The Infinity Center - Frankfort LLC
83 C. Michael Davenport Blvd. Suite C
PO Box 4307, Frankfort, KY 40604
PH: 502-352-2300 **FX:** 502-352-2302

AFTER READING THIS PACKET YOU MUST SIGN BELOW AND ON NEXT PAGE PLUS INITIAL EACH PAGE OR WE WILL NOT BE ABLE TO TREAT YOU.

PATIENT TREATMENT CONTRACT

CLINIC GUIDELINES AND TREATMENT PROTOCOL

January 1, 2019

Confidentiality of Alcohol- and Drug-Dependence Patient Records

The confidentiality of alcohol- and drug-dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol- or drug-dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

I understand that I am to comply fully with the following guidelines and protocols of The Infinity Center – Frankfort.

Signature_____ **Date:** _____

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RELEASE OF INFORMATION / COORDINATION OF CARE AGREEMENT

I authorize: **The Infinity Center-Frankfort, LLC.**
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Frankfort, KY 40604

to release or obtain information concerning services provided to the patient indicated below to or from:

_x_ Medical facilities, medical practices, physicians, pharmacies and pharmacists.
_x_ Insurance companies
_x_ Kentucky Commonwealth or County court systems or any court of competent jurisdiction
_x_ Child Protective Services or from agencies within Kentucky Cabinet for Health and Family Services
___ Family (name)_____
Any other entity that you wish to receive information will require a separate signed consent form.
If you do not wish information to be shared with one of the above, write no beside the statement of concern and initial.

Information to be disclosed:

_x_ Dates of treatment
_x_ Participation in Program
_x_ Progress
_x_ Discharge Summary
_x_ Clinical Records
_x_ Labs/Drug Screens
_x_ Treatment Plan
_x_ Assessment and Recommendations
_x_ Date and Type of Charge
_x_ Medical Records
_x_ Prescriptions and dosages

Purpose or needs for such disclosure is to

_x_ Inform the referring person or agency of my status, condition, progress
_x_ fulfill conditions of treatment, probation/parole or court order
_x_ obtain information for assessment
_x_ verify medical treatment and inform physicians of program participation
_x_ coordinate treatment
_x_ discuss conditions with family/friends
_x_ facilitate referral
____other: _____

SIGN HERE

Patient Signature: _____**Patient Printed Name**_____
Date: ____/___/_____

This authorization expires at the end of treatment affiliated with **The Infinity Center-Frankfort, LLC**, and may be revoked at any time except when the disclosing agency has already acted in reliance on it.

This information has been disclosed to you from records protected by Federal confidentiality rules. 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 person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. Mental Health and drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR parts 160 and 164. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

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REQUIREMENTS FOR ATTENDANCE & COMPLIANCE

Attendance

For medically assisted treatment to be successful, counseling is required.
Our treatment program requires you to attend counseling every other week and meet with the Provider once every 4 weeks.
Attendance requires being present and participating.

Appointments

You are provided a specific appointment time for the Provider, individual counseling or group counseling.
There are items that **must be completed before your actual appointment**.

- Paying for the appointment
- Filling out the progress sheet
- Having all blood or urine sampling completed
- **ALL BEFORE YOUR APPOINTMENT**

Example: If your appointment is for 1:30 you should be here at 1:00. If you arrive too late to get the items mentioned complete you are late. You will not be allowed to leave the clinic until labs are complete.

To complete the above items, you must arrive 30 minutes before your scheduled appointment.

If the items above are not completed before your appointment you **will** wait until the next counseling session or be moved to an available later Provider appointment or rescheduled.

NOTE: The 6:00pm Tuesday and 5:30pm Wednesday groups are the last groups of those days. There is not another group to attend that day. So, if you are late for either of these groups you **will not get your prescription that day**. If your group is the Tuesday group, you can make it up on Wednesday. If your group is 5:30 on Wednesday, you will have to wait until the next Tuesday to get into a group.

Payment

You must pay in full at check in. No exceptions.
You know at least two weeks ahead of time that you have an appointment and that you must pay.
Arrange for reliable transportation and money **before** the day you are to be here.

You will be charged for missed appointments if you haven't notified us 24 hours ahead of time. This includes Provider's appointments, Group Counseling sessions and Individual Counseling sessions.

You are allowed 1 prescription called in. But only if you are in full compliance with our program. For any more than one (1) you will be billed for each appointment and prescription called in.

We will not call in prescriptions just because your pharmacy closes. There are numerous pharmacies open late, or you can always fill your prescription the next day.

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THE INFINITY CENTER-FRANKFORT PATIENT POLICY AND PROCEDURES

By signing Page one, I agree to the following statements. I understand that:

☑ I should call the office right away at ***502-352-2300*** if I have ***any*** concerns or adverse events that I think might be related to taking this medication and that I should ***stop taking the medication until I discuss it with a Physician.***

☑ Patients taking medications are still subject to unrelated medical events which may be severe or life-threatening. Therefore, if I have symptoms that would usually prompt me to call my primary care provider or go to an emergency room, ***I will go there immediately and not wait for a physician to return my call.***

☑ All patients who take medications should carry with them an up-to-date card, sheet of paper or medical bracelet listing all their medications, the doses, and the number of times each medication is taken each day.

