WELCOME

JOSEPH T. HAYES, M.D., M.P.H.
MERCY SUBURBAN HOSPITAL -MAP
2705 DeKalb Pike, Ste. 307
East Norriton, PA 19401
Telephone: (610) 633-6814

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

3 PHONE NUMBERS

Home (_____) _____ Cell (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

ALIVE DECEASED	FATHER ☐ ☐	Present health or cause of death	MOTHER ☐ ☐	Present health or cause of death	SPOUSE ☐ ☐	Present health or cause of death
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED		CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED		CAUSE OF DEATH
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED		AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**
☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other _____

5 HEALTH HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

6 MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

_____

7 HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

8 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

Joseph T. Hayes, M.D.
Mercy Suburban Med. Ctr.
Medical Arts Pavilion
2705 DeKalb Pike, Suite 307
East Norriton, PA 19401

Office of Dr. Joseph T. Hayes

PHYSICIAN-PATIENT AGREEMENT FOR SUBOXONE/SUBUTEX (BUPRENORPHINE PROGRAM)

This is an agreement between Joseph T. Hayes, M.D., M.P.H. _____
(Patient Name)
Date_____. The purpose of this agreement is to give you information about Suboxone/Subutex (buprenorphine) management to ensure that you and Dr. Joseph T. Hayes comply with all the state and federal laws and regulations concerning the prescribing of Suboxone/Subutex. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends upon mutual trust and honesty in the physician/patient relationship and full agreement understanding of the risks and benefits of using Suboxone/Subutex. Because Suboxone/Subutex has potential for abuse or diversions strict accountability is necessary when use is prolonged. **Furthermore, a physician cannot prescribe controlled substances if an individual is taking illegal substances such as, but not limited to: Marijuana, heroin, THC, PCP, ecstasy, cocaine, and/or methamphetamines.**

For the reasons stated above the following policies agreed by you the patient, as a consideration for and a condition of the willingness of Dr. Joseph T. Hayes to consider the initial end/or continued prescription of controlled substances to treat opiate dependency and/or addiction.

1. You must have only one physician to prescribe and monitor all Suboxone/Subutex medication and any adjunctive controlled substances, which include but not limited to: Benzodiazepines such as Xanax, Valium, Ativan, or Klonopin. All other drugs include muscle relaxants such as Soma, Flexeril, and Baclofen and sleep aides such as Ambien, Lunesta and Restoril.

2. You should use only one pharmacy to obtain all Suboxone/Subutex prescriptions as prescribed from this office. There may be exceptions when seeking a pharmacy that provides the best price for these medications. Dr. Hayes realizes these are very expensive and the price varies from time to time from various pharmacies. If you change pharmacies, you must notify Dr. Hayes immediately.

   Pharmacy Name: _____

   Pharmacy Phone Number: _____

3. You should inform Dr. Hayes of all medications you are taking including herbal remedies since Suboxone/Subutex can interact with over the counter medications and other

prescribed medications, especially cough syrup containing alcohol, codeine or hydrocodone.

You will be seen on a regular basis and given a prescription for a limited amount of strips or tablets. Currently, buprenorphine is available in generic strips at 12, 8, 4, and 2 milligrams strengths. It is also available in generic tablets at 8 and 2 milligrams strengths. Subutex is only available in 8 and 2 milligrams tablets. Buprenorphine is also available in another brand formulation called Zubsolv. Your appointments will be scheduled based on your requirement for buprenorphine. Your visits will be initially every two weeks for at least the first two visits and then will be scheduled less frequently based on your requirement for medication.

4. Prescription for Suboxone/Subutex will only be done during an office visit or during regular office hours. No refills of any medication will be done during the evening or on weekends.

5. You must bring your Suboxone/Subutex bottle and/or box at each visit.

6. You are responsible for keeping your medication in a safe and secure place such as a locked cabinet or safe. You are expected to protect your medication from loss or theft. Stolen medication should be reported to the police and Dr. Joseph Hayes immediately. If your medications are lost, misplaced or stolen, your physician may choose not to replace the medications or to taper or discontinue the medications. **Stolen medications require a valid police report for consideration of replacement.**

7. **You may not give, sell or share your medications to any other person under any circumstances. If you do you endanger other people's health and it is against the law!**

8. Any evidence of drug hoarding, acquisition of any other opiate medication adjunctive or buprenorphine from other physicians, which includes emergency room visits or uncontrolled dose escalation or reduction, loss of prescriptions or failure to follow the agreement may result in termination of the doctor/patient relationship.

9. You will communicate fully with Dr. Joseph Hayes, to the best of your ability, at the initial visit and all following visits your level of cravings, urges or thoughts about using opiates, any relapses of using opiates, any symptoms of withdrawal sickness such as increased sweating, nausea, feelings of restless leg, diarrhea, constipation, or any other withdrawal symptoms that Dr. Joseph Hayes will review with you at the time of your intake.

10. You should not use any illicit substances such as cocaine, heroin, marijuana, methamphetamine, etcetera while taking these medications. This may result in change of your treatment plan including safe discontinuation of your buprenorphine when applicable or complete termination of the doctor patient relationship.

