MINDFULNESS
HOLISTIC WELLNESS & HEALING

PLEASE FILL IN ALL APPLICABLE SECTIONS

Personal Information

Name: _____
First MI Last

Address: _____ Zip Code:_____

Phone: _____ _____ _____
Home Work Cellular

Email Address: _____

Sex: ▫ Female ▫ Male Birth Date: _____/_____/_____ SSN: _____

Marital Status: ▫ Single ▫ Married ▫ Other Spouse's Name: _____

Employment Status: ▫ Employed ▫ Full-time ▫ Part-time ▫ Student ▫ Full-time ▫ Part-time

Is Patient's condition related to: ▫ Employment ▫ Auto Accident ▫ Other: _____

Responsible Party (ONLY If other than yourself) ***This is the person that is financially responsible (billing statements).***

Name: _____
First MI Last

Address: _____ Zip Code: _____

Phone: _____ _____ _____
Home Work Cellular

Email Address: _____ Sex: ▫ Female ▫ Male Birth Date: _____/_____/_____

SSN: _____ Marital Status: ▫ Single ▫ Married ▫ Other Spouse's Name: _____

Employment Status: ▫ Employed ▫ Full-time ▫ Part-time ▫ Student ▫ Full-time ▫ Part-time

Insurance Information

ARE YOU THE POLICY HOLDER? Yes No: *IF NO - Complete ALL of the Policyholder Information section below*

Name of Policyholder: _____

Name of Insurance Company: _____ Gov/State Funded? (Medicaid) ____

Policy ID/Member ID: _____ Group Number: _____

Policyholder Information (If different than patient)

Name: _____
First MI Last

Address: _____ Zip Code: _____

Phone: _____ _____ _____
Home Work Cellular

Email Address: _____

Sex: ▫ Female ▫ Male Birth Date: ___/_____/_____ SSN: _____

Marital Status: ▫ Single ▫ Married ▫ Other Spouse's Name: _____

Relationship to the insured: ▫ Self ▫ Spouse ▫ Child ▫ Other

**** If you are covered under another insurance plan, please fill out another intake front page & write "SECONDARY INSURANCE" on the top****

Emergency Contact Information:

Name: _____ Relationship: _____ Phone Number: (_____)_____

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party below. I authorize payment of medical benefits to Mindfulness, LLC for services.

Signature: _____ **Date:** _____

FINANCIAL POLICY / AGREEMENT

SESSIONS:

Medical management sessions are typically scheduled as 25 minutes in length as scheduled as the provider deems medically necessary. Psychotherapy sessions are typically scheduled as 50 minutes in length as the provider deems medically necessary. You can always call the office in an emergency at (304) 699-1419. If the therapist cannot talk with you, they will call you back as soon as possible. ****PHONE CALLS exceeding 15 minutes will be billed as follows:**

15 to 30 minutes $40 (not billable to insurance)

30 to 60 minutes $80 (not billable to insurance)

We do have voicemail available if you need to cancel any appointments after business hours. **ANY APPOINTMENTS NOT CANCELED WITH 24-HOUR NOTICE WILL BE CHARGED A FEE OF $75 (not billable to insurance).** This also applies to any appointments that you miss: **ANY APPOINTMENTS THAT YOU ARE A "NO SHOW" WILL BE CHARGED A FEE OF $75** (not billable to insurance). The ONLY exceptions to this policy are when driving conditions are hazardous (in which case we will be happy to schedule a FaceTime or phone appointment), or **if you are insured by Medicaid/Medicaid MCO's as your only insurance; however, recurring missed appointments with no 24-hour cancellation may result in termination of services.**

_____ **initial**

PAYMENT POLICY:

All payments for services are due at the time of your scheduled appointment during check-in. As a courtesy, we will bill any insurance you may have; but copays, coinsurance, and deductibles are **due at the time of service**. If we do not participate with your insurance, you agree that you are considered a "Self Pay" client. We are happy to assist in explaining how your insurance has processed your visits; however, it is your responsibility to understand your coverage and benefits and the amounts that you owe for the services you receive. If payment is not made at the time of service, a late payment fee of 10% may be assessed for each date of service that is not paid.

In any custody situation, the parent that brings the child for treatment, is responsible for any payment.

