Assignment of Benefits

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with our practice financial counselor. Necessary forms will be completed to help expedite insurance carrier payments. However, YOU ARE responsible for all fees, regardless of insurance coverage.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Dr. Masters for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Masters to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, and to allow a photocopy of my signature to be used to process my insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Masters on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I will pay for today's charges by (circle one): CASH CHECK

PATIENT/RESPONSIBLE PARTY SIGNATURE:_____

Date:_____

WITNESS:_____ Date:_____

New Patient Registration Information

PATIENT INFORMATION

Name:_____ Date of Birth:_____

Address:_____ Social Security No.:_____

City:_____State:_____Zip:_____ Sex (circle one): M F

Home Phone:_(___)_____ Work Phone:_(___)_____

Referring Physician's Name and Address:_____

RESPONSIBLE PARTY

Name:_____ Date of Birth:_____

Address:_____ Social Security No.:_____

City:_____State:_____Zip:_____ Driver's License No.:_____

Sex (circle one): M F Marital Status (circle one): Single Married Widowed Divorced

Home Phone:_(___)_____ Work Phone:_(___)_____

Employer's Name and Address:_____

Person to call (who does not live with you) in case of Emergency:_____

Emergency person's phone number:_____

INSURANCE INFORMATION

Primary Insurance Carrier:_____ Secondary Carrier:_____

Address:_____ Address:_____

Subscriber Name:_____ Subscriber:_____

Group Name:_____ Group:_____

Policy ID #:_____ Policy ID #:_____

Group No.:_____ Group No.:_____

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

Responsible Party's Signature:_____ Date:_____

As a participant in the buprenorphine protocol for treatment of opioid abuse and dependence, I freely and voluntarily agree to accept this treatment agreement/contract, as follows:

I agree to keep, and be on time to, all my scheduled appointments with the doctor and his/her assistant.

I agree to conduct myself in a courteous manner in the physician's office.

I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the doctor will not see me, and I will not be given any medication until my next scheduled appointment.

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

I agree not to deal, steal, or conduct any other illegal or disruptive activities in the doctor's office.

I agree that my medication (or prescriptions) can be given to me only at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.

I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.

I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines such as valium and other drugs of abuse, can be dangerous. I also understand that a number of deaths have been reported among individuals mixing buprenorphine with benzodiazepines.

I agree to take my medication as the doctor has instructed and not to alter the way I take my medication without first consulting the doctor.

I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education and relapse prevention programs, as provided, to assist me in my treatment.

_____	_____	_____
Printed Name	Signature	Date

1. I (name of patient) _____

2. Authorize: Dr. _____

3. To disclose: (kind and amount of information to be disclosed)
Any information needed to confirm the validity of my prescription and for submission for payment for the prescription.

4. To: (name or title of the individual or organization to which disclosure is to be made)
The dispensing pharmacy to which I present my prescription or to which my prescription is called/sent/faxed, as well as to third party payors.

5. For (purpose of the disclosure)
Assuring the pharmacy of the validity of the prescription, so it can be legally dispensed, and for payment purposes.

6. Date (on which this consent is signed)

7. Signature of patient

8. Signature of parent or guardian (where required)

9. Signature of individual authorized to sign in lieu of the patient (where required)

10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate on: (specific date, event, or condition)

Termination of treatment.

(c) Expired, deficient, or false consent. A disclosure may not be made on the basis of a consent which: (1) Has expired; (2) on its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section; (3) is known to have been revoked; or (4) is known, or through a reasonable effort could be known, by the individual holding the records to be materially false. (Approved by the Office of Management and Budget under control number 0930-0099.)

Notice to accompany disclosure:

Each disclosure made with the patient's written consent must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.