11. The use of alcohol with Suboxone is contraindicated.

12. There are side effects with Suboxone/Subutex, which are uncommon, but they do occur which may include: Headache, nausea and constipation. There may be also sexual dysfunction, sleep abnormalities, sweating, edema, sedation, or possibility even impaired cognition (mental status) and/or motor abilities. Overuse of Suboxone/Subutex can cause decreased respiration (breathing).

13. You agree to a family conference or conference with a spouse, significant other or close friend if the physician feels it is necessary.

14. You agree to give Dr. Joseph Hayes permission to discuss all diagnostic and treatment details to a dispensing pharmacist or other professionals who provide your health care for purposes of maintaining accountability.

15. **DRUG SCREENS:** Unannounced drug screens may be requested and your cooperation is required. Dr. Joseph Hayes may require drug screens on a regular basis. Federal and State guidelines require physicians to drug screen all patient's who are receiving controlled substances including Suboxone/Subutex. Drug screening is done with dignity and confidentially. Our drug screening is done in privacy of one of our restrooms. It is no reflection of your integrity. The office must perform this test upon all patients; otherwise, there may be issues with discrimination. Urine drug testing is **NOT forensic testing.** It is strictly confidential and not shared with police agencies. This is done for your benefit as a diagnostic tool in accordance with certain legal and regulatory requirements on the use of controlled substances to treat substance abuse, dependancy and/or addiction. If requested to provide a urine sample you agree to cooperate. If you decide not to provide a urine sample, you understand that Dr. Joseph Hayes may change your treatment plan including safe discontinuation of your Suboxone/Subutex and complete termination of doctor patient relationship. The presence of a nonprescribed drug or illicit drugs in urine can be grounds for termination of further prescription of Suboxone/Subutex or termination of the doctor patient relationship in accordance with the Medical Practice Act of the Commonwealth of Pennsylvania.

16. The cost of drug screening will be the responsibility of the patient. Some health plans cover drug screening. Otherwise, the patient is required to pay for screening in advance.

17. Prescriptions in vials or boxes of Subutex or Suboxone may be sought by individuals with chemical dependency, abuse, addiction and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication prescription. They should not be left where others may see or have access to them. Since these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially children, you must keep them out of the reach of such people.

By affixing your signature below, you agree to all the terms of this agreement. Failure to comply with any parts of this agreement may result in cessation of further prescription and/or termination of the doctor patient relationship in accordance with the Medical Practice Act of the Commonwealth of Pennsylvania.

The above agreement has been explained to me by Dr. Joseph T. Hayes, M.D., M.P.H. and agree to the terms that Dr. Joseph Hayes can provide quality addiction and/or opiate dependency using Suboxone/Subutex and any other adjunctive medication that he may deem necessary.

Patient Signature:_____

Patient's Printed Name:_____

Date:_____

Dr. Joseph T. Hayes, M.D., M.P.H. Signature_____

Date:_____

Joseph T. Hayes, M.D., M.P.H.
Montgomery Hospital Medical Center Professional Building
Suite 200
1330 Powell Street
Norristown, PA 19401
Ph: 610-270-2405

SUBOXONE PROGRAM

Dear New Patient:

We welcome you as a new patient and we are glad that you are taking this step as a new start in life.

We need to have three items completed before we can start the Intake and Induction Program

- **Number ONE**: please complete the attached documents on the clip board.
- **Number TWO**: Federal guidelines require us to perform the drug screen **BEFORE** we start the initial visit.
- **Number THREE**: All fees must be paid **BEFORE** to the initial visit.

We appreciate your cooperation with our policy.

Mary Stevens

Office Manager.

Dr. JOSEPH T. HAYES, M.D.

OFFICE DRUG SCREENING POLICY

It is the policy of this office based on federal guidelines to perform random drug testing on ALL patients who receive controlled substances under the DEA (Federal Drug Enforcement Agency) from Dr. Joseph Hayes. Our patient's are very special and we want to ensure the highest level of medical care without intrusion or challenge to personal integrity. However, in order to provide this high level of care we must comply with federal and state guidelines. Accordingly, we have instituted a drug testing problem accordi to these guidelines. A patient will be tested if they are prescribed one or more of the following medicatior These include but not limited to the following medications:
All opiates such as **Vicodin, Loricet, Lortabs, Norco, Oxycontin, OxyIr, Avinza, Kadian, and MSContin. MSIR, and other drugs such as Valium, Lorazepam, Ultram, Talwin, Zanaflex, Baclofe or Flexeril.**

The above list is not all inclusive and the patient may be tested for other drugs and will be informed of thi at the time that the patient receives the prescription.

The purpose of the testing is to ensure that the patient is not taking any other elicit drugs such as amphetamines, THC (Marijuana), PCP, Cocaine. It is also performed to ensure that the patient is taking th medication. The latter helps to ensure compliance to the medical regimen and also reduces the chances of diversion. Drug testing is a simple urine test which is given too ALL Patients taking DEA controlled medications on a random basis. RANDOM means there will be no notice given at the time of visit. A Positive drug test may result in NO Refill of current prescription and a termination of the doctor/patient relationship according to the Commonwealth of Pennsylvania Medical Practice Act.

By signing below I confirm that I understand and agree with the terms of the office drug screening policy

Signed_____ Date_____

Name_____