- **COURT: If required to testify in court, the provider's rate is $250.00 per hour**
- **LETTER: If a written letter/report to either the court or attorney is requested, a fee of $50.00 will be charged to the requesting parent.**

_____ **initial**

****If copays are not paid at the time of service, a 10% billing fee may be charged to your account.**** _____ **initial**

DOCUMENTS:

Documents (documents, letters, reports, FMLA, etc.): Fees for any documents, letters, reports, etc. are NOT billable to insurance and are required to be paid before they will be released, faxed, mailed, etc.

_____ **initial**

_____ _____

Signature of Patient (if minor over 12 years of age) **Signature of Parent / Guardian Date**

CONFIDENTIALITY

Confidentiality is one of the most important elements of healthcare, and one of your most important rights. Within certain legally defined limitations, any information revealed by you or learned about you from another source during the course of our work together, will be kept strictly confidential, and will not be revealed to another person or agency, without your written permissions.

However, there are a few exceptions to this policy: If, in your provider's professional judgment, you threaten to harm yourself or another person; or if your provider believes that a child or elder is being abused or neglected.

As you may know, your health insurance company may help cover the cost of your sessions, but in order for claims to be processed, insurance companies require that we provide them with certain information including a clinical diagnosis. All insurance companies claim to keep all information confidential, but once they receive this information, we have no control over what they do with it and who may see it. If you are concerned with this, you may want to contact your insurance company before authorizing us to bill them.

If you choose for us not to bill your insurance, and to pay for services privately, you may do so at the time of service. Once the insurance company has been billed, you may not change to self-pay, as we are contractually obligated with the insurance company to follow their guidelines and pricing, as well as their processing and applications of copays, coinsurances, deductibles, etc.

If you are under 16 years of age, you should be aware that your parents, in most cases, can view your records without your permission. However, we can refuse to allow that to happen without a court order.

_____ _____

Signature of Patient (if minor over 12 years of age) **Signature of Parent / Guardian Date**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal law that provides privacy protections and patient rights regarding the use and disclosure of protected health information (PHI) that is used for the purpose of treatment, payment, and healthcare operations. HIPAA requires that **Mindfulness LLC** post and provide you with a Notice of Privacy Practices to inform you of your rights as well as how your information can legally be used and disclosed. This notice is included in the Notice of Information Practices and Privacy Statement and you may request a separate copy of the currently effective notice at any time. **Mindfulness LLC** has the right to change the terms of this notice from time to time and is required to provide you with an updated copy if and when that occurs. It is very important that you read this notice carefully before you initiate treatment with **Mindfulness LLC**.

HIPAA requires that we obtain your signature acknowledging that we have provided you with this information. You may refuse to sign this acknowledgment, in which case we must document our good faith effort to obtain acknowledgment and the reason why it was not obtained. I, the undersigned, hereby acknowledge that I have received a copy of the currently effective NOTICE OF INFORMATION AND PRIVACY PRACTICES for **Mindfulness LLC.** A copy of this signed and dated document shall be as effective as the original.

I, _____, have received a copy of this office's notice of privacy practices.

_____

PLEASE PRINT NAME

_____

SIGNATURE

_____

DATE OF SIGNATURE

For Office Staff Use Only

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICE, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED DUE TO:

_____ INDIVIDUAL REFUSED TO SIGN
_____ COMMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
_____ AN EMERGENCY SITUATION PROHIBITED US FROM OBTAINING ACKNOWLEDGEMENT

_____ OTHER: _____

_____ _____

SIGNATURE OF PROFESSIONAL **DATE OF SIGNATURE**

Reason for your visit/why are you here? _____

Please explain more about this issue: _____

_____

_____

Are there any more issues you have?_____

_____

Family Members: _____

Relationships: Are you in a relationship? (Circle all that apply) Married Betrothed Committed Casual

Do you have friends? _____ Are they close? _____

Do you have trouble with them? _____

_____

Do you have pets? ▫ Yes ▫ No What kind? _____

Military Service: ▫ Active ▫ Retired ▫ National Guard ▫ None Discharged: ▫ Yes ▫ No Honorably: ▫ Yes ▫ No

