LIVING WELL
WELLNESS

PATIENT REGISTRATION FORM

Patient Name: _____ Birthdate: _____

Address: _____Apartment: _____

City, State Zip Code _____ SSN _____ - _____- _____

Best Contact Number _____Alternate Number _____

Email Address _____

Alternate Names used for PDMP _____

Emergency Contact _____Phone Number _____

Please list any doctors who have prescribed controlled substances for you. Failure to disclose this information may lead to your dismissal as a patient of LWW.

Doctor	Phone Number	Date Last Seen
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

With my signature, I affirm that all of the information provided is true and I have omitted nothing. I waive any applicable privilege and give permission to Living Well Wellness to obtain my medical records and discuss my medical history with any physicians, hospitals, clinics, diagnostic centers, pharmacies, insurance companies, family and law enforcement without violating HIPPA. I hold Living Well Wellness, its officers, directors, employees and contractors harmless for any information that may be discussed with any physician, hospital, clinic, diagnostic center, pharmacy, insurance company, family and law enforcement.

_____ _____

Patient Signature Date

LIVING WELL
WELLNESS

HIPPA Privacy Agreement

Due to Federal HIPPA patient privacy regulations I agree to not discuss my treatment with other patients at anytime while I am a patient of Living Well Wellness.

Patient:_____ Date:_____

LIVING WELL
WELLNESS

MEDICAL LIABILITY RELEASE FORM

Living Well Wellness's Policy for Malpractice. As per Florida Law we post on the wall that the doctor does not cary malpractice insurance. The patient agrees not to hold Living Well Wellness and Its Physicians and Staff responsible for any medical liability. The New Patient must complete this form to be eligible for Addiction Therapy care at Living Well Wellness.

PLEASE TYPE OR PRINT ALL INFORMATION
Patients Name:
Home Address:
Date Of Birth:
Telephone:
Patients Primary Care Physician:

LIABILITY RELEASE: I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her emergency care. I hereby release the Living Well Wellness and its Physicians and Staff any legal or financial responsibility.

PATIENT /PARENT/GUARDIAN: Please check one of the following and sign your name.
_____ I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.
_____ I do not give permission for medical treatment until I have been contacted.

Parent/Guardian's Signature _____

Date _____
(the above line is applicable for delegates under the age of 18 and must be signed by the parent or legal guardian.)

Patients Signature _____

Date _____

COMM PATIENT QUESTIONNAIRE

Patient Name: _____

As you know, opined analgesic medications can be abused, and they are sometimes diverted from legitimate medical use to illegal users. Your answers to these questions will allow us to determine the level of risk to which you and we are exposed when we prescribe opioid analgesics to you. Your answers to these questions will not result in your being denied medication. Depending on yours answers, we may provide an additional level of care to you, so the risk to us and to you is reduced.

If we discover that you have not answered these questions truthfully, that may result in our no longer being able to provide medical services to you. Once completed, this document contains confidential Protected Health Information. It may be disseminated only if specifically permitted under federal and state laws.

IN THE LAST 30 DAYS	Never	Seldom	Sometimes	Often	Alot
Have you had trouble thinking clearly or memory issues?	O	O	O	O	O
Have others complained that you did not complete tasks?	O	O	O	O	O
Have you received pain or any other medicine from more than 1 doctor?	O	O	O	O	O
Have you taken your medication differently than prescribed?	O	O	O	O	O
How often have you seriously thought about hurting yourself?	O	O	O	O	O
How often did you think about opioid medications or heroin?	O	O	O	O	O
How often have you been in an argument?	O	O	O	O	O
How often have you had trouble controlling your anger?	O	O	O	O	O
How often have you taken another person's pain medicine?	O	O	O	O	O
How often have you worried about how you are controlling your meds?	O	O	O	O	O
How often have	O	O	O	O	O
How often have you made emergency call or come to Healthy Life Medical, Inc. without appt?	O	O	O	O	O
How often have you gotten angry with people?	O	O	O	O	O
How often have you taken more medication than prescribed?	O	O	O	O	O
How often have you borrowed pain or other medication from others?	O	O	O	O	O
How often have you used pain medication to treat other illnesses (stress)?	O	O	O	O	O
How often have you visited the Emergency Room?	O	O	O	O	O

