TO TREAT-BUPRENORPHINE TREATMENT

Patient Name (print) _____ do hereby: ***(initial all statements)***

_____Give my willful and informed consent to the physicians at Corebella Health and Wellness and members of their staff at the above location(s) to administer Buprenorphine to me, as treatment of for opioid addiction.

_____Agree that I have had ample opportunity to discuss treatment and have all my questions answered in a manner that I understand.

_____Agree that I can withdraw this consent at any time with written notice of my intent to withdraw delivered to either the physician or his staff.

_____Understand my rights and responsibilities as a patient of the above-named facility as outlined to me by the physician and staff.

_____Agree I will be given copies of relevant information relating to the treatment to which I am consenting at my request.

_____Understand the risks and benefits to me of Buprenorphine Treatment and agree to follow the program as outlined in my treatment plan and treatment contract

_____ _____

Patient Name (Print) Date

_____

Patient/ Responsible Party Signature

_____ _____

Witness Name/ Title Date

_____

Witness Signature

Advance Beneficiary Notice (ABN)

Patient Name: Insurance ID:

Insurance Carrier: _____Insurance Group: _____

***NOTE:* You need to make a choice about receiving these health care items or services**

We expect that your insurance company will not pay for the item(s) or service(s) that are described below. Your Insurance Company does not pay for all your health care's costs. Your Insurance Company only pays for **covered items** and services when your insurance company's rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. **There may be a good reason your doctor recommended it. Right now, in your case, your Insurance Company probably will not pay for:**

Item or Service:

Office Visit(s)[1]
Drug Testing (Dip Stick)[1]
Specimen Handling (collection and transfer of sample to Lab)[1,2]
Medical Injections & Administration [1,2]
A variety of procedures not listed above

Reasoning:

[1] Opioid Dependence treatment and procedures are often deemed "experimental" or "not medically necessary" by insurance agencies. However, your doctor will advise you otherwise. *

[2] Most Therapeutic/Hormonal Drug Injections are often deemed "experimental" or "not medically necessary" by insurance agencies

*When **Opioid Dependence treatment and procedures** are denied being deemed "experimental" or "not medically necessary", there will be an appeal by the billing department to resolve to the best of our ability. Yet, payment by insurance is not a guarantee.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you do not understand why your Insurance Company probably will not pay.
- Ask us how much these items or services will cost you

Advance Beneficiary Notice (ABN)

PLEASE CHOOSE *ONE* OPTION. CHECK ONE BOX. SIGN & DATE.

☐ Option 1: YES, I WANT TO RECEIVE THESE ITEMS OR SERVICES.

I understand that my Insurance Company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my Insurance Company is making its decision. If my insurance company does pay, you will refund me any payments I made to you that are due to me. If my Insurance Company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my Insurance Company's decision.

☐ Option 1: NO, I HAVE DECIEDED NOT TO RECEIVE THESE ITEMS OR SERVICES.

I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company will not pay.

_____ _____

Patient/Responsible Party Signature **Date**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.

Corebella Health and Wellness Financial Agreement

In efforts to keep business efficient and all patient accounts current, Corebella Health and Wellness DOES COLLECT FEES AT THE TIME OF SERVICE.

All monies collected upfront will be either Co-Pay, Coinsurance, Deductible, or payment for services not covered by an insurance plan.

Co-Payment- A contracted, pre-determined, amount determined by the patient's health plan that the patient is responsible for at the time of service. If this amount is not paid by the patient that insurance company can reject responsibility leaving the patient responsible of ALL CHARGES

Coinsurance- A contracted amount, most commonly a set percentage, is the responsibility of the patient. The patient's health plan agrees to be financially responsible of a percentage of the charges for services ONLY WHEN the patient will be held responsible for the percentage NOT COVERED by the insurance plan.

Deductible- A pre-determined, contracted amount, the patient has agreed to pay, per their health plan. This amount must be paid by the patient BEFORE insurance will accept financial responsibility for covered Medical expenses.

Payment for services not covered by an insurance plan- In the case that-
A) A patient does not have Health Insurance
B) Corebella Health and Wellness is a non-participating &/or non-contracted provider with a patient's Health Insurance
C) A patient's Health Insurance plan does not cover the services rendered
The Patent is responsible for the cost of the services.

As a courtesy, to show our appreciation and support to our patients for being active participants in their health, it is Corebella Health and Wellness' Policy that our patients will NOT pay more than our going Self Payment Pricing for services.

All payments deemed patient overpayments after insurance reimbursement is applied to services rendered will be credited to each patient's account to cover future charges that are deemed patient responsibility (i.e. Co-Pay, Coinsurance, Deductible, or payment for services not covered by an insurance plan), unless otherwise requested.

Patient account reviews are available at the patient request. Please reach out to Corebella Health and Wellness' Billing Department at (623) 258-4970. You may also email chelsea@corebellawellness.com stating your concern and request. You will be contacted at the departments earliest availability and all account reviews will be conducted in the order in which it was received.

I have READ and UNDERSTAND Corebella Health and Wellness' Financial Agreement. I accept financial responsibility contracted by my health plan, whether that be a health insurance plan or self-payment. I understand that my account will be credited in any excess payments made to benefit my future treatments, unless otherwise requested.

_____ _____
Patient /Responsible Party Name (Print) Date

_____ _____
Patient /Responsible Signature Date

_____ _____
Witness Signature / Title Date

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PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

Corebella Health and Wellness is committed to delivering quality medical care to you, our patient, and to offering you the highest level of customer service possible. It is our goal to demonstrate our commitment to providing you with medical care that is of extraordinary value by ensuring the medical care we provide is of the highest quality and delivered with exceptional customer service and aligned with our mission and philosophy, applicable law and regulation.
The following "Statement of Patient's Rights" applies to all patients.
In the event that you are unable to exercise these rights on your own behalf, then these rights are applicable to your designated/legal representative.

