Seattle Healing Arts

9730 3rd Ave NE, #208, Seattle, WA 98115
Tel: (206) 522-5646

PATIENT REGISTRATION

Please fill out completely

Last Name: MI: First Name: Age: Gender: Female Male

Street Address: City: State: Zip Code:

E-mail Address: Date of Birth: Drivers Lic #:

Daytime Tel #: ( ) MSG Okay: Y N Evening Tel #: ( ) MSG Okay: Y N

Preferred Form of Contact: ( ) E-mail ( ) Day Phone ( ) Evening Phone

Race: ( ) AA/ Black ( ) Asian ( ) Hispanic ( ) White ( ) Declined to Specify

Ethnicity: ( ) Hispanic/ Latino ( ) Not Hispanic/ Latino ( ) Declined to Specify

Employment: ( ) Employed ( ) F/T Student ( ) P/T Student ( ) Retired ( ) Other (specify):

Employer: Tel. #:

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Dependent ( ) Partnered ( ) Other

Responsible Party/ Guarantor: Phone: ( )

Emergency Contact: Phone: ( ) Relationship:

Referred By:

PRIMARY INSURANCE

Insurance Company Name:

Subscriber's Name: **Date of Birth:**

Relationship to you: ( ) Self ( ) Spouse ( ) Dependent ( )Other

I.D. # as shown on card: **Group #:**

SECONDARY INSURANCE

Insurance Company Name:

Subscriber's Name: **Date of Birth:**

Relationship to you: ( ) Self ( ) Spouse ( ) Dependent ( )Other

I.D. # as shown on card: **Group #:**

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature: **Date:**

(Please Print) This information will be contained in your confidential medical history (Please Print)

HEALTH HISTORY

Name (Last, First, Middle)	Age	Today's Date

PLEASE STATE YOUR CHIEF CONCERNS, MAIN PROBLEM, OR REASON(S) FOR SEEING THIS DOCTOR:

How would you rate your general health? Excellent Good Fair Poor (why?)

PAST MEDICAL HISTORY

☐ Allergies/Hay Fever	☐ Depression	☐ Anxiety	☐ Gout
☐ Arthritis	☐ Suicide	☐ Intestinal Problems	☐ Rheumatic Fever
☐ Asthma/Emphysema	☐ Glaucoma	☐ Kidney Stones/Disease	☐ Blood Clots
☐ Bladder/Kidney Infection	☐ Heart Attack	☐ Mitral Valve Prolapse	☐ Seizure/Epilepsy
☐ Bleeding/clotting	☐ Heart Failure	☐ Liver Problem	☐ Sexually Transmitted Disease
☐ Cancer	☐ Heart Murmur	☐ Abnormal PAP	☐ Thyroid Problems
☐ Diabetes	☐ Heart Surgery	☐ High Cholesterol	☐ Tuberculosis
☐ Angina	☐ High Blood Pressure	☐ Reflux Disease	☐ Other _____

Hospitalizations or Surgeries:	Age	Date

Please list all with dose, frequency, date started, and reason (use back of form for additional space)

MEDICATIONS AND SUPPLEMENTS

Prescription Drugs	Supplements

WELL BEING

Goals for health:

What practices or activities do you use to sustain your health and well being?

Who do you turn to for support? Who are in your community?

What causes stress for you?

HEALTH HISTORY (page 2)

(Circle all that apply)

HABITS

Diet: Vegan Vegetarian Omnivore Fast Foods Other:

Alcohol: Never Occasional Moderate Heavy Specify Type: Wine Beer Hard liquor Other
Is your alcohol use ever a concern for you or others? No Yes (explain):

Tobacco: Never Current Prior (Date last used): Cigarettes - # Packs/Day? # of years?
Cigars: #/day? # of years? Chewing Tobacco: How often? How long?
Are you interested in quitting? Yes No

Caffeine: None Chocolate Coffee Tea | # cups/day: | Soda drinks, # cans/bottles/day:

Exercise: Rarely Occasional Moderate Often Favorite Types:

How long: **How Often:**

Do you use recreational drugs? Y N If yes, what type? How often?