Patient Signature:_____ Date: _____

LIVING WELL
WELLNESS

Addiction Treatment Program Statement

We here at Living Well Wellness are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills and physician follow ups. It is your responsibility to make it to your scheduled appointments. If we have to cancel or change your appointment for any reason please let us know within 48 hours prior to your appointment or there is a $50 missed appointment fee.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

Patient signature _____Patient name_____printed Date____

Provider signature_____ Provider name_____printed Date____

LIVING WELL
WELLNESS

Payment Agreement and Release

PATIENT NAME: _____

Assignment of Benefits: I hereby irrevocably assign payment to Living Well Wellness of all medical benefits applicable and otherwise payable to me. Where Medicare benefits are applicable, I certify that the information given by me in applying for payment, under Title XVIII or XIX of the Social Security Act is correct, and request said payment of authorized benefits are made on my behalf. I understand that I am financially responsible to Living Well Wellness for charges which the carrier declines to pay. It is further agreed that any credit balance resulting from payment by my insurance or other sources may be applied to any other accounts owed to Living Well Wellness to me or my immediate family.

Release of Information for Payment Purposes: I hereby authorize and consent Living Well Wellness release of medical information to obtain payment as noted in the HIPAA notice.

Obligation of Payment: I hereby agree to pay all charges for all services provided by Living Well Wellness except those covered by insurance. Living Well Wellness will assist in insurance matters, but I understand that it is my responsibility to comply with all requirements for insurance coverage. I agree to pay all charges not paid by insurance. In the event that I fail to fulfill any obligation in this section, I agree to pay all collection costs incurred by Living Well Wellness in the enforcement of this section.

_____	_____	_____
Patient Signature	Date	Living Well Wellness

LIVING WELL
WELLNESS

Payment Agreement

PATIENT NAME: _____

I understand that at this time Living Well Wellness. does not accept insurance and collects cash only in the form of payment for services rendered.

Payments for Services: I hereby agree to pay all charges for all services provided by Living Well Wellness. Living Well Wellness will assist in insurance matters, but I understand that it is my responsibility to comply with all requirements for insurance coverage for the cost of the medications.

_____	_____	_____
Patient Signature	Date	Living Well Wellness

LIVING WELL
WELLNESS

OFFICE POLICIES ACKNOWLEDGEMENT

PATIENT NAME: _____

I acknowledge receipt or signing of the following from Healthy Life Medical, Inc.:

- HIPAA notice
- Payment Agreement and Release
- Controlled Substances Agreement
- Consent and Authorization
- COMM Questionnaire

I further acknowledge and reiterate acceptance of the following protocols at Living Well Wellness.

1. Appointments and walk in are taken for Suboxone Therapy.
2. Cancellation of appointment incurs no fee if 48 hours notice is provided.
    - The morning of your appointment is not 48 hours notice.
3. Missed Visits incur a $50 fee.
4. Patients who fail to maintain the appointment schedule may be discharged.
5. We do not prescribe medication by calling into a pharmacy unless authorized by the physician and only under certain circumstances.
6. Prescriptions are only written during the appointment.
7. No physician coverage or authorizations after hours or on the weekend.
8. Living Well Wellness can report any criminal activity to law enforcement officials.
9. Operating Hours Monday - Friday 9 to 5.

