Advantage Medical Group

PREGANCY TESTING PERMISSION AND WAIVER FORM

I _____ understand that Advantage Medical Group, LLC (AMG) has requested a pregnancy test **prior to or during** my treatment while using Suboxone, Zubsolv, Subutex, or Bunavail to treat my opioid dependency. I understand that should I be pregnant, there is risk to my unborn child both in terms of spontaneous abortion, miscarriage and/or birth defects.

_____ **Initial -** By signing this waiver, I release AMG and any health care providers working with AMG from all liability based on my decision to participate in this program. By my signature I give AMG permission to test for pregnancy each month of treatment. **I assume all responsibility for having or not having informed agency of pregnancy prior to or during treatment.**

_____ **Initial -** I acknowledge that AMG has informed me of the risk of taking Suboxone, Zubsolv, Subutex, or Bunavail medication during pregnancy and the potential harm that can be caused by usage of this drug during pregnancy**.** I understand that I should not take Suboxone, Zubsolv, Subutex, or Bunavail while breast feeding. I understand that newborns can develop withdrawal from one of the listed medications. I understand the risk of breast feeding while on this medication and **cannot hold AMG liable** for usage of any of these medication while breast feeding.

_____ **Initial -** I consent to the pregnancy test and acknowledge at this time of me signing this consent form that I acknowledge that I am not pregnant and assume responsibility for not describing any medical condition if found to be pregnant..

_____ **Initial -** I am fully aware that if I become pregnant during any point of my treatment or identify that I am pregnant from monthly pregnancy test conducted by AMG, it is understood that AMG **will not prescribe or continue to prescribe any medication to address my opioid dependency**. I understand that if I am made aware that I am pregnant or become pregnant that it is my responsibility to seek treatment through another provider for opioid dependency

_____ _____

Patient Name Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above plan.

Office Phones (803) 223-9193 OR (803) 788-4454) Office Fax 1(877) 837-4072 OR (803) 788-7152
AIKEN SITE/ COLUMBIA SITE/ FLORENCE SITE / MYRTLE BEACH SITE

Advantage Medical Group

Wavier of Liability

Patient Name:_____ Social Security #: _____-_____-_____

Date of Birth: _____/_____/_____ Phone #: _____

Permanent Address: _____

_____

I, _____ (participant) hereby waive my right or any family member, legal guardian, or significant other on my behalf the rights not to sue or hold in liability **Advantage Medical Group, LLC** and any of the officers, agents and contract-employees (**Medical Doctors**) of the above-mentioned entities (hereinafter referred to as **AMG**) for any liability, claim and/or cause of action arising out of or related to **any loss, damage or injury, including death**, that occurs as a result of my participation related to the use of **Suboxone/ ZUBSOLV/Subutex/ or Bunavail (buprenorphine and naloxone**) medication to address opioid dependency treatment. I am aware that withholding any information of past drug history could jeopardize my treatment. In addition you must take medication how it prescribed by the treating physician. Any deviation from treatment (i.e. self-medicate), I do not hold AMG liable or responsible.

_____ **Initial -** I have been advised about the drug interactions with Buprenorphine/Naloxone with any *benzodiazepines* ***(i.e. Xanax, Paxil, Klonopin, Ativan, Clonazepam and any other benzodiazepines),*** *alcohol,* amphetamine **(i.e. Adderall, Vyvanse, Concerta and any other amphetamine), Methadone,** and any **illicit drugs**.

_____**Initial -** I have been informed about combining these medications can cause the individual to stop breathing, heart rhythm, or **death**.

_____**Initial -** Participant has indicated that he/she has had 24-48 hours to evaluate their participation in **AMG** treatment program and **have been advise to stop** all prescribed benzodiazepine or amphetamine while being *prescribed SUBOXONE/ ZUBSOLV/SUBUTEX/ or BUNAVAIL* (buprenorphine and naloxone) and to consult with a primary physician about other non-benzodiazepines or non-amphetamine drug to use while taking *SUBOXONE/ZUBSOLV/ SUBUTEX/ or BUNAVAIL* medication.

_____**Initial -**I understand the risk and have indicated that I wish to continue with treatment.

By signing below, I assume any **risk of harm, injury or death** which could occur to the participant due to his/her/participation while or after treatment. I release **AMG, LLC** and all parties of **AMG** from any all liability, costs and damages which might arise from participation in this treatment program during treatment or after treatment has ended.

_____

Patient Name Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above plan.

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Patient Treatment Contract

Patient Name: _____ Date: _____

As a participant in medication treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

____**Initial** I agree to keep and be on time to all my scheduled appointments.

____**Initial** I agree to adhere to the payment policy outlined by this office.

____**Initial** I agree to conduct **myself or family members** in a courteous manner in the provider office.

____**Initial** I agree to report my history and symptoms honestly to my physician and the office staff. I will inform my physician about any medications (prescription and non-prescription) that I am taking. I will report any changes in my medical history, such as becoming pregnant.

____**Initial** I agree **not to sell, share or give any of my medication to another person**. I understand that such mishandling of my medication is serious violation of this agreement and would result in my treatment being **terminated without any recourse for appeal**.

____**Initial** I understand that my medication must be stored, safely, where it cannot be taken accidentally by children, pets or stolen. If anyone else, including a child takes my medication, I will call 911 or Poison Control at 1-800-222-1222 immediately.