Occupational Exposures: Asbestos Other (describe)

Drug Allergies (list all drug allergies and type of reaction):

Food Sensitivities (list all foods and type of reaction):

Latex Allergy Yes No **Allergy to I.V. Contrast Yes No**

Height: _____ft _____inches **Weight:** _____lbs Weight age 20: _____Weight change last year: gain ___lbs lost ____lbs Do you have concerns about your weight? No Yes (explain):

Your current sex partner(s) are: Male Female Both None
Are you interested in being screened for sexually transmitted disease: Yes No

FAMILY HISTORY

	Living? Y or N	Age now (or at time of death)	Major Illnesses and Cause of Death
Mother			
Father			
Brother(s) #:			
Sisters(s) #:			
Children #:			

Family History (please check all that apply and relation to you, e.g. F, M, GM, GF, B, S, C, etc):

	Alcohol Problem		Diabetes		Cholesterol		Osteoporosis		Prostate Cancer
	Drug Problem		Heart Attack		Hyperthyroid		Smoking.Hx		Colon Cancer
	Allergies/Hay Fever		Heart Failure		Hypothyroid		Stroke		Other Cancer
	Autoimmune Disease		Heart Surgery		Glaucoma		Suicide		Breast Cancer
	Bleeding/Clotting		High Blood Pressure		Obesity		Tuberculosis		
	Early Heart Attack (Female 65 y.o. or less, Male 55 y.o. or less)				Depression/other mental/emotional disorder				
	Other:				Other:				

SOCIAL HISTORY

Birthplace:	Education:	Occupation:

Marital Status: ( )Single ( ) Married ( ) Divorced ( ) Partnered ( ) Other (describe)

Who lives in your household?

Number of children in your household:

Do you have pets in your household? No Yes (what kind):

Some people can by hurt or threatened by people they love. Is this happening to you No Yes (details)

Is violence at home a concern for you? No Yes

HEALTH HISTORY (page 3)

(Please check any significant problems)

SYSTEM REVIEW

	Fatigue		Frequent cough		Bursitis/Tendonitis		Liver disease
	Weakness		Coughing up blood		Neck pain		Gall bladder issues
	Weight problem		Coughing up phlegm		Back pain		Sugar in urine
	Fluid retention		Frequent chest cold		Hernia		Urination problems
	Tire easily		Bronchitis		Food intolerance		Skin problems
	Headache		Pneumonia		High blood sugar		Easy bruising
	Migraine		Shortness of breath		Low blood sugar		Anemia
	Fainting		Wheezing		Indigestion		Infertility
	Dizziness		Pleurisy		Heartburn		Sexual difficulty
	Ear/hearing problem		Chest pain		Ulcers		Nervous/anxious
	Ringing in the ears		Chest tightness/pressure		Vomiting blood		Tense/irritable
	Stuffy nose		Heart Palpitations		Black/bloody stool		Insomnia
	Nose bleeds		Enlarged heart		Rectal bleeding		Relationship problems
	Sinus problems		Leg pain on walking		Abdominal pain		Job problems
	Persistent hoarseness		Restless legs at night		Spastic colon		Personal problems
	Glasses		Leg cramps		Colitis		Decreased appetite
	Vision/Eye problems		Phlebitis		Diarrhea		Seen a psychiatrist/therapist
	Glaucoma		Varicose Veins		Constipation		Nervous breakdown
	Cataract		Shortness of breath on exertion		Change in bowel habits		Changing mole
	Swallowing trouble		Ankle/leg swelling		Hemorrhoids		**OTHER:**
	Fever		Joint pain/swelling		Night sweats		
	Excessive thirst		Excessive urination		Heat or cold intolerance		

MEN ONLY		**WOMEN ONLY**
	Prostate trouble	Age at 1st period: _____ Periods: ( ) N/A ( )Regular ( )Irregular ( )Painful ( )Heavy Every _____ days Last menstrual period: date(s)
	Date of last prostate exam/result:	( )Menopausal Age at menopause: Do you have concerns about Menopause? No Yes (explain):
	Stream weak or slow	Date of Last PAP: ( ) Normal ( ) Abnormal (explain):
	Pain/swelling in testes	Date of Last Mammogram: ( ) Normal ( ) Abnormal (details):
	Discharge from penis	If sexually active, method used to prevent pregnancy:
	Erectile problems	# of Pregnancies: # of Births: # of Miscarriages/abortions:
	Any other issues?:	Age of first pregnancy:
		Any other issues?:

PREVENTIVE CARE

Indicate whether you have had any of the following by listing dates

	Date		Date	
Last Physical Exam		Hepatitis B Vaccine		Do you have guns in your home? No Yes
Last Dental Exam		Tetanus Booster		Do you wear seatbelts? No Yes Occ
Last Eye Exam		Pneumonia Vaccine		Do you wear a bicycle helmet? No Yes
Last Chest X-Ray		PPD (TB skin test)		
Last EKG		Mammogram		
Osteoporosis screening (Dexascan)		Stool Test for Blood		
Flu Shot		Colonoscopy		
Varicella (Chickenpox) Vaccine		Cholesterol tests		
Measles/Mumps/Rubella Vaccine		HIV/AIDS test		

Mary G. Bolton, MD, PhD
Seattle Healing Arts Center, 9730 3rd Ave NE, Suite #208, Seattle, WA 98115
TEL#: (206) 522-5646 FAX #: (888) 972-4693

NOTICE TO PATIENTS REGARDING WELL EXAMS

If you schedule an annual exam, PAP or physical, your insurance company may call this visit "preventative", "yearly", or "annual". Please take a moment to read the remainder of this letter.

Due to national coding laws, we must bill your insurance company for your exam as a preventative care visit. If during your visit you have additional concerns or conditions that require diagnosis and treatment, you may incur additional office or lab charges. These charges will be submitted to your insurance company as well as the preventative visit. If your insurance company does not cover some or all of the charges, you will be billed for the balance that your insurance company indicates as patient responsibility. Please do not ask us to re-bill by changing a procedure or diagnostic code. By asking this of your physician, you are asking him/her to commit insurance fraud.

Medicare Patients

Please be aware of your insurance coverage and benefits. If preventative care coverage is not part of your insurance benefits, we may ask for payment at the time of service. If you are experiencing financial hardship, we can assist you with payment options. Insurance plans do not cover DOT (Department of Transportation) exams or most other exams done purely for administrative purposes such as immigration/emigration, adoption, college entrance and others. In certain cases, those forms may be completed as a part of a routine physical examination, but not always. Please ask your physician if you have any questions.

Please be aware that the Initial Physical Examination (IPPE) also known as the "Welcome to Medicare" visit is not the "routine physical checkup" that some seniors may receive every year or two from their providers. Medicare DOES NOT provide coverage for routine physical exams. An IPPE consist of a history, medication review, fall risk screening, depression screening and vital signs. An EKG may be done and will be billed separately. Laboratory testing is not part of the service and is ordered and billed separately. Coverage of the IPPE visit is provided as a Medicare Part B benefit. The Medicare deductible is waived for the IPPE. A patient may have one IPPE exam in a lifetime and it must be done within one year of becoming eligible for Medicare. If you are here for the "Welcome to Medicare" JPPE, please be sure to tell your physician.

Thank you for your understanding in this matter. Your cooperation is greatly appreciated.

_____ _____
Signature Date of Birth

_____ _____
Please print name Date

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MEDICATION HISTORY AUTHORITY

I give Mary G. Bolton MD, PhD my permission to retrieve my medication history as provided by my insurance company.

Background: This feature allows us to fill in your medication history, cross-reference and verify which medications you are taking, create a more accurate history, be more aware of interactions, and prescribe you more safely.

_____ _____

Patient Signature Date

RELEASE OF BILLING INFORMATION

I hereby give permission to my physician to submit health information to my insurance plan in order to receive payment for services rendered.

Background: Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed or recommended care.

_____ _____

Patient Signature Date

ASSIGNMENT OF BENEFITS

I authorize my insurance benefits to be paid directly to my physician. I understand that I am financially responsible for any balance.

_____ _____

Patient Signature Date

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CANCELLATION POLICY

Our practice provides a unique clinical experience and we value the depth of the relationship that we build with the people we serve. To that end, we generally spend significantly more time during each patient visit than is standard in health care today.