STATEMENT OF PATIENT'S RIGHTS

You have the right to receive individualized, considerate and respectful care in a safe setting. Care is delivered in a manner and setting intended to preserve your personal dignity.
Care is provided without discrimination as to your race, color, religion, gender, age, sexual orientation, familial status, national origin, genetic information, physical or mental disability, veteran status or how your bill is paid.
You have the right to effective communication, based on your individual needs. Special services will be given to address your needs, as appropriate. They can relate to your age, understanding, language, vision, speech or hearing.

You have the right to be involved in decisions about your care.

- Before, during treatment, and at discharge; whenever medically possible.
- To receive information about your diagnosis and help make the plan for your care.
- To be involved in resolving dilemmas about your care.
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of your refusal, including end of life treatment.

You have the right to agree to your care. Before agreeing to your care, you will understand:

- Why the treatment is suggested.
- What its possible benefits, risks and side effects are, including what could happen if refused.
- What other treatments could be used.
- What the outcomes are, including those that are unexpected.
- What limitations on protecting your confidential information are, if any.

If you do not agree to the recommended treatment, Corebella Health and Wellness may do one of these things:

- Suggest other ways of treating you and continue to see you.
- Refer you to another place to get care if possible.
- In special emergency cases, seek a court order to allow the treatment. You have the right to have your pain treated effectively and to be given information about pain and pain relief measures.
-

You have the right to know about the staff that treats you.

- All staff wears name badges to identify themselves.
- All staff providing your care will introduce themselves to you and describe their roles.

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STATEMENT OF PATIENT'S RIGHTS cont.

You have the right to privacy, confidentiality and security.

- Your personal information is treated in a confidential manner and in accordance with HIPAA law.
- You may refuse to allow observation by anyone not directly involved in your care.
- Your personal privacy will be respected to the extent possible in a healthcare setting.
- We will make sure that you and your property are safe and secure.

You have the right to review or obtain a copy of your medical record.

- Your physician may review it with you.
- You have the right to access your medical record and to receive an accounting of disclosures of your health information as permitted by law.
- If you do not agree with the accuracy of information/documentation in your medical record you may ask for the record to be reviewed by your doctor. If information is deemed inaccurate by your doctor it will be amended in a way allowed by law.

You have the right to be free from mental, physical, sexual and verbal abuse, neglect and exploitation. **Any allegations are promptly investigated, and appropriate action is taken.** You have the right to access protective services. You may ask the staff for information about state protection and advocacy agencies for children and adults or resources pertaining to domestic violence.

You have the right to choose or refuse to take part in research. Before agreeing to take part, you will understand the research procedures, expected benefits, possible discomforts and risks, the extent to which your private information will be kept confidential and any other relevant information. You can withdraw from the study at any time. If you refuse to take part in or withdraw from the study, the care you receive will not be affected.

You have the right to make health care decisions in advance or to appoint a healthcare agent through an advance directive. When necessary to give informed consent, a surrogate may be appointed on your behalf if you are unable to do so.

- Contact the social worker or ask any AZPC employee for more information.

You have the right to be free from restraint, *except* when it is temporarily necessary to prevent injury to yourself or others.

- In such emergency restraint is used in a safe manner and with care and respect.

You have the right to speak with someone about your concerns if you are not satisfied with any aspect of your care and are unable to resolve the situation.

- You may discuss it with the staff involved, their supervisor, your physician, or social worker. If you are still concerned, you may also speak with The Practice Manager and/or The Medical Director at 480-409-0322
    - or fill out a Patient Complaint Form. These forms are available from the Reception Desk.

You have the right to receive an explanation of the charges for which you are responsible.

- If finical inquiries cannot be answered to your satisfaction in office, you may reach out to Corebella Health and Wellness' Billing Department at (623) 258-4970. If your call is not answered please leave a detailed message of your concern and you will be contacted at the earliest convenience of the department.

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STATEMENT OF PATIENT'S RIGHTS cont.

If your concern is not resolved to your satisfaction, you have the right to request a review by:

AZ Department of Health
150 North 18th Avenue Phoenix, AZ 85007
Phone: 602-542-1025
Fax: 602-542-0883

Or the Department of Health Services Center for Medicare and Medicaid Services (CMS) call 1-800-MEDICARE

YOUR RESPONSIBILITES

Corebella Health and Wellness expects patients and families to act in a **reasonable and responsible way at all times**. You have the responsibility to:

- Provide complete and accurate information about your health and any other requested information.
- Follow the instructions related to your care plan and be responsible for the outcomes if you do not follow your care plan.
- Ask questions when you do not understand what your doctor or other caregivers tell you about your medications and treatment.
- Express your concerns if you anticipate problems in following prescribed treatment and if you are considering alternative therapies.
- Follow Corebella rules and regulations,
    - including visitor and smoke-free guidelines.
- **Show respect and consideration for the Corebella staff, other patients and their families and their property**.
- Meet any obligations for payment.
- Provide your doctor or Corebella staff with a copy of your "ADVANCE DIRECTIVE" if you have one and want it to apply during your visit.
- Keep appointments, be on time for your appointments and call as soon as possible if you cannot keep your appointments.
- Keep confidential any information regarding another patient that you may hear or see.
- Leave valuables at home and bring only those items necessary during your visit.

By signing my name below, I certify that I have read the **Statement of Patent Rights & Patent Responsibilities**. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and an agreement with the policies. I understand I am responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

_____ _____
Patient/Responsible Party Signature Date
Please check below if patient refused to sign provide additional staff signature: Patient refusal to sign

_____ _____
Witness Signature Date