Branch: _____ Position and Rank: _____

Psychiatric / Substance Abuse Information

Substance Category	Common Names (Circle all that apply)	Never Used	Did Use But Quit	Less than one time per month	1-4 times per month	1-4 times per week	1+ times per day	Age first used
Caffeine	Coffee/tea, No Doz, Soda/Pop, Chocolate, Energy drinks							
Tobacco	Cigarettes, Snuff, Cigars, Chewing Tobacco							
Alcohol	Beer,Wine, Hard Liquor							
Marijuana	Marijuana, Dabs, Hashish, Grass, Reefer, Hash Oil							
Cocaine	Coke, Snow, Crack, Rock, Blow, Nose Candy							
Other Stimulants	Amphetamines, speed, Crank, Dexedrine, Diet Pills							
Inhalants	Glue, Gasoline, Aerosols, Dusters, Poppers, Rush, Nitrous Whippets							
Opiates	Codeine, Vicodin (Hydrocodone), MS Contin Kadian (morphine)							
Hallucinogens	LSD, Peyote,Mescaline, PCP, Acid, Mushrooms, Ecstasy							
Depressants	Benzodiazepines, Klonopin, Xanax, Ativan, Valium, Pentobarbital							
Over the Counter Drugs	Cold Pills, Diet Pills, Cough Syrup, Compose, Sleep Aids, Mini-Thins, Yellow Jackets							

Have you ever been treated for alcohol or drug use or abuse? ▢ Yes* ▢ No

*If yes, for which substances, when, and where were you treated? _____

_____

ONLY For Minors / Children:

Where were you born? _____ Birth weight: _____ pounds _____ ounces

Were there any developmental delays? ▢ No ▢Yes: _____

_____

Name of School Attending: _____ Grade: _____

Are there any learning problems? ▢ No ▢Yes: _____

_____

Current Job: _____ Length of time there: _____ How long have you been working? _____

Medical History:

Primary Care doctor name, address, phone number: _____

_____

Name of any other medical doctor you currently receive treatment from, the reason/condition seen for, name, address, phone number: _____

_____

Medical Issues:

Date: Reason:

_____

_____

Past Surgeries:_____

_____

Head Injuries/Concussions/Headaches: _____

_____

Date last Eye Exam: _____ Date last Dental Exam: _____

Special Diet: _____

Current medications (include name, dose, and reason you are prescribed/taking): _____

_____

_____

Past psychiatric medications (include name, dose, and reason you are prescribed/taking): _____

_____

MEDICATION Allergies: _____

_____

REGULAR Allergies: _____

_____

Is there any information that you would like to add? _____

_____

_____

_____

_____

Please check the following words that apply to you:

▫ Social / Outgoing	▫ Assertive	▫ Impulsive	▫ Note liked by others	▫ Intelligent
▫ Not easily depressed	▫ Out of control	▫ Impatient / Edgy	▫ Can't concentrate	▫ Self controlled
▫ Resourceful	▫ Unimaginative	▫ Disrespectful	▫ Creative	▫ Mostly able to relax
▫ Can forgive	▫ Patient	▫ Isolated / Loner	▫ Full of hate	▫ Financially stressed
▫ Respects others	▫ Bottled up	▫ Worthless	▫ Perfectionist	▫ Can ask for help
▫ Unstable	▫ Unattractive	▫ Stable	▫ Secure	▫ Have enough money
▫ Insecure	▫ Secure	▫ Faithful	▫ Physically unattractive	▫ Can accept love from others
▫ Motivated	▫ Happy	▫ Confident	▫ Shy / Backwards	▫ Worthwhile / "good enough"
▫ Stupid / Dumb	▫ Unfaithful	▫ Lazy	▫ Unmotivated	
▫ Depressed	▫ Easily discouraged	▫ Passive / Pushover	▫ Tense most of the time	

▫ Other- Description: _____

Please check the following words that apply to you:

▫ Death of a child/spouse	▫ In-law troubles	▫ Death of a close friend	▫ Death of a close family member
▫ Divorce	▫ Marital separation	▫ Major injury or illness	▫ Detention or jail/other institution
▫ Marriage	▫ Fired from work	▫ Marital reconciliation	▫ Retirement
▫ Major change in health	▫ Pregnancy	▫ Sexual difficulties	▫ Major change in behavior of family member
▫ Gaining a new family member	▫ Change in financial state	▫ Change in job	▫ Change in amount of arguments with spouse
▫ Taking on a significant mortgage	▫ Foreclosure on mortgage	▫ Default on loan	▫ Change in responsibility at work
▫ Child leaving home	▫ Began formal schooling	▫ Trouble with boss	▫ Graduated formal schooling
▫ Major change in spiritual activities	▫ Minor violations of the law	▫ Vacation	▫ Major change in social activities
▫ Change in eating habits	▫ Stressful Holiday	▫ New school	▫ Change in residence

▫ Other - description: _____

Please check any of the following issues you are currently having:

- ▫ Custody issues
- ▫ Substance abuse
- ▫ Interpersonal problems
- ▫ Anger problems
- ▫ Depression
- ▫ Behavior of adult children
- ▫ Substance dependence
- ▫ Unfaithful partner
- ▫ Parenting problems
- ▫ Financial difficulty
- ▫ Health problems in family
- ▫ Excessive computer use
- ▫ Distance from loved one
- ▫ School problems
- ▫ Grief
- ▫ Personal health problems
- ▫ Problems with pornography
- ▫ Gambling
- ▫ Victim of physical/sexual abuse
- ▫ Family relationships

Please check any of the symptoms that apply to you:

Physical	**Emotional**	**Thoughts**	**Behaviors**
▫ Headaches	▫ Sadness	▫ Memory problems	▫ Using drugs or alcohol
▫ Bowel/stomach	▫ Worry	▫ Paranoia	▫ Avoiding loved ones
▫ No appetite	▫ Overexcited	▫ Confusion	▫ Missing work or school
▫ Dizziness	▫ Agitated	▫ Repetitive thoughts	▫ Laugh or cry inappropriately
▫ Tremors	▫ Panicky	▫ Racing thoughts	▫ Nervous habits
▫ Muscle weakness	▫ Nervous	▫ Attention problems	▫ Losing temper
▫ Fainting spells	▫ Empty	▫ Thoughts of escape	▫ Becoming violent
▫ Hair, skin problems	▫ Grieving	▫ Decision problems	▫ Risky behaviors
▫ Jaw problems	▫ Despair	▫ Poor judgment	▫ Grind teeth
▫ Reproductive problem	▫Hopelessness	▫ Hallucinations	▫ Less or more sexual contact
▫ Sexual problems	▫ Fits of rage	▫ Disorganized thinking	▫ Less or more sleeping
▫ Excessive sweating	▫ Jealousy	▫ Other symptoms:	▫ Other symptoms:
▫ Heart problems	▫ Moodiness	_____	_____
▫ Heart racing/pounding	▫ Desire to cry	_____	_____
▫ Nausea	▫ Resentment	_____	_____
▫ Fatigue	▫ Frustration	_____	_____
▫ Other Symptoms:	▫ Inadequacy	_____	_____
_____	▫ Other Symptoms:		
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____			

Please explain what you have done to cope with the symptoms and issues you have checked above: _____

_____

_____

_____

Patient Medication Reconciliation

Name: _____ DOB: _____ Date: _____

Your preferred Pharmacy: _____

Mail-In Pharmacy: _____

Psychiatric Medications you are currently taking: _____

_____

Systemic (all other) Medications and Doctor that prescribes them, including vitamins and supplements:

_____

_____

Birth control (if applicable): _____

Primary Care Physician and contact information: _____

_____

Specialty Physician and contact information: _____

_____

_____

_____

Review of Systems:

Please list any places you have problems: _____

_____

Updated Patient Information and Consent

Payment Policy

We require payment in full for outstanding balances before seeing any provider. If you cannot pay the balance you will be offered a payment plan. If you refuse to pay and decline the payment plan, your appointment may be canceled or rescheduled and you may be charged a late-cancellation/no-show fee. If you do not have insurance, or we do not participate with your insurance, you are considered self-pay and may qualify for our Sliding Fee Scale with reduced payments for those at or below 200% of poverty level. If you need any assistance paying your bill please let the front desk know.