☑ While under TICF treatment I am required to report all changes in my condition.

☑ I must inform the TICF staff of any other medications that I am taking during my treatment.

☑ This program requires a counseling session once every two weeks that I **must** attend.

☑ Random Urine Screens as well as pill counts will be conducted in office. If I fail to submit to either upon staff request it can result in termination of my participation in the program.

☑ Urine drug screens may be supervised or observed.

☑ It is my responsibility to be on time for all appointments, **late or missed appointments can result in me not receiving my medication.**

☑ Violent, threating or disrespectful behavior towards staff or other patients will not be tolerated under any circumstance.

☑ Diversion ***(i.e. selling, trading or altering dosage of medication)*** is a **very serious** offense and may be grounds for immediate dismissal from the program

☑ If I do not take my medication as prescribed and/or continue to abuse other drugs, I inhibit the ability of TICF to treat me.

☑ TICF will take every possible step necessary to ensure that my treatment is a success.

SUMMARY

Potential Reasons for Discharge from the Clinic

Non-Compliance Examples:
Dirty or inconsistent drug screens or confirmations
Dishonesty
Missed appointments
Being late
Refusal of supervision or observation of urine collection.
Violent, threating or disrespectful behavior towards staff or other patients
Diversion ***(i.e. selling, trading or altering dosage of medication)***
Abusing other drugs

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PATIENT CONFIDENTIALITY STATEMENT

DO NOT TELL ANYONE ABOUT ANY OTHER PATIENT IN OUR CLINIC

All patient Protected Health Information (PHI-which includes patient medical and financial information), employee records, financial and operating data of the practice, and any other information of a private or sensitive nature are considered confidential. Confidential information should not be read or discussed by any employee or patient unless pertaining to his or her specific job requirements. Examples of inappropriate disclosures include:

- Patients discussing or revealing PHI or other confidential information to friends or family members.
- Patients discussing or revealing PHI or other confidential information to other patients without a legitimate need to know.
- The disclosure of a patient's presence in the office, hospital, or other medical facility, without the patient's consent, to an unauthorized party without a legitimate need to know, and that may indicate the nature of the illness and jeopardize confidentiality.

The unauthorized disclosure of PHI or other confidential information by patients can subject each individual patient and the practice to civil and criminal liability. Disclosure of PHI or other confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, is grounds for immediate disciplinary action up to and including termination.

Patient Confidentiality Agreement

I hereby acknowledge, by my signature on this contract that I understand that the PHI, other confidential records, and data to which I have knowledge and access during my treatment with The Infinity Center-Frankfort, LLC (TICF) is to be kept confidential, and this confidentiality is a condition of my participation in the treatment program. This information shall not be disclosed to anyone under any circumstances, except to the staff members at TICF. I understand that my duty to maintain confidentiality continues even after I am no longer a patient at TICF.

I am familiar with the guidelines in place at TICF pertaining to the use and disclosure of patient PHI or other confidential information. Approval should first be obtained before any disclosure of PHI or other confidential information not addressed in the guidelines and policies and procedures of TICF is made. I also understand that the unauthorized disclosure of patient PHI and other confidential or proprietary information, including electronic media sharing (ex: social media sites and texting) of patient information (including photos of patients and staff from TICF is grounds for disciplinary action, up to and including immediate dismissal.

- **Do not use cell phones while in group therapy session.**
- **Do not take photos while in the building.**
- **Do not post photos on social media sites.**

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PATIENT WAIVER AND AGREEMENT FOR PAYMENT

The purpose of this notice is to help you make an informed choice about whether you want to receive our treatment or services.

Please be advised that your insurance may or may not pay for all your health care costs. Some items and services are not considered "covered benefits" under some health insurance plans and as such, your insurance may not pay for these services if they are performed in our office. You have chosen to self–pay for non-covered health care services provided by:

The Infinity Center-Frankfort, LLC (TICF) & all contractors at this location

You have decided to self-pay even though you may have health insurance that covers these services and waive your right to have a claim submitted to your insurance company on your behalf.

Payment for non-covered services are due in full on the date you are seen in the clinic.

I acknowledge that I have been informed in advance of receiving these services, and that these services may or may not be covered by my health insurance plan if they are performed in the office. I have chosen to receive these non-covered services and understand that my insurance might cover other services.

I understand that I will be financially responsible for the charges indicated above. I understand that I may not submit this bill to my insurance carrier for future reimbursement. I agree that these services should be provided in the TICF office.

By signing this medical services waiver, I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with these medical services described in this document.

Informed Consent: A staff member of **The Infinity Center-Frankfort, LLC** and I have discussed to my satisfaction the purposes of this medication, the scientific evidence for its effectiveness, it's possible risks and side effects, and possible alternatives to it. I understand that these alternatives include being in psychotherapy without medication, taking different medications, doing nothing different from what I am doing now, or doing nothing at all. I also understand that this medication may not work as well as I hope it will. I agree to take this medication as prescribed, hoping it will relieve my symptoms and improve my condition.

Follow - up appointments. Please inform the office ASAP of any special circumstances or accommodations that you may need. We are here to help; and we will do our best to accommodate any reasonable request.
