WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600

SUMMARY OF SUBOXONE PROGRAM

1) The first month of care patients may be seen several times. Once a dosage is established, patients may be seen on a 28 day cycle as long as all drug screens are appropriate and they are following treatment recommendations. Patients cannot be seen earlier than their scheduled appointment except in an emergency and then only 24 hours prior to a scheduled appointment.

2) Urine drug screening is a regular feature of SUBOXONE therapy because it provides physicians with important insights into the health and treatment of the patient. Patients will be drug screened on EVERY visit. This sample will be referred to an outside lab from whom the patient and/or their insurance company will receive a bill. Should questions arise about that bill, contact that lab directly. Furthermore, if a drug screen is failed, the patient may be asked to return for weekly drug screens. (Note: These visits are at a charge of $75.00 or appropriate co pay.)

3) All patients are required to participate in a regular program of professional counseling while in treatment with buprenorphine and evidence of attendance will be required at each visit.

4) Patients may obtain all controlled medications from the pharmacy of their discretion.

5) Early in care patients will have blood drawn for a complete screening of liver functions, a lipid panel, Hepatitis screen, HIV screen, etc. The outside lab will bill the patient and/or their insurance company independently for those services. Contact the lab directly with any questions about that bill. These samples may be repeated periodically to monitor the body's response to the buprenorphine treatment.

6) If a patient cannot make a scheduled appointment, they must call to reschedule. If a patient misses an appointment without rescheduling, they may be dropped from the Suboxone program. A $25.00 fee will be charged for any missed appointment without prior notification having been given. If a patient is late for an appointment (fifteen minutes), the office is under no obligation to see the Patient on that date.

7) The Patient agrees to immediately notify the office of any change of address and/or telephone number. All patients must be accessible to this office at any time when this office needs to contact them. Voice mail must be set up and checked on a daily basis. If this office cannot reach the Patient, this office has a right to discharge the Patient without further notice.

8) All co pays/ payments/ and a percentage of any outstanding balances are due at each visit. If the patient cannot pay at the time of the visit, they will be rescheduled.

By signing below, the patient acknowledges understanding all the program guidelines noted above.

_____ _____

Patient Signature Date

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BUPRENORPHINE TREATMENT AGREEMENT

Patient Name_____ **Date**_____

As a participant in buprenorphine treatment for opioid addiction, I freely and voluntarily agree and understand this treatment agreement, 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 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.
___ 3. I agree to provide proof of counseling at every visit.
___ 4. I agree to abstain from **all** illegal drugs, alcohol and other addictive substances while in treatment with buprenorphine.
___ 5. I agree that I will be subject to random drug screens and/or pill counts. I understand that I am responsible for the cost of a nurse visit. This sample will be referred to an outside lab from whom I and/or my insurance company will receive a bill. I agree to report to this office for random pill counts or drug screens within two hours of being called. Should I be out of town when called for a pill count or drug screen, I understand that I must bring in proof of my whereabouts at the time of the call (a credit card receipt which is time and date stamped with my name on it or a notarized statement from an official entity).
___ 6. I agree to keep and be on time for all my scheduled appointments.
___7. I agree to immediately notify the office of any change of address and/or telephone number. All patients must be accessible to this office at any time when this office needs to contact them.
___8. 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 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 that I have a means to store my medication(s) safely where it cannot be taken accidentally by children or stolen by others. I further agree that if my buprenorphine is ingested by anyone besides me, I will call 911 or the Poison Control Center at 1-800-288-9999.

___ 12. 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.

___ 13. 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.

___ 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 conduct any illegal or disruptive activities in or around the doctor's office and/or pharmacy and to treat all office and pharmacy staff with respect. I understand that should such behavior occur, I will be terminated from treatment without recourse for appeal and the appropriate authorities will be notified.

___ 16. I agree that my medication/prescriptions can only be given to me at my regularly scheduled office visits. No medication will be called in to any pharmacy.

___ 17. I agree not to obtain medication(s) from any other doctors, pharmacies, or other sources without informing the doctor.

___ 18. 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.**

___ 19. 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).

___ 20. I agree that I should 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.

___ 21. I agree that I will be open and honest with my doctor and treatment team about my addiction and overall health history and will 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.

___ 22. I understand that I may be witnessed by a staff member when giving urine samples. I also understand that attempts to alter my urine or bring in urine from others will result in termination from treatment without recourse for appeal.

___ 23. I understand that, if I am prescribed the Suboxone film, the empty packets MUST be returned to Westbrook Medical Center to be counted and destroyed. I further understand that if I fail to return these packets, I will not be seen and could possibly be discharged from the program.