No-Show/Late-Cancellation Policy

We schedule our appointments so that each person has the right amount of time with our providers, that's why it is important to keep your appointment. Mindfulness also sends out a reminder a day in advance for your appointment. If you cannot keep your appointment please contact us so we may reschedule you, and accommodate others who are waiting for an appointment. If you are going to be late to your appointment, please contact the office ahead of time, if you are more than 15 minutes late to your appointment with no notice you will be rescheduled and charged a $75 no-show fee. If you do not cancel or reschedule your appointment with at least a 24 hour notice you will be charged a $75 no-show fee which is not reimbursable by your insurance and will be billed directly to you. After three consecutive no-shows our office may terminate our services to you.

Consent Information for Facetime/Phone Appointments

PLEASE READ THE FOLLOWING AND ACKNOWLEDGE THAT YOU UNDERSTAND AND ACCEPT ALL PROVISIONS BY SIGNING ON THE NEXT PAGE. When you have an appointment via Facetime or phone call you will receive healthcare services such as assessment, treatment, or diagnosis using audio and video. You will not be in the same room as your provider. You will receive the same level of care that you would receive in person from your provider. Our providers take every step to ensure their servers are safe to use, but it is not guaranteed that your personal servers/Apple device is, which could potentially release personal information. This is extremely unlikely to happen, but in the event it does occur, Mindfulness is not responsible for any private information released. By using FaceTime or phone appointments you are aware of the potential risks associated with it.

Patient Acknowledgment and Consent

I have read this form carefully and fully understand its contents. I understand I am to pay my bill, or make arrangements to pay my bill, before seeing my provider or I will be charged a late-cancellation fee as well as have my appointment rescheduled. I understand that if I cannot make my appointment I need to cancel or reschedule with at least 24 hour notice or I will be charged a no-show fee of $75 that I will be responsible for. I understand that if I have three consecutive no_shows my services at Mindfulness may be terminated. I understand that I cannot be anymore than 15 minutes late to my appointment or I will be rescheduled and charged a fee. I understand and agree that if I decide to have my appointment virtually via Facetime or phone call, it is not guaranteed that the servers are completely confidential and in the event my information may be released due to this Mindfulness cannot be held responsible for that.

Name: _____

DOB: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Signature: _____ Todays Date: _____

MINDFULNESS
HOLISTIC WELLNESS & HEALING

712 6th Street Saint Marys WV 26170

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name: _____ Date of Birth: _____

I understand that as a subscriber to Mindfulness, LLC I am eligible to receive a range of services at Mindfulness Holistic Wellness & Healing. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me.

The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that if I "no show" or cancel my appointment with less than 24 hours notice, this will count against my total number of sessions.

I understand that all information shared with the clinicians at Mindfulness is confidential and no information will be released without my consent. My Mindfulness treatment records are electronic and stored on a secure server as part of my Mindfulness treatment records. Access to Mindfulness records by Mindfulness providers and vice versa is done only on a need to know basis (e.g., referral for medication, evaluations for eating disorders, etc.).

In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provide Mindfulness services. All professionals-in-training are supervised by licensed staff.

I understand that while psychotherapy and/or medication may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

I understand that Mindfulness therapists may routinely videotape therapy sessions. I Understand that such recording(s) will be used only for educational purposes within Mindfulness and that the professionals involved will respect and protect the confidential nature of the sessions. I understand that the tapes will be the property of Mindfulness and are deleted on a regular basis. I also understand that if I object to being videotaped. It will, in no way, jeopardize my relationship with Mindfulness but may result in my having to change therapists.

If I have any questions regarding this consent form or about the services offered at Mindfulness, I may discuss them with my therapist. I have read and understood the above. I consent to participate in the evaluation and treatment offered to me by Mindfulness. I understand that I may stop treatment at any time.

Signature: _____ Date: _____

Mindfulness Holistic Wellness & Healing
Drug Testing Authorization and Consent Form

I, _____, hereby knowingly and voluntarily authorize and consent to the collection and testing of specimens (urine, blood, or saliva) by your office staff for the purpose of random drug testing.

I authorize the laboratory site (Mako Medical and/or Pac Tox) to disclose the results of my drug test(s) to Mindfulness Holistic Wellness and Healing, LLC. I acknowledge that the drug test results will be utilized by Mindfulness Holistic Wellness and Healing to determine my eligibility for and/or continuation of controlled substance prescriptions.