We require at least 24 hours' notice for cancellations so that we may offer that appointment to another patient in our community. The 24 hour notice excludes weekend hours. If you need to cancel an appointment for Monday, please call on Thursday of the preceding week. Appointments can also be requested and cancelled online through your Care Cloud Portal. The link for this portal is: http://community.carecloud.com/

The charge for a missed appointment or late cancellation is $100. The fee will not be covered by your health plan.

Reminder calls and emails are often done as a courtesy to patients, but we do not guarantee that you will receive a call. Please ask for appointment reminder card if needed.

I, the undersigned, have read and had an opportunity to ask questions about this Late Cancellation and Missed Appointment Policy. I understand and agree to the contents of the policy.

_____ _____

Patient/ Guardian Signature Date

_____

Please Print Name

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NOTICE OF PRIVACY PRACTICE- ACKNOWLEDGEMENT

We keep a record of health services we provide you. You may ask to see and obtain a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorized or compels us to do so. You may see your record or get more information about it by contacting your practitioner.

We have a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how. can access your health care information, and whom to contact if you have questions, concerns, or complaints.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. We may change the Notice of Privacy Practice.at any time.

If you have any questions, you can contact Spencer Haugen, Privacy Officer at 206-522-5646.

By my signature below I acknowledge that I have reviewed the Notice of Privacy Practices and that a copy has been provided if I have requested one.

_____

Printed name of patient

_____ Date _____

Patient or legally authorized individual's signature

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in vour medical record.

For Office Use Only

Office staff complete below:
I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: _____ Staff member initials: _____

Reasons:

Buprenorphine Treatment
Intake History and Physical

NAME: _____ DATE: _____

Chief Complaint: _____

Opiate use history: Drugs used: _____

Yrs/mos of use: _____ Routes of Admin: _____ Current length of continuous use: _____

Amount of current use: _____ Last use (date/time): _____

Frequency of Use: _____

Present Symptoms: _____

_____

History of drug abuse treatment: _____

_____

_____

Other Drug Abuse History:

Cocaine/stimulants:_____ Current amount:_____ Mos/Yrs of Use:_____

Route:_____ Last Use_____

Medical/Psychiatric Complications of Use: _____

_____

_____

Alcohol: Current amount:_____ Yrs of Use:_____ Last Use_____

Medical/Psychiatric Complications of Use: _____

_____

Benzodiazepines:_____ Current amount:_____ Yrs of Use:_____ Last Use_____

Medical/Psychiatric Complications of Use: _____

_____

Marijuana:_____ Current amount:_____ Yrs of Use:_____ Last Use_____

Medical/Psychiatric Complications of Use: _____

Pertinent Medical History:

Hepatitis: YES NO If YES,Type: _____ Date of Diagnosis: _____If No, Last Test: _____

Treatment: _____

Endocarditis (date): _____ Treatment: _____

HIV _____ Last Test: _____ TB_____ (last test): _____

STD (type): _____ (last test): _____

(Women): LMP_____ # of Pregnancies _____ # of Births: _____ # of Abortions: _____

Method of Contraception: _____

Screening Laboratory Results:

Urine Drug Screen Results: _____ Date: _____

Pregnancy Test (if needed): _____ Date: _____

Buprenorphine/Naloxone Maintenance Treatment
Intake Questionnaire for Patient Treatment-Planning Questions

Name: _____ **Date:** _____

Please answer the following questions which will help us design your plan of treatment:

1. What is the best time of day and day of week for you for clinic visits?
   _____
2. Are there any months of the year when you may have difficulty making it in for appointments?
   _____
3. Is there any problem that makes it hard for you to give routine urine specimens?
   _____
4. Do you have any disabilities that make it hard for you to read labels or count pills?
   _____
5. What are your reasons for being interested in Buprenorphine/Naloxone treatment?
   _____
   _____
6. What "triggers" do you know which have put you in danger or relapse in the past or which might in the future? _____
   _____
   _____
7. What coping methods have you developed to deal with these triggers to relapse?
   _____
   _____
   _____
8. What plans do you have for the coming year?
   Work: _____
   Home: _____
   Other: _____
9. What kinds of help would you like from a counselor? _____
   _____
   _____

10. What are your strengths and skills to handle take-home Buprenorphine/Naloxone (Suboxone)?

11. What worries do you have about extended take homes?

12. Is anyone in your home actively addicted to drugs or alcohol? If yes, who, what do they take?

13. What are the major sources of stress in your life?

14. What family or significant others will be supportive to you during your treatment?

15. Who is your primary care physician?
(Please provide telephone #):

16. Do you have a therapist/counselor? YES NO , If YES, please provide name and phone number of your therapist/counselor:

17. Have you ever been treated for a psychiatric problem or mental illness or prescribed psychiatric medications? Please describe all diagnoses and medications taken.

