Patient Registration Form

Use this form to collect core demographic, contact, emergency-contact, pharmacy, and care-coordination information.

Legal Name _____

Preferred Name _____

Date of Birth _____

Address _____

City / State / ZIP _____

Phone _____

Email _____

Emergency Contact / Relationship / Phone _____

Preferred Pharmacy / Phone _____

Other Treating Clinicians / Controlled-Medication Prescribers

List clinicians, facilities, or pharmacies relevant to safe coordination of care.

Clinician / Facility 1 _____

Clinician / Facility 2 _____

Clinician / Facility 3 _____

Patient Attestation

I certify that the information I provided is complete and accurate to the best of my knowledge. I understand that I should promptly update the practice when this information changes.

Patient / Representative Signature: _____ **Date:** _____

Printed Name: _____

Health History Form

Patient Name _____

Date of Birth _____

Primary Care Clinician _____

Reason for Visit / Primary Concern _____

Current Conditions / Symptoms

- ■ High blood pressure
- ■ Diabetes
- ■ Liver disease
- ■ Respiratory disease
- ■ Chronic pain
- ■ Anxiety
- ■ Pregnancy / breastfeeding
- ■ Heart disease
- ■ Kidney disease
- ■ Seizure disorder
- ■ GI symptoms
- ■ Depression
- ■ Sleep concerns
- ■ Other

Medication & Allergy History

Current medications and doses _____

Medication allergies / reactions _____

OTC medications / supplements _____

Substance & Treatment History

Alcohol use _____

Nicotine use _____

Cannabis use _____

Other substance use _____

Prior treatment / counseling / hospitalization _____

Surgical / Family / Social History

Prior surgeries / hospitalizations _____

Relevant family history _____

Occupation / living situation / support system _____

Patient / Representative Signature: _____ **Date:** _____

Printed Name: _____

Consent for Evaluation & Treatment

I voluntarily request evaluation and treatment from the practice. I understand that care may include history-taking, physical or telehealth assessment, diagnostic testing, medication management, counseling, referrals, care coordination, and follow-up as clinically appropriate.

I understand that no treatment is risk-free and that expected benefits, material risks, alternatives, and questions should be discussed with my treating clinician. I may decline or withdraw consent for non-emergency treatment, subject to applicable law and clinical limitations.

I understand that treatment outcomes cannot be guaranteed and that urgent or emergency symptoms may require care outside this practice.

Communication & Care Coordination

I authorize routine communications needed for treatment, payment, and healthcare operations as permitted by applicable law. Additional authorization may be required for specially protected information.

Patient / Representative Signature: _____ Date: _____

Printed Name: _____

Controlled Medication Treatment Agreement

This agreement establishes safety expectations when a clinician determines that a controlled medication is clinically appropriate.

- ■ I will take medication only as prescribed.
- ■ I will use one designated pharmacy when requested.
- ■ I will store medication securely and away from children or unauthorized persons.
- ■ I will participate in monitoring that is clinically indicated and legally permitted, which may include PDMP review, toxicology testing, medication reconciliation, or pill/film counts.
- ■ I understand that unsafe medication combinations may require a change in treatment.
- ■ I will not sell, share, trade, or intentionally divert medication.
- ■ I will disclose controlled medications prescribed by other clinicians.
- ■ I understand early replacement for lost, stolen, or damaged medication is not guaranteed.
- ■ I will attend required follow-up visits and discuss side effects, relapse, cravings, or safety concerns promptly.
- ■ I understand that the treatment plan may be modified or discontinued when risks outweigh benefits or when safer alternatives are indicated.

Patient-Specific Plan

Medication / indication _____

Designated pharmacy _____

Monitoring plan / frequency _____

Additional expectations _____

Patient / Representative Signature: _____ **Date:** _____

Printed Name: _____

Opioid Use Disorder Treatment Program Agreement

This template is intended for practices providing medication treatment for opioid use disorder. The treatment relationship should support access, safety, recovery goals, harm reduction, and continuity of care.

- ■ I will participate in scheduled clinical follow-up.
- ■ I will tell my clinician about other medications, sedatives, alcohol use, relapse, cravings, overdose events, and significant side effects.
- ■ I will discuss lost or stolen medication promptly; replacement is not guaranteed.
- ■ I understand counseling and recovery-support services may be recommended based on my goals and clinical needs.
- ■ I understand that abrupt discontinuation can increase risk and should be discussed with my clinician.
- ■ I will take buprenorphine or other prescribed medication exactly as directed.
- ■ I understand that toxicology testing and PDMP review may be used as clinical tools, not as punishment.
- ■ I will store medication securely and will not share or sell it.
- ■ I will receive or be offered overdose-prevention education and naloxone when appropriate.

Recovery / Treatment Goals

Goal 1 _____

Goal 2 _____

Goal 3 _____

Referrals / supports offered _____

Patient / Representative Signature: _____ **Date:** _____

Printed Name: _____

Privacy & Confidentiality Acknowledgment

I acknowledge that I have been offered or provided the practice's Notice of Privacy Practices, when applicable. I understand that my health information will be handled under applicable privacy laws and practice policies.

I understand that information related to substance use disorder treatment may receive additional federal or state confidentiality protections and may require specific authorization for certain disclosures.

I agree to respect the privacy of other patients and not disclose information I may incidentally learn about them while receiving services.

Preferred confidential phone number _____

Permission to leave voicemail? Yes / No _____

Preferred secure communication method _____

Patient / Representative Signature: _____ **Date:** _____

Printed Name: _____

Financial & Payment Policy

Customize this policy to reflect whether your practice is cash-pay, in-network, out-of-network, or hybrid.