_____	_____	_____
Patient Signature	Date	Living Well Wellness

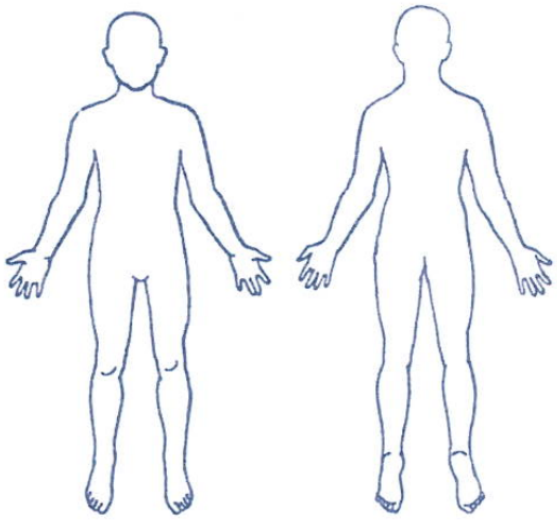
LIVING WELL
WELLNESS

Health History

_____

_
Patient Name

1. Please mark anywhere you may have pain and if it travels or radiates:



XXXXX-Pain
OOOOO-Numbness

/////////-Aching

*******-Pins & Needles

If you have pain is it CONTINUOUS?
_____

2. Please mark any applications you have tried in the past.
Injections, joint _____ Injections, epidural _____Acupuncture_____
Yoga _____ Chiropractor _____ Ultrasound _____ Massage_____-
Electrical Stimulation _____ Hot Pack_____ Pain Psychologist _____

3. Please check any positions that aggravate your pain.
Standing _____ Sitting_____Lying down _____
Bending waist _____ Bending, knees_____ Sleep w pillow_____
Walking_____ Bowel Movement _____

4. Do you have control of your bowels and bladder? YES NO

5. Please check any symptoms you have now or have had in the past.

GENERAL
_____ Chills
_____ Depression
_____ Dizziness
_____ Fainting
_____ Fever
_____ Forgetfulness
_____ Headache
_____ Loss of sleep

GENITO-URINARY
_____ Blood in urine
_____ Frequent Urination
_____ Painful urination

MUSCLE/BONE/JOINT
Pain, weakness numbness in:
_____ Arms _____ Hips
_____ Back _____ Legs

CARDIOVASCULAR
_____ Chest Pain
_____ High Blood Pressure
_____ Irregular heart beat
_____ Poor circulation
_____ Rapid Heart Beat Low
_____ Low Blood Pressure
_____ Ankles swelling
_____ Varicose veins

_____ Loss of weight	_____ Feet	_____ Neck
_____ Nervousness	_____ Hands	_____ Shoulders

7. Please check any symptoms you have had within the past 12 months.

GASTROINTESTINAL	EAR, EYE, NOSE, THROAT	SKIN
____Appetite poor	____Bleeding gums	____Bruise easily
____Bloating	____Blurred vision	____Hives
____Bowl changes	____Crossed eyes	____Itching
____Constipation	____Difficulty swallowing	____Change in moles
____Diarrhea	____Double vision	____Rash
____Excessive hunger	____Earache	____Scars
____Excessive thirst	____Ear discharge	____Non-healing sores
____Gas	____Hay fever	
____Hemorrhoids	____Hoarseness	
____Indigestion	____Loss of hearing	
____Nausea	____Nosebleeds	
____Rectal bleeding	____Persistent Cough	
____Stomach Pain	____Ringing in ears	
____Vomiting	____Sinus problems	
____Vomiting blood	____Vision - flashes or halos	

8. Please check any symptoms you have had within the past 12 months.

MEN	WOMEN	
____Breast lump	____Abnormal pap smear	____ Nipple discharge
____Erection difficulties	____Bleeding between period	____ Painful intercourse
____Lump in testicles	____Breast lump	____ Vaginal discharge
____Penis discharge	____Extreme menstrual pain	
____sore on penis	____Hot flashes	_____Last GYN exam

