Dr. Clayton S. Hall, DO & Associates, LLC.

3229 Summit Square Place, Suite 200
Lexington, KY 40509
Phone: (859) 333-1477

PATIENT DEMOGRAPHIC INFORMATION

First Name:_____ Middle Name:_____ Last Name:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Main Phone:_____-_____-_____ Work Phone:_____-_____-_____ Cell Phone:_____-_____-_____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Marital Status (Check One): Single_____ Married_____ Separated_____ Divorced_____Widowed_____

Employment Status: Employed_____ Unemployed_____ Student_____ Retired_____ Disabled_____

Who referred you?_____ Referral Phone Number: _____-_____-_____

Why are you seeking help? _____

Primary Care Physician:_____ Primary Care Physician Phone: _____-_____-_____

Name of your Pharmacy:_____ Pharmacy Phone: _____-_____-_____

Name of Emergency Contact: _____ Emergency Contact Phone:_____-_____-_____

Current Medical Conditions:_____

_____

Current Medications (Please list the Name, Dose, Frequency): _____

_____

_____

Allergies to Drugs and Medications:_____

Have you ever been diagnosed or treated for a Mental Health or Psychiatric Disorder? _____Y _____N

If so please explain:_____

_____

Current Psychiatric Medications: _____

_____

_____

Past Psychiatric Medications: _____

_____

Dr. Clayton S. Hall, DO & Associates, LLC.
3229 Summit Square Place, Suite 200
Lexington, KY 40509
Phone: (859) 333-1477

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

NOTE: You are consenting to treatment by Dr. Clayton Hall, D.O. & Associates, LLC. This office does not accept or bill insurance plans or programs, including but not limited to Medicare or Medicaid (this includes Medication Assisted Treatment (MAT). You must pay out-of-pocket for all services. Medication may or may not be covered by your insurance plan and this will be filed by your pharmacy. Laboratory testing services required for controlled substance monitoring may or not be paid for by insurance but will be filed by the laboratory. A copy of your insurance card will be necessary.

Controlled substances medications (i.e. benzodiazepines, opioids for MAT, and stimulants) are very useful in treating some mental health conditions and/or dependence issues but can pose a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. The intent is to treat many different diagnoses in an effort to improve quality of life, function and/or ability to work. **I will inform the provider of any current or past substance abuse history.**

TREATMENT GOALS

I understand that the main treatment goal is to reduce symptoms (i.e. anxiety, ADHD, withdrawal and cravings from opioid dependence) to a bearable level and improve the quality of my life. This includes the ability to function and/or work. I understand that in many cases the symptoms may not be completely eliminated. In consideration of this goal, and because of the fact that I am being given a controlled medication to help me reach my goal, I agree to help myself by following better health habits. These include increase in activity and exercise, weight control, and avoidance of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

PATIENTS' RESPONSIBILITY

1. I understand that Dr. Hall and Associates do not bill or accept insurance. Full payment is expected at the time of check-in.
2. I will take full responsibility for my actions and will be completely honest with all my treating physicians and/or providers.
3. I will be on time for all scheduled appointments. If I am unable to keep an appointment, I will call 24 hours in advance to cancel. If I do not cancel in a timely manner, there will be a **$50** charge for the missed appointment.
4. I will be courteous to everyone. I will not be rude, abusive, or disruptive to anyone.
5. I will never abuse, misuse, share, sell or trade my medications.
6. I will take my medications as prescribed by my physician or provider.
7. I will inform my physicians of **ALL** prescribed and over-the-counter medications.

Dr. Clayton S. Hall, DO & Associates, LLC.
3229 Summit Square Place, Suite 200
Lexington, KY 40509
Phone: (859) 333-1477

8. I will avoid taking alcohol with my medications.
9. I will be honest about my problem, misuse, or abuse of any drugs or medications. The drugs may include alcohol, opiates, barbiturates, stimulants, cocaine, marijuana, hallucinogens or any other drugs, not including over-the-counter medications.
10. I will keep my medications safe and secure—especially from children. I understand that damaged, lost or stolen medications will not be called in or replaced for any reason.
11. I agree to undergo random urine drug testing or oral swab tests at the discretion of the office staff. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of this contract and therefore possible grounds for dismissal. Failure to comply with the test will be considered grounds for dismissal.
12. I will comply with random PILL COUNTS. These will be performed during regular office hours. The purpose of the PILL COUNT is to monitor medication usage. The number of pills missing from the bottle must correlate to the number of days since the prescription has been filled. A discrepancy in the number of pills missing is to be considered a breach of this contract and thus grounds for termination. Patients who fail to show for random pill counts will be immediately terminated from the practice. The pill counts will be randomly scheduled by the office staff.
13. I consent to all monitoring of my medication use such as the Kasper system (Kentucky All Schedule Prescription Reporting).
14. I will avoid excessive/unwarranted phone calls to my physician.
15. In case of emergency, I agree to **call 911** or go to the nearest Emergency Room/hospital. Emergency is defined as **ANY** concern you may have about your personal safety OR safety of others.
16. Notice of Privacy Practices. I have received the Notice of Privacy Practices. I have read the document carefully and understand the restrictions and limitations of this practice.
17. I agree to prompt payment at the time of service by either cash, debit/credit card or check. In the event of a returned check, and upon notification from the office manager, I will be responsible for the check amount plus the returned check fee. This will be accepted as cash, money order or credit card ONLY.
18. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the State while taking the prescribed medications.