____**Initial** I agree not to **deal drugs, steal, or conduct any illegal or disruptive activities** in or around the physician's office. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees or the pharmacy where my medication is filled, that the behavior will be reported to my physician's office and could be result in my treatment being **terminated without any recourse for appeal**.

____**Initial** I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place.

____**Initial** I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next schedule visit.

____**Initial** I will be careful with my take-home prescription supplies of my medication. If I report that my supplies have been lost or stolen, my physician will **not provide** me with a make-up supply.

____**Initial** I agree that lost medication will not be replaced regardless of why it was lost.

____**Initial** I understand that every visit, my physician may ask me to bring my unused supply of medication for mediation count and that I may not get a refill if I do not bring my medication with me.

____**Initial** I agree not to obtain mediates for any physician, pharmacies, or other sources without telling my treating physician.

____**Initial** I understand that mixing this medicine with other medications, especially benzodiazepines **(Valium, Klonopin, or Xanax)** can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if take outside the care of physician, using routes of administration other that sublingual or in higher that recommended therapeutic doses).

____**Initial** I agree to read the Medication Guide and consult my physician should I have any questions or experience any adverse events.

____**Initial** I agree to take my medication as physician has instructed and not to alter the way I take my medication without first consulting my physician.

____**Initial** I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling and discussed and agreed upon with my physician and specified in my treatment plan.

____**Initial** I agree to abstain from alcohol, opioids, marijuana, cocaine and other addictive substances (except nicotine) and provide random urine samples and have my doctor test my blood alcohol level.

____**Initial** **I understand that violations of the above my be grounds for termination of treatment**.

Advantage Medical Group

Opioid Overdose Intervention Plan

The goal of the Advantage Medical Group, LLC is to reduce unintentional, life-threatening poisonings related to the ingestion of opioids, including both illicit opioid drugs (i.e. heroin) and pharmaceutical opioid analgesics. The goal is to give the caregiver means a person who is not at risk of an opioid overdose but who, in the judgement of a physician, may be in a position to assist another individual during an overdose and who has received patient overdose information as required by Section 44-130-30, South Carolina General Assembly, **A54, R85, H3083** on the indications for an administration of an opioid antidote

I _____, understand the risk of overtaking or misuse of opioids

PLEASE PRINT PATIENT NAME

Or any illicit drugs can cause death.

My caregiver _____, has been informed and given

PLEASE PRINT NAME Caregiver/Spouse Name

Information on Opioid overdose response instructions. I am fully aware of opioid misuse and illicit drug use.

I _____, hereby waive **my** rights and **any family members**

PLEASE PRINT PATIENT NAME

Rights to pursue any legal action against Advantage Medical Group, LLC and any provider working with AMG during or after treatment for my dependency. Nor will issued any liability to Advantage Medical Group, LLC and any provider working with the group, due to any overdose that may result in **death or physical impairment caused by an overdose**

_____

Patient Name Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above plan.

Advantage Medical Group

Acknowledgement of Primary Care Physician

Patient Name: _____ Date: _____/_____/_____

I _____ acknowledge that **I do / do not** have a primary care physician.

_____**initial -** I understand that I must follow up with my primary care provider to address any physical problems that are identified. I will also inform the provider that I participate in a *BUPRENORPHINE* Clinic.

I have been referred to the following provider:

_____

_____

Patient Name Date

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above acknowledgement. ☐

Commercial Driver's Licenses and Heavy Machinery

I understand that **Suboxone, Subutex, Zubsolv, and/or Bunavail** are **controlled substance**. A **controlled substance** is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as prescription medication that are designated by law. _____**Initial**.

I understand that **Suboxone, Subutex, Zubsolv, and/or Bunavail** are **narcotics**, a drug or other substance affecting mood or behavior. _____**Initial**.

I understand that by law I ***cannot*** operate heavy equipment/machinery while participating in this program. _____**Initial**.

I understand that by law I **CANNOT** obtain a Commercial Driver's Licenses (CDL) while participating in the program. _____**Initial**.

I understand that violations of the above will be grounds for termination of treatment. _____**Initial**.

By signing below, I assume any risk of harm, injury or death which could occur to the participant due to his/her/participation while or after treatment. I release AMG, LLC and all parties of AMG from any and all liability, costs and damages which might arise from participation in this treatment program during treatment or after treatment had ended

_____

Patient Name Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above plan.

Advantage Medical Group

Acknowledgement of MEDICAID/MEDICARE OPT-OUT

I _____, understand that Advantage Medical Group, LLC
PLEASE PRINT NAME

Nor any of their Medical Doctors **DOES NOT** participate in the **Medicaid or Medicare program** for buprenorphine program.

_____**Initial** - I understand Advantage Medical Group, LLC **will not bill Medicaid or Medicare** on my behalf for any services rendered by any provider seen by this agency.

_____**Initial** – I will not seek any reimbursement from Medicaid or Medicare for services reindeer to me by any provider while in the buprenorphine program.

_____**Initial** – I am fully aware that I am responsible for all financial obligations while I am in this program.

_____

Patient Name Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above opt-out.

Lost or Stolen Medication Policy

I _____, am aware that I must keep up with all my
PLEASE PRINT NAME
medications. I was informed that I must **purchase a lock box** or store your medication in a secure area. I fully understand that **Advantage Medical Group will NOT replace any stolen or lost medication for me once it has been prescribed. In addition I understand that no additional medication will be called in or re-written to replace any stolen or lost medication for the month in accordance to DEA and SC DHEC policy.** _____**Initial.**

_____

Patient Name Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above policy.

Submit Package

(download form to submit via email)