I acknowledge that at the time of collection, a refusal to authorize the collection and testing of my specimen by the office staff, or a refusal to authorize the above disclosure of the test results from the laboratory site will be treated as a positive and/or failed drug test. I also further acknowledge that a positive and/or failed drug test will result in disciplinary action up to and including termination of services.

I acknowledge that I have the right to receive a copy of this authorization.

I also acknowledge that this authorization and consent is valid for 2 years from the date it is signed.

I have read and understand the above authorization and consent in its entirety, and I agree that a copy of this document is as valid as the original.

Please be aware: if you are prescribed or are found to be positive for Suboxone, you will NOT be prescribed any controlled substances.

_____ _____ Client Signature

Date

_____

Client's Parent/Guardian Signature if a Minor

_____

Client's Printed Name

_____

Mindfulness Holistic Wellness and Healing Witness Signature

MINDFULNESS
HOLISTIC WELLNESS & HEALING

Controlled Substance Contract

Patient Responsibility

1. I agree to take any Controlled Substances exactly as instructed. I am NOT allowed to change the dose or number of times per day that I take my medication without first talking to my Controlled Substance Provider. **____ (Initial)**

2. I will NOT take Controlled Substances written by another provider or specialist unless I have notified my provider prior to filling the prescription. This includes Suboxone, Methadone & Medical Marijuana. **____(Initial)**

3. I agree to safekeeping of my Controlled Substances and medications. I understand that lost, misplaced or stolen prescriptions or medications will not be replaced unless a police report is filed. **____(Initial)**

4. I will bring in all my Controlled Substances in their original container to every appointment. **____(Initial)**

5. I will bring in all my Controlled Substances in their original container within 24 hours of request for random pill counts. **____(Initial)**

6. I will be responsible for making and keeping appointments for Controlled Substance refills at least every 1 month. Terms of appointment keeping are in your Patient Intake Form. **____(Initial)**

7. I will be responsible for having a working phone number on file which the office will use to contact me about random Drug Screens and pill counts. I understand that once notified by the office, either directly or by voicemail I will have 24 hours to report. Inability to report is a violation of this contract. **____(Initial)**

8. I understand that not all insurances cover the cost of Drug Screening and that I may be responsible for part or all of the bill. **____(Initial)**

9. I understand that I will not receive Controlled Substances until my provider has been able to review my medical records. If I am a new patient it is my responsibility to ensure my medical records have been obtained from my previous provider and this practice has results of Initial Drug Screen. **_____(Initial)**

10. I understand it is my responsibility to make sure the Initial Drug Screen has been done. **_____(Initial)**

11. **I will not lie or tell misleading information to my provider to obtain Controlled Substances. _____(Initial)**

12. **I will not get angry or make threatening remarks to ANY provider or staff member in an attempt to obtain Controlled Substances. _____(Initial)**

MINDFULNESS
HOLISTIC WELLNESS & HEALING

Controlled Substance Contract

Provider Responsibility

1. I will provide the best evidence based care for your condition.
2. I will help set functional goals with you.
3. I will obtain a random drug screen at least 4 times a year or anytime we deem necessary.
4. I will only refill Controlled Substances at your designated medication refill appointment.
5. I will assess the risk/benefit/safety of your medications including.
    - Side effects
    - Functional abilities
    - Pain Control

Consequences of NOT adhering to any part of this contract:

1. Mindfulness Holistic Wellness & Healing and our providers will no longer:
    - Prescribe any Controlled Substance for you. It will be at the provider's discretion if a taper of medication will be given.
    - May stop providing medical care for you.
    - May refer you for drug abuse treatment.

Consequences of NOT signing this contract.

1. We will not prescribe Controlled Substances to you.

Should you be discharged from our practice due to breakdown of provider/patient communication, your provider will provide 30 days of care from the date of discharge. This may not apply to Controlled Substances if the reason for discharge was a violation of this contract.

SIGNATURES

Date:_____ Time:_____ Patient/Guardian Signature:_____

Print Patient First Name: _____ Print Patient Last Name:_____

Date:_____ Time:_____ Provider Signature:_____

Print Provider First Name: _____ Print Provider Last Name:_____