NAME _____ DATE: _____

Agreement for Treatment with Buprenorphine/Naloxone

Please circle YES or NO and initial in the column to the right.

1	YES	NO	I understand that buprenorphine/naloxone is a medication to treat opiate addiction (for example: heroin, prescription opiates such as oxycodone, hydrocodone, methadone). Buprenorphine/naloxone contains the opiate narcotic analgesic medication, buprenorphine, and the opiate antagonist drug, naloxone, in a 4 to1 (buprenorphine to naloxone) ratio. The naloxone is present in the tablet to prevent diversion to injected abuse of this medication. Injection of buprenorphine/naloxone by a person who is addicted to opiates will produce severe opiate withdrawal.	Initital S
2	YES	NO	I agree to keep appointments and let staff know if I will be unable to show up as scheduled. There is a $60 fee for missed appointments without a prior notice of at least one business day. I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.	
3	YES	NO	I agree to report my history and my symptoms honestly to Dr. Bolton, and other people involved in my care. I also agree to inform Dr. Bolton of all other physicians and dentists who I am seeing; of all prescription and non-prescription drugs I am taking; of any alcohol or street drugs I have recently been using; and whether I have become pregnant or have developed hepatitis.	
4	YES	NO	I agree to cooperate with witnessed urine drug testing whenever requested, to confirm if I have been using any alcohol, prescription drugs, or street drugs.	
5	YES	NO	I have been informed that buprenorphine is a narcotic analgesic, and thus it can produce a "high"; I know that taking buprenorphine/naloxone regularly can lead to physical dependence and addiction, and that if I were to abruptly stop taking buprenorphine/naloxone after a period of regular use, I could experience symptoms of opiate withdrawal. I also understand that combining buprenorphine/naloxone with benzodiazepine (sedative or tranquilizer) medications (including but not limited to Valium, Klonopin, Ativan, Xanax, Librium, Serax) has been associated with severe adverse events and even death. I also understand that I should not drink alcohol with buprenorphine/naloxone since it could interact with buprenorphine/naloxone to produce medical adverse events such as reduced breathing or impaired thinking and death. **I agree not to use benzodiazepine medications or to drink alcohol while taking buprenorphine/naloxone and I understand that Dr. Bolton may end my treatment with buprenorphine if I violate this term of the treatment agreement.**	
6	YES	NO	I have been informed that buprenorphine/naloxone is to be placed under the tongue for it to dissolve and be absorbed, and that it should never be injected. I have been informed that injecting buprenorphine/naloxone after taking buprenorphine/naloxone or any other opiate regularly could lead to sudden and severe opiate withdrawal.	
7	YES	NO	I have been informed that buprenorphine/naloxone is a powerful drug and that supplies of it must be protected from theft or unauthorized use, since persons who want to get high by using it or who want to sell it for profit, may be motivated to steal my take-home prescription supplies of buprenorphine/naloxone. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and will result in my treatment being terminated without recourse for appeal	
8	YES	NO	I have a means to store take-home prescription supplies of buprenorphine/naloxone safely, where it cannot be taken accidentally by children or pets, or stolen by unauthorized users. 1 agree that if my buprenorphine/naloxone pills are swallowed by anyone besides me, 1 will call 911 or Poison Control at 1-800-222-1222 immediately and I will take the person to the doctor or hospital for treatment	
9	YES	NO	I agree that if Dr. Bolton recommends that my home supplies of buprenorphine/naloxone should be kept in the care of a responsible member of my family or another third party, I will abide by such recommendations.	