___24. I understand that the recommended period of treatment in a recovery program is twelve-eighteen months in the majority of cases.

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

_____

Patient name (print)

_____ _____

Patient signature Date

_____ _____

Witness signature (employee) Date

WESTBROOK MEDICAL CENTER

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TELEPHONE APPOINTMENT REMINDER AND CONTACT CONSENT

I, _____ give the medical providers at the above address and/or
Patient name (print)
members of his/her staff my permission to call me either for treatment purposes and prior to an appointment to remind me of the appointment date and time.

I can be contacted at the numbers (please give at least two contact numbers):

□ Home _____

□ Work _____

□ Cell _____

Yes, this office may leave (check all that apply):

□ Voice mail at my Home □ Voice mail at my Work □ Voice mail on my Cell

□ Messages with people at my Home □ Messages with people at my Work

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 on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

_____ _____
Patient Signature Date

_____
Patient Name (Print)

_____ _____
Witness Signature Date

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CONSENT TO TREAT-BUPRENORPHINE TREATMENT

I_____ do hereby: (initial all statements)
Patient Name (print)

___ Give my willful and informed consent to Dr. Richard Poehlein or Dr. Clifford Davidson and members of their staff at the above location to administer to me the treatment of Buprenorphine 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 verbal or 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 his staff.

___ Agree I have been given copies of relevant information relating to the treatment to which I am consenting.

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

_____ _____
Patient Name (print) Date

_____
Patient Signature

_____ _____
Witness Name (print) Date

_____
Witness Signature

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CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Dr. Richard Poehlein, or Dr. Clifford Davidson, and members of their staff at the above address to:

Check all that apply

___ Receive my medical history information from the following physicians:
Primary Care Physician _____
(name, address) _____

___ Receive my treatment records from the following therapist, counselor, sponsor, etc.
(name, address) _____

___ Release my treatment information/records to the following healthcare professional, family member, etc
(name, address) _____

__ Release my treatment information to the health insurance company listed below for billing purposes:
Insurance Provider _____ Address _____
_____

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 specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

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.

_____ _____ Patient Signature Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

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PATIENT INTAKE: MEDICAL HISTORY

Please print legibly.

Name _____

Address _____ City _____ State _____ Zip _____

Phone (w) _____ (h) _____ (c) _____

DOB _____ Age _____ SS# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

Date of last physical _____ Have you ever had an EKG? ( ) N ( ) Y Date _____

Patient current or past medical conditions (check all that apply)

( ) Asthma/respiratory
( ) Cardiovascular (heart attack, high cholesterol, angina)
( ) Hypertension
( ) Epilepsy or seizure disorder
( ) GI disease
( ) Head trauma
( ) HIV/AIDS
( ) Diabetes
( ) Liver problems
( ) Pancreatic problems
( ) Thyroid disease
( ) STDs
( ) Abnormal Pap smear
( ) Nutritional deficiency

Other (Please describe) _____

_____

_____

_____

MD NOTES: _____

_____

_____

_____

_____

Immediate family members current or past medical conditions (check all that apply)

( ) Asthma/respiratory ( ) Cardiovascular (heart attack, high cholesterol, angina)

( ) Hypertension ( ) Epilepsy or seizure disorder ( ) GI disease

( ) Head trauma ( ) HIV/AIDS ( ) Diabetes

( ) Liver problems ( ) Pancreatic problems ( ) Thyroid disease

( ) STDs ( ) Abnormal Pap smear ( ) Nutritional deficiency

Other (Please describe) _____

_____

_____

MD NOTES: _____

_____

_____

Have you ever had **surgery** or been **hospitalized**? (Please describe) _____

_____

MD NOTES: _____

_____

Childhood Illnesses: Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? (Please describe)

_____

Have you ever taken or been prescribed **antidepressants**? ( ) N ( ) **Y**

Medication(s) and dates of use _____ Why stopped _____

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) _____

_____

_____

Please list all current **herbal medicines**, **vitamin supplements**, etc. and how often you take them

_____

_____

Please list **any allergies** you have to foods, drugs, seasonal, pets, and etc. _____

_____

MD NOTES: _____

Tobacco History

Cigarettes: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day on average? _____ For how many years? _____

Other Tobacco: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How often per day on average? _____ For how many years? _____

Have you ever been **treated for substance misuse**? ( ) N ( ) Y (Please describe when, where and for how long)