9. Please check any conditions you have had within the past 12 months.

____AIDS	____Chicken Pox	____HIV Positive	____Prostate problem
____Alcoholism	____Diabetes	____Kidney Disease	____Psych care
____Anemia	____Emphysema	____Liver Disease	____Rheumatic fever
____Anorexia	____Epilepsy	____Measles	____Scarlet fever
____Appendicitis	____Glaucoma	____Migraines	____Stroke
____Arthritis	____Goiter	____Miscarriage	____Suicide attempt
____Asthma	____Gonorrhea	____Mono	____Thyroid problem
____Bleeding D/O	____Gout	____MRSA	____Tonsillitis
____Breast lump	____Heart Disease	____MS	____Tuberculosis
____Bronchitis	____Hepatitis	____Mumps	____Typhoid fever
____Cancer	____Hernia	____Pacemaker	____Ulcers
____Cataracts	____Herpes	____Pneumonia	____Vaginal infect
____Chemical Dep	____Hi Cholesterol	____Polio	____Venereal Disease

10. Please list any medications or substances to which you have had allergic reactions.

11. List all medications you are currently taking.

Medication	Strength	Quantity per day

12. Do you have a history of substance abuse? YES NO When

13. Please check if you use any of the substances listed and how often.

Herion_____	How often_____	How much_____
Opioid Pain Pills_____	How often_____	How much_____
Benzos_____	How often_____	How Much_____
Alcohol _____	How often _____	How much _____
Caffeine _____	How often _____	How much _____
Cocaine _____	How often _____	How much _____
THC _____	How often _____	How much _____
Tobacco _____	How often _____	How much _____

14. Why are you seeking care from Living Well Wellness , Inc.?

_____

15. Please list your immediate blood relatives and, if deceased, please note cause of death.

	Living/Deceased	Age	Cause of Death
Father	_____	___	_____
Mother	_____	___	_____
Brothers	_____	___	_____
Sisters	_____	___	_____

16. Have you been to any detox treatment centers or addiction/drug counseling for your addiction? If so please explain when and where and for what exactly.

_____

_____

_____

I certify that the information I have provided on this health history questionnaire is correct to the best of my knowledge. I will not hold my doctor, Living Well Wellness , Inc., its affiliates, officers, directors, employees and contractors responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____
Patient Signature	Date	Living Well Wellness

LIVING WELL
WELLNESS

DRUG ABUSE SCREENING TEST

1.	Y	N	Have you used drugs other than those required for medical reasons?
2.	Y	N	Have you misused prescription drugs?
3.	Y	N	Do you misuse more than one drug at a time?
4.	Y	N	Can you get through the week w/o drugs other than those for medical reasons?
5.	Y	N	Are you always able to stop using drugs when you want to?
6.	Y	N	Do you misuse drugs on a continuous basis?
7.	Y	N	Do you try to limit your drug use to certain situations?
8.	Y	N	Have you had "blackouts" or "flashbacks" as a result of drug use?
9.	Y	N	Do you ever feel bad about drug misuse?
10.	Y	N	Does your spouse (or parents) ever complain about your involvement with drugs?
11.	Y	N	Do your friends or relatives know or suspect you misuse drugs?
12.	Y	N	Has drug misuse ever created problems between you and your spouse?
13.	Y	N	Has any family member ever sought help for problems related to your drug use?

Have you ever:

14.	Y	N	Lost friends because of your use of drugs?
15.	Y	N	Neglected your family or missed work because of your use of drugs?
16.	Y	N	Been in trouble at work because of drug misuse?
17.	Y	N	Lost a job because of drug misuse?
18.	Y	N	Gotten into fights when under the influence of drugs?
19.	Y	N	Been arrested because of unusual behavior while under the influence of drugs?
20.	Y	N	Been arrested for driving while under the influence of drugs?
21.	Y	N	Engaged in illegal activities to obtain drugs?
22.	Y	N	Been arrested for possession of illegal drugs?
23.	Y	N	Experienced withdrawal symptoms as a result of heavy drug intake?
24.	Y	N	Had medical problems due to your drug use (memory loss, hepatitis or bleeding)
25.	Y	N	Gone to anyone for help for a drug problem?
26.	Y	N	Been in a hospital for medical problems related to your drug use?
27.	Y	N	Been involved in a treatment program specifically related to drug use?
28.	Y	N	Been treated as an outpatient for problems related to drug dependence or misuse?