NAME _____ DATE: _____

10	YES	NO	I will be careful with my take-home prescription supplies of buprenorphine/naloxone, and agree that I have been informed that if I report that my supplies have been lost or stolen, that Dr. Bolton (or her covering physicians) will not be requested or expected to provide me with make-up supplies. This means that if I run out of my medication supplies this may result in symptoms of opiate withdrawal. Also, I agree that if there has been a theft of my medications, I will report this to the police and will bring a copy of the police report to my next visit.	
11	YES	NO	I agree to bring my bottle/box of Buprenorphine/naloxone in with me for every appointment with Dr. Bolton so that remaining supplies can be counted.	Initials
12	YES	NO	I agree to take my Buprenorphine/naloxone as prescribed, to not skip doses, and that I will not adjust the dose without talking with Dr. Bolton about this so that changes in orders can be properly communicated by to my pharmacy.	
13	YES	NO	I agree that I will not drive a motor vehicle or use power tools or other dangerous machinery during my first days of taking Buprenorphine/naloxone, to make sure that I can tolerate taking it without becoming sleepy or clumsy as a side-effect of taking it	
14	YES	NO	I agree that I will arrange transportation to and from the treatment facility during my first days of taking Buprenorphine/naloxone so that I do not have to drive myself to and from Dr. Bolton's office.	
15	YES	NO	I want to be in recovery from addiction to all drugs, and I have been informed that any active addiction to other drugs besides heroin and other opiates must be treated by counseling and other methods. I have been informed that buprenorphine, as found in Buprenorphine/naloxone, is a treatment designed to treat opiate dependence, not addiction to other classes of drugs.	
16	YES	NO	I agree that medication management of addiction with buprenorphine, as found in Buprenorphine/naloxone, is only one part of the treatment of my addiction, and I agree to participate in a regular program of professional counseling while being treated with Buprenorphine/naloxone.	
17	YES	NO	I agree that professional counseling for addiction has the best results when patients also are open to support from peers who are also pursuing recovery. I agree to participate in a regular program of peer/self-help while being treated with Buprenorphine/naloxone	
18	YES	NO	I agree that the support of loved ones is an important part of recovery, and I agree to invite significant persons in my life to participate in my treatment. I will provide Dr. Bolton with the name(s), phone number, and address of at least one person in my life who is aware of my addiction and with whom she can communicate. (Please provide this information below)	
19	YES	NO	I agree that a network of support, and communication among persons in that network, is an important part of my recovery. I agree that Dr. Bolton may contact outside parties including physicians, therapists and other parties when she has decided that open communication about my case, on my behalf, is necessary.	
20	YES	NO	I agree that I will be open and honest with Dr. Bolton and inform her about cravings, potential for relapse to the extent that I am aware of such, and specifically about any relapse which has occurred - before a drug test result shows it.	
21	YES	NO	I am aware of Dr. Bolton's schedule, including hours of operation, the clinic phone number, and responsibilities to me as a recipient of addiction treatment services, including buprenorphine treatment with Buprenorphine/naloxone. I agree not to call after hours or on weekends for prescriptions for Buprenorphine/naloxone or for problems other than general medical emergencies.	
22	YES	NO	I agree that while I am under the care of Dr. Bolton for my opiate addiction, she will be the only doctor whom I will ask to prescribe Buprenorphine/naloxone for me. **I understand that Dr. Bolton may end my treatment with buprenorphine if I violate this term of the treatment agreement.**	
23	YES	NO	I agree to conduct myself in a courteous manner at all times in the Dr. Bolton's office.	
24	YES	NO	I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, I will be asked to leave and I will not be given any medication until my next scheduled appointment.	
25	YES	NO	I agree not to deal, steal, or conduct any other illegal or disruptive activities in the vicinity of Seattle Healing Arts or anywhere else.	

NAME _____ DATE: _____

26	YES	NO	I agree to pay all fees for my treatment at the time of my visits.	
27	YES	NO	I understand that there are alternatives to buprenorphine/naloxone treatment for opioid addiction including: a. medical withdrawal and drug-free treatment	
			b. naltrexone treatment c. methadone treatment Dr. Bolton will discuss these with me and provide a referral if I request this	

Name of Contact: _____
(Please print clearly)
Telephone #: _____

Address: _____

_____

_____

Patient Signature: _____ Date: _____