_____

_____

How long have you been **using substances?** _____

Substance Use History

	No	Yes/Past or Yes/Now	How Taken (Route)	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
Anxiety Meds							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers Please Specify all:							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? ( ) N ( ) Y (Please list)

What was your longest period of abstinence? _____

MD NOTES: _____

Have you ever been a victim of abuse? If so, describe when and circumstances_____

Are you receiving or have you ever received counseling support? _____ if so, please describe when and for how long. _____

MD Notes: _____

Staff Signature _____ Date_____

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PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name _____ Date_____

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married/ in long-term relationship _____Times Married _____Times Divorced _____

Children? ( ) N ( ) Y Current ages (list) _____

Residing with you? ( ) N ( ) Y If no, where? _____

Where are you currently living? _____

Do you have family nearby? ( ) N ( ) Y(Please describe) _____

Education (check most recent degree):

( ) Graduate school ( ) College ( ) Professional or Vocational School

( ) High School Grade _____

Are you currently employed? ( ) N ( ) Y Where? (if "no," where were you last employed?)_ _____

What type of work do/did you do? _____ How long have/did you work/ed there? _____

Have you ever been arrested or convicted? ( ) N ( ) Y

( ) DWI ( ) Drug-related ( ) Domestic violence ( ) Other _____

Have you ever been abused? ( ) N ( ) Y

( ) Physically ( ) Sexually (including rape or attempted rape) ( ) verbally ( ) emotionally

Have you ever attended:

AA ( ) Current ( ) Past **NA** ( ) Current ( ) Past **CA** ( ) Current ( ) Past

ACOA ( ) Current ( ) Past **OA** ( ) Current ( ) Past

If you are not currently attending meetings but did in the past, what factors led you to stop?_____

_____

Have you ever been in counseling or therapy? ( ) N ( ) Y (Please describe) _____

REGISTRATION FORM

Date_____

Patient Name_____
Last First Middle Suffix
Sex: Male_____ **Female**_____ **Patient's Social Security Number**_____
Birth date _____**Single** ___ **Divorced** ___ **Married** ___ **Widowed** ___ **Separated** ___

Home Street Address_____
City_____**State**_____**Zip**_____
Home Phone (_____**)**_____ **Cell Phone (**_____**)**_____
Cell Phone Company_____ **email address** _____
Name of Primary Care Physician_____ **Phone #**_____
Referral Source_____ **Patient's Driver's License Number**_____
PHARMACY **Pharmacy Name, Address, and Phone Number** _____
_____

EMPLOYER OF PATIENT
(or Guardian if patient is minor)

Company Name_____
Address_____
City _____**State** _____**Zip**_____
Occupation _____ **Phone Number(**_____**)**_____

Circle appropriate answer:
Race: **American Indian** **Asian** **Black** **Caucasian** **Other** **Declined**
Ethnicity: **Hispanic** **Non-hispanic** **Declined**

Primary Language Spoken_____

Name of Parent or Guardian (if patient is a minor)_____
Date of birth of Guardian_____ **SSN of Guardian** _____
Driver's License # of Guardian_____

SPOUSE OF PATIENT
(or Guardian if patient is minor)

Name_____
Birthdate _____**Social Security Number**_____
Employer Name_____
Address_____
City_____**State**_____**Zip**_____**Phone**_____

REASON FOR VISIT

Condition related to: Illness_____ **Well visit**_____**Accident**_____
Other_____ **Date of Accident, if applicable**_____

INSURANCE INFORMATION

Insurance Company_____
Insured Name _____**Relationship to Patient**_____
Group or Policy Number_____ **ID #**_____

Westbrook Medical Center
7328 Middlebrook Pike
Knoxville, TN 37909

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ DOB_____

Review of Systems: (Check all that apply)

Head & Neck
___ Eye Disease
___ Double vision
___ Blurred vision
___ Prior-Ear Surgery
___ Ear Ache
___ Hearing loss
___ Dizziness
___ Ringing in ears
___ Nasal Obstruction
___ Nosebleeds
___ Nasal Discharge
___ Altered sense of smell
___ Sinusitis
___ Nasal Polyps
___ Snoring
___ Excessive sleepiness
___ Facial pain
___ Pain with chewing
___ Recent dental work
___ Mouth sores
___ Lumps in the neck
___ Allergies

Respiratory System
___ Hoarseness
___ Chronic cough
___ Throat clearing
___ Heart Burn
___ Regurgitation
___ Spitting up blood
___ Shortness of breath
___ Wheezing
___ Asthma
___ Chronic bronchitis
___ Chest Pain
___ Emphysema
___ Tuberculosis
___ Lung cancer