RISKS OF CHRONIC USE OF CONTROLLED SUBSTANCES

I understand that long-term use of controlled substances has advantages and disadvantages. My treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long term use of controlled substance, and that my physician will advise me of any advances in this field and will make treatment changes deemed appropriate. Tolerance or failure to respond to the medication may force the doctor to choose another form

Dr. Clayton S. Hall, DO & Associates, LLC.
3229 Summit Square Place, Suite 200
Lexington, KY 40509
Phone: (859) 333-1477

of treatment.

I have been fully informed by Dr. Hall and his associates regarding the potential for psychological dependence (addiction) of controlled substance medications. I know some individuals may develop a tolerance to their medication and they may become physically dependent. This can occur if I am on the medication even for a short period of time. Therefore, if and when I need to stop taking the medications, I must do so slowly and under medical supervision or I may have withdrawal symptoms. My doctor is not responsible for withdrawal symptoms if the medications are used inappropriately.

(Female patients only) I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately call my obstetric doctor and inform them. I am aware that there could be some adverse effects on my baby.

(TO BE FILLED OUT ONLY BY THOSE BEING EVALUATED FOR (MEDICATION ASSISTED TREATMENT = SUBOXONE)

Please initial the option you choose as well as each individual line if indicated:

☐ **OPTION 1:** I want the MAT services and acknowledge that Dr. Hall or his associates will NOT bill my insurance, including Medicare or Medicaid.
_____ I understand Dr. Hall may collect payment for MAT services
_____ I understand I am responsible for this payment in its entirety. **I may or may not be eligible for reimbursement from my insurance.**
_____ I also understand my insurance may or may NOT cover the cost of the medication that this office prescribes to me for MAT
_____ I understand I may have to pay out-of-pocket for this medication. This office is NOT responsible for any decision(s) my insurance company may make.

☐ **OPTION 2:** I do NOT want MAT services. I understand with this choice I am NOT responsible for payment.

I will work with my physicians/providers to develop a Relapse Prevention Plan.
Alcohol and Drug Abuse Counseling. I agree to see a Certified Substance Abuse Counselor (or equivalent) in addiction to my medication provider. This is not mandatory but 12 step programs, such as AA, NA are voluntary, but strongly encouraged.

This notice gives OUR opinion and is NOT an official Medicare or Medicaid decision.
If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE.
If you have other questions on this notice or Medicaid billing, please contact your Medicaid plan.

Dr. Clayton S. Hall, DO & Associates, LLC.
3229 Summit Square Place, Suite 200
Lexington, KY 40509
Phone: (859) 333-1477

TERMINATION OF CARE

I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be terminated with notice that is sufficient to ensure the patient is not at risk for adverse effects. I am responsible for any withdrawal syndrome that may occur due to my misuse of the controlled medications and/or termination of my care.

SIGNING BELOW MEANS THAT YOU HAVE READ THE CONTRACT AND UNDERSTAND THIS NOTICE. All my questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement.

NOTICE OF PRIVACY PRACTICES

_____ Copy given to patient _____ Patient refused copy Date _____ by _____

By signing below, I also certify that I have been offered a copy of the Health Insurance Portability & Accountability Act (HIPPA) Notice of Privacy Practices (which also is available at www.drclayhall.com/hippa), that I understand this document, and that I agree with its content and the office policies related to my privacy and HIPPA.

Patient_____ Date: _____

Witness_____

Dr. Clayton S. Hall, DO & Associates, LLC.

3229 Summit Square Place, Suite 200
Lexington, KY 40509
Phone: (859) 333-1477

Consent for Treatment

Today's Date: (Month/Day/Year):_____/_____/_____

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: (Month/Day/Year) _____/_____/_____ SSN:_____

Street Address: _____ City:_____ State:_____ Zip Code:_____

By signing this consent form, I give my permission for Clayton S. Hall, D.O. and Associates LLC to provide me with evaluation and treatment.

I understand that Clayton S. Hall, D.O. & Associates, LLC does not accept any form of insurance and I am responsible for the payment of my office visits.

I understand that all information will be confidential by all staff and providers, except in situations explained in the NOTICE of PRIVACY PRACTICES, which has been provided to me.

I understand that my Confidential Records can be released to persons, groups, providers or organizations with my authorized, written consent.

I understand that I may revoke my Consent for Treatment at any time.

APPOINTMENTS: Patient visits are by appointment ONLY. Our office will make every effort to adhere to our schedule so that you are seen on time. However, emergencies do occur and you will be advised if the doctor is running behind. In turn, we ask that you be punctual. If you are late by 10 minutes of the scheduled appointment time you may be rescheduled.

If you cannot keep an appointment, please call our office as soon as possible.
****Failure to keep an appointment or cancel 24 hours in advance will result in a $50 missed appointment fee. ****
We have a voicemail system that takes messages 24 hours a day. Patients who frequently miss scheduled appointments will be terminated from the practice for noncompliance.

Termination of Care: I understand that either party may terminate this Patient-Provider relationship. Reasons to terminate care may include, but not to be limited to the following:

1) **Providing dishonest or misleading information**
2) **Not following the agreed treatment plan**
3) **Excessive missing or re-scheduling appointments**
4) **Inappropriate, late or disruptive behavior**
5) **Abuse or misuse of alcohol, drugs or prescription medications**
6) **Excessive unwarranted phone calls during the workday and/or after hours**
7) **Failure to keep medications safe from children, theft or damage**
8) **Using medication outside the prescribed directions, resulting in early refills**
9) **Aggressive or inappropriate behavior towards doctors/staff**

Patient Signature: _____ Date: _____