Visit / service fee _____

Deposit, if any _____

Late cancellation / no-show fee _____

Payment methods accepted _____

- ■ I understand the fees disclosed to me before services are rendered.
- ■ I understand that I am responsible for balances assigned to me under the practice's financial policy and applicable law.
- ■ I understand that financial questions should be raised before treatment whenever possible.
- ■ I understand that insurance coverage, reimbursement, deductibles, copays, and medication costs may be separate from practice fees.
- ■ I understand that the practice will provide receipts or documentation consistent with its billing model.

Patient / Representative Signature: _____ **Date:** _____

Printed Name: _____

Template notice: This free resource is educational and operational in nature. It is not legal advice, a substitute for clinical judgment, or a guarantee of compliance. Customize it to your practice, payer contracts, state law, federal law, professional board rules, and applicable privacy/substance-use confidentiality requirements before use.

Office Policies Acknowledgment

■ Appointments are scheduled in advance unless the practice offers walk-in care.

■ Prescription requests require appropriate clinical review and may require an appointment.

■ The practice may require identity verification and current contact information.

■ Telehealth availability, response times, refill timing, and office hours are governed by current practice policy.

■ Cancellation and no-show rules have been explained to me.

■ After-hours messages are not a substitute for emergency care.

■ Threatening, abusive, fraudulent, or unsafe conduct may result in limits on services or discharge consistent with law and continuity-of-care obligations.

Practice-Specific Details

Office hours _____

Cancellation notice required _____

No-show / late cancellation fee _____

After-hours instructions _____

Prescription / refill policy _____

Patient / Representative Signature: _____ **Date:** _____

Printed Name: _____

Substance Use Clinical Assessment Worksheet

A clinician-facing worksheet for documenting substance-use history and diagnostic reasoning without reproducing proprietary screening instruments.

Primary substance(s) _____

Route / typical amount _____

Frequency _____

Age at first use _____

Date / time of last use _____

Longest period of remission _____

Prior overdose(s) / naloxone use _____

Prior detox / residential / outpatient / MOUD treatment _____

Clinical Domains to Assess

- ■ Loss of control / larger amounts or longer use than intended
- ■ Unsuccessful efforts to cut down
- ■ Time spent obtaining, using, or recovering
- ■ Craving
- ■ Role impairment
- ■ Interpersonal consequences
- ■ Hazardous use
- ■ Continued use despite harm
- ■ Tolerance
- ■ Withdrawal
- ■ Remission status / current environment
- ■ Co-occurring psychiatric or medical conditions

Clinical impression / diagnosis _____

Severity / rationale _____

Immediate safety concerns _____

Initial treatment plan _____

Clinician Signature: _____ **Date:** _____

Clinician Name / Credentials: _____

Drug Use Screening Worksheet

This is an original intake worksheet, not a substitute for a validated or licensed screening instrument. If your program requires a specific tool (for example, DAST, COMM, AUDIT, or another instrument), confirm current licensing and scoring requirements before reproducing it.

- ■ Have you used non-prescribed drugs or medications in the past 12 months?
- ■ Have you had difficulty cutting down or stopping?
- ■ Have you experienced withdrawal symptoms?
- ■ Have you had an overdose or needed naloxone?
- ■ Have you received prior treatment for substance use?
- ■ Have you taken a prescription medication differently than prescribed?
- ■ Has substance use affected work, school, relationships, finances, or legal status?
- ■ Have you used substances in situations that could be physically dangerous?
- ■ Have you combined opioids with alcohol, benzodiazepines, or other sedating substances?
- ■ Would you like help reducing risk, stopping use, or starting treatment?

Substances / details _____

Clinician follow-up needed _____

Referral / treatment action _____

Patient / Representative Signature: _____ **Date:** _____

Printed Name: _____

Opioid Withdrawal Assessment Record

Generic clinician documentation sheet. This does not reproduce the Clinical Opiate Withdrawal Scale (COWS). Use the validated COWS instrument separately when your protocol requires it.

Patient Name _____

Date / Time _____

Last opioid use _____

Substance / route _____

Recent buprenorphine or methadone use _____

Vitals: BP / HR / RR / Temp / O2 _____

Observed / Reported Withdrawal Findings

- ■ Restlessness
- ■ Anxiety / irritability
- ■ Sweating
- ■ Yawning
- ■ Runny nose / tearing
- ■ Dilated pupils
- ■ Tremor
- ■ Gooseflesh
- ■ GI upset
- ■ Muscle / joint aches
- ■ Nausea / vomiting
- ■ Sleep disturbance

Validated scale used / score _____

Clinical interpretation _____

Medication administered / prescribed _____

Reassessment time / findings _____

Disposition / follow-up _____

Clinician Signature: _____ **Date:** _____

Clinician Name / Credentials: _____

Treatment Commitment Statement

Our practice is committed to providing respectful, evidence-informed care and to working collaboratively with patients toward safer, healthier outcomes.

- ■ We will explain the treatment plan, expected benefits, important risks, and reasonable alternatives.
- ■ We will support continuity of medication when clinically appropriate and within legal, pharmacy, payer, and operational constraints.
- ■ We will help identify counseling, recovery, behavioral health, primary care, or specialty resources when appropriate.
- ■ We will discuss changes in treatment, including tapering or transition of care, in a clinically responsible manner.
- ■ We will monitor treatment effectiveness and safety at clinically appropriate intervals.
- ■ We will coordinate with other treating professionals when authorized or otherwise permitted by law.
- ■ We will use monitoring tools to improve safety and treatment quality rather than as punishment.
- ■ We will encourage overdose-prevention planning and access to naloxone when opioid risk is present.

Patient Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____