Neurologic
___ Headaches
___ Head injury
___ Numbness or tingling
___ Transient black-outs
___ Transient vision loss
___ Seizures
___ Strokes

General
___ Night Sweats
___ Fevers
___ Skin diseases
___ Arthritis
___ Bleeding Disorder
___ Easy Bruisability
___ HIV infection or AIDS
___ Psychiatric Diseases

Gastrointestinal
___ Difficult swallowing
___ Pain on swallowing
___ Diarrhea
___ Constipation
___ Jaundice
___ Liver disease
___ Hepatitis
___ Kidney Disease
___ Bloody stools
___ Diverticulosis
___ Gall bladder disease
___ Heartburn or ulcers

Cardiovascular
___ Hypertension
___ Heart disease
___ Angina
___ Swelling of the ankles
___ Heart surgery
___ Angioplasty
___ Pacemaker
___ Anemia

Endocrine
___ Diabetes
___ Heat/cold intolerance
___ Thyroid imbalance
___ Menstrual disorders

Urologic
___ Difficulty on urination
___ Frequent urination
___ Blood in the urine
___ Prostate problems

Other
_____

Past and present medical problems:

_____
_____
_____
_____
_____
_____
_____

Previous surgeries and dates (month/year)

_____
_____
_____
_____
_____
_____
_____

List all current medications and dosages (including OTC):

_____
_____
_____
_____
_____
_____
_____

Do you smoke?
___Yes ___ No
If yes, how much ?_____

Do you drink alcohol?
___Yes ___ No
If yes, how much ?_____

Please list all allergies: (medications, inhalants, foods, contact allergies) _____
_____

Patient Signature_____ Date_____

ASSIGNMENT – AUTHORIZATION & LIEN

I hereby irrevocably authorize and direct my insurance company, my attorney, and/or any third party payers to pay directly to the provider, Westbrook Medical Center, PLLC, all sums of money due for any and all services rendered to me (or a minor child for which I m responsible) by reason of accident, illness or any and all reasons. I further direct said insurance company, attorney, or third party payer to withhold such sums from any payment, including but not limited to health and accident benefits, disability benefits, workers' compensation benefits, medical payment benefits, no fault benefits, foundation grants, government or agency benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignees.

I further agree that this agreement acts as an assignment of my rights and benefits to the extent this office rendered services; therefore if my insurance company and/or attorney obligated to make payment to me for the charges incurred at this office refuse to make such payment, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or in the assignee's name. This office is also authorized to settle or otherwise resolve said claim or cause of action as they see fit. I understand that this does not relieve me of my personal responsibilities for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges. I hereby agree to give a full lien to said office against any and all insurance benefits named herein, or any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injuries or illness for which I have been treated by said office and assignees. I further agree that the assignee's right for payment shall not be bound by a statute of limitations until a reasonable time has lapsed after either negotiations or litigation between third parties and myself are resolved. A photocopy of this assignment shall be considered as effective and valid as the original. I voluntarily waive the statute of limitations regarding my doctors and/or this office's rights to recover and, and I agree to be held fully responsible for all debts I incur in this office.

It is further agreed that I shall remain personally responsible for the total amount due this office and assignee for its services. I further understand and agree that this Assignment, Authorization, and Lien does not constitute any consideration for the office to wait for payment(s) and that they may demand full payment from me immediately and at any time upon rendering service at their option. Such option requires that I pay for all sums due and owing in full within ten (10) days of demand. I further understand that a monthly service charge is computed by a periodic rate of 1% per month which is an annual percentage rate of 12% applied to the previous balance after deducting current payments and that the service charge may change without notice. I understand that all money due this office will be paid in a timely manner with no amount of money due past 90 days from the date of service, regardless of attorney liens, representations of any attorney, pending settlement(s) or other matters unless approved in writing by this office in advance of the 90 day limit. I further agree and understand that, if the need arises, accounts delinquent may be placed for collection and that I am fully responsible for all court costs, filing fees, attorney costs, and all associated collection costs.

I further understand and agree that, as necessary, this office and its staff may submit, prepare or complete medical records, consultations, depositions and/or court appearances on my behalf which I understand must be paid in full in advance and are not considered part of my account. I authorize this office to release any information pertinent to my case to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. I agree that Westbrook Medical Center, PLLC is given full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office and assignee. I understand that this office, the doctors and the staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However, as with any doctor's treatment, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I do agree that I am fully obligated to pay for all charges for all services rendered to me.