Each Positive Response yields 1 point except questions 4, 5, 7 which yields 1 for negative response.
A score greater than 5 requires further evaluation for substance misuse problems.

CRITERIA FOR SUBSTANCE DEPENDENCE AND ABUSE

Once a thorough patient assessment has been performed, a formal diagnosis of either dependence or abuse can be made. A substance dependence or abuse diagnosis, is based on clusters of behaviors and physiological effects occurring within a specific time frame. A diagnosis of dependence always takes precedence over that of abuse. A diagnosis of abuse can only be made if criteria for dependence have never been met.

DEPENDENCE 3 or more in a 12 month period	**ABUSE** 1 or more in a 12 month period
Tolerance (increase in amount, decrease in effect)	Recurrent use resulting in failure to fulfill obligations
Characteristic withdrawal (take substance to avoid w/d)	Recurrent use in physically hazardous situations
Substance taken in larger amounts/longer time than intended	Recurrent substance related legal problems
Persistent desire to quit taking substance	Continued use despite persistent social problems
Much time/activity to obtain, use, recover	
Important social or recreational activities given up	
Use continues despite knowledge of adverse consequences	

CONTROLLED SUBSTANCES AGREEMENT

Patient Name: _____

The purpose of this agreement is to protect the patient's access to controlled substances and to protect Healthy Life Medical, Inc.'s ability to prescribe appropriate treatment.

Because controlled substances have potential for substance abuse or diversion strict accountability is necessary. Addiction is a medical condition. Any and all medication prescribed shall be used only for this purpose. As a condition of the Living Well Wellness physician treating me, I agree to the following policies.

1. I will obtain all my suboxone, buprenorphine or subutex medication from Healthy Life Medical, Inc.
2. I will not sell, share or trade medicine. I will only use medication prescribed to me.
3. I will not use any illegal controlled substances.
4. I will safeguard my medication from loss or theft. Medication will not be replaced.
5. I will keep my medication out of the reach of children or others who may not tolerate the medication's effects.
6. I will submit to random urine test and medication counts as deemed necessary by Living Well Wellness Failure to submit to such tests will require me to be discharged.
7. I give permission to Living Well Wellness to discuss my diagnosis and treatment with doctors, pharmacies, family, law enforcement, state agencies and others deemed necessary to receive proper care. I agree to waive any applicable privilege or right of privacy or confidentiality in the event of an investigation or any possible misuse, abuse or violations regarding my treatment.
8. I agree to come to scheduled appointments. Continuation of therapy is based on following the protocol of Living Well Wellness and the demonstrated benefit of the medication. Refills will only be made at the time of my appointment.
9. I agree to use the medication only as prescribed.
10. I will inform Living Well Wellness of any adverse effects from the medication.
11. I will not stop prescribing medication abruptly. This could cause withdrawal. If Living Well Wellness chooses to stop prescribing medication, the doctor will taper the medication, prescribe detoxification services or provide ample time to find a new physician.
12. I will communicate fully with the doctors of Living Well Wellness about the severity of my addiction, the effect on my daily life and how the medicine is helping with that.
13. I agree to bring pharmacy receipts and any unused medication to each office visit.
14. I agree not to take Alcohol or Benzos During my treatment.
15. I understand that trust and confidence is necessary for proper treatment.
16. I understand that failure to follow these policies will require discharge from Healthy Life Medical, Inc.

_____ _____

Patient Signature Date

LIVING WELL
WELLNESS