Print Name_____

Signature _____ **Date** _____

Westbrook Medical Center

"Consent for Purposes of Treatment, Payment & Healthcare Operations"

(In this document, "I" and "my" refer to the patient, and "facility" refers to Westbrook Medical.)

I consent to the use or disclosure of my protected health information by Westbrook Medical Center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Westbrook Medical Center. I understand that analysis, diagnosis or treatment of me by this facility may be conditioned upon my consent which is evidenced by my signature below. Diagnostic testing may be required so a thorough analysis can be completed.

I understand that payment is due at the time services are rendered unless other arrangements have been approved in advance by the staff. I understand that Westbrook Medical Center may accept insurance assignments when the insurance coverage is through a group with whom they participate. If applicable, my consent for an assignment of my benefits to Westbrook Medical Center is designated by my signature below. Deductibles and co-payments must be honored at the time services are rendered. A finance charge will be added to outstanding balances. I understand that Westbrook Medical Center accepts cash, Visa, and MasterCard.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Westbrook Medical Center is not required to agree to the restrictions that I may request. However, If Westbrook Medical Center agrees to a restriction that I request, the restriction is binding to the facility.

I have to right to revoke this consent, in writing, at any time, except to the extent that Westbrook Medical Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition.

_____ _____

Signature of Patient or Representative | Print Name of Patient or Representative

_____ _____

Date of Signing | Description of Representative's Authority

CONSENT FOR PATIENT TESTING AFTER HEALTHCARE WORKER EXPOSURE

Westbrook Medical Center health care workers handle blood and other body fluids for many reasons such as when performing lab tests and cleaning equipment. It is the policy of Westbrook Health Center to test a patient for Hepatitis B, Hepatitis C and HIV (the virus that causes AIDS) if any employee or health care worker is exposed to a patient's blood or other body fluid in such a way that transmission of these infections could occur. Should an accidental exposure occur, the tests would be conducted at no cost to you. We are requesting that you consent to these tests prior to treatment. My signature below indicates my consent to test my blood or body fluid for Hepatitis B. Hepatitis C, or HIV.

_____ _____

Signature of Patient or Representative | Date

I decline to authorize the above testing:

_____ _____

Signature of Patient or Representative | Date

ADVANCED DIRECTIVES

Federal law requires that we give you information about your right to make advance health care decisions. You may be capable of making your own health decisions right now; however, you may not always be able to do so. By giving advance directives, you can tell your health care provider and family about the medical care you would like to receive and whether or not you want another person to be able to accept or refuse treatment for you.

You can name a person to make medical treatment decisions for you by appointing someone to have a "Durable Power of Attorney for Health Care" for you. That person is allowed to make health care decisions for you, including life-support decisions, but ONLY after your health care provider certifies that you are no longer able to make your own decisions.

You can also leave advance directives about life-support by executing a "Living Will". A Living Will tells your health care provider and family about the types of life-support that you want to be provided or withheld in case you are ever kept alive by artificial means and no longer able to make decisions for yourself.

If you already have a "Living Will" or "Durable Power of Attorney for Health Care", please provide a copy of that document to be placed in your medical chart to ensure that your wishes are honored. If you want more information on these documents, please ask your health care provider or attorney.

It is our policy to honor our patients' health care decisions to the full extent required or allowed by law. You are NOT required to give advance health care decisions in order to receive care at this facility.

Please answer the following questions:

Do you have a Living Will? Yes_____ No_____
If yes, have you given us a copy? Yes_____ No_____
If no, shall we provide one for you? Yes_____ No_____

Do you have a Durable Power of Attorney? Yes_____ No_____
If yes, have you given us a copy? Yes_____ No_____
If no, shall we provide one for you? Yes_____ No_____

_____ _____
Patient's Signature Date

WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600
865/769-2616 FAX

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Westbrook Medical Center located at the address above to receive my medical history information or treatment records from any source needed to enhance my care with their facility.

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 by providers at this facility unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the facility specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to 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.

Unless otherwise specified, please release ALL records related to my care.

_____	_____	_____
Printed name of Patient	Patient Date of Birth	Patient Social Security Number

_____	_____
Patient Signature	Patient Signature Date

If you have received this form in error, please notify the above office immediately.

Please fax records as soon as possible unless noted otherwise.

Note: Faxed to _____ *at fax #* _____
FACILITY/PROVIDER *NUMBER*

I give my permission for Westbrook Medical Center staff to discuss any aspect of my care with my counselor. This will remain in effect until revoked by written consent.

_____

Patient Printed Name

_____

Patient Signature

_____

Date

_____

Witness Signature