Maltman Medical Center   Health Information Questionnaire

Name ______________________________ Date Of Birth ______________________

Male ____ Female____ Marital Status __________________________________

Social Security # __________________________ Phone # ________________________

Address ____

E-Mail ____ (to access Patient Portal)

Primary Insurance

Insurance __________________________

Member ID __________________________

Group # ____________________________

Name of Subscriber ____________________

Relationship to Patient __________________

Subscriber DOB ______________________

Subscriber SSN ______________________

Secondary Insurance

Insurance __________________________

Member ID __________________________

Group # ____________________________

Name of Subscriber ____________________

Relationship to Patient __________________

Subscriber DOB ______________________

Subscriber SSN ______________________

It is OK to contact me via: ☐ Phone for appt reminders ☐ Text Message
☐ Email for appt reminders

Preferred Pharmacy Name:____

Location/Phone # ____

Emergency Contact: ________________________ Phone #___________________________

What is the Reason for Visit Today? ____

How did you hear about our clinic? (circle all that apply)

Family/Friend   Facebook   Twitter   Google   Radio   TV   Flyer   Sign

Referral from another Provider _________________________

Festival _____________________________ Other _________________________________

Maltman Medical Center

PATIENT CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Maltman Medical Center (MMC), through it's individual physicians, providers, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician/provider and provided by Maltman Medical Center.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the provider/physician or Maltman Medical Center.

I acknowledge that I have received a copy of Maltman Medical Center's Notice of Privacy Practices and I understand that the notice is also posted at each location where services are provided and on the internet at www.maltmanmedical.com. I consent to be called on my cell phone/home phone concerning healthcare services rendered to me, messages may be left on my voice mail, and receiving email or postal mail related to healthcare services.

To protect against the transmission of blood borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test by blood for certain diseases while I am a patient at Maltman Medical Center. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my provider/physician and that the results of all test will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

______________________________	______________________________
Patient Name	Patient Signature
______________________________	______________________________
Witness	Date

Patient, ______________________________ is a minor, or is unable to sign.

______________________________	______________________________
Person Giving Consent	Relationship to Patient
______________________________	______________________________
Witness	Date

Maltman Medical Center
Consent & Financial Responsibility

This consent is required by the Health Insurance Portability and Accountability Act of 1995 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice
I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed. If such restriction is requested, it must be done in writing.

Consent for Care
I, with my signature, authorize the providers of MMC, and any employee working under the direction of the Nurse Practitioner/Physician/PA to provide medical care for me, or to this patient for which I am the legal guardian or representative. This medical care may include services and supplies related to my health (or the identified person) and may include, but not limited to, preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information and Assignment of Benefits
I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy
We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received. I understand that I am responsible for all co-payments, amounts applied to deductibles, co-insurance, and other amounts that may be deemed my responsibility by the payment sources; as required by my contract with my insurance plan and state regulations. I understand that if I have an insurance co-payment I am expected to make payment when checking in for my appointment.
I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. Maltman Medical Center is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving services. For example, not all health plans cover health screenings as a benefit. If I seek care outside the contract terms of my plan, I am aware that I will be responsible for all charges that are incurred.

Maltman Medical Center is a Nurse Practitioner owned and operated facility.

Thank you for your understanding and cooperation with this policy. It is our privilege to provider your medical care.

I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above. I have received and read the Privacy Notice (HIPAA) and agree to the terms.

____

Patient/Responsible Party Date

Previous Primary Care Provider ______________________________

Location/Phone # ______________________________

Last seen ____________ Last Physical ____________ Last Labs ____________

Medication ALLERGIES & Reaction ______________________________

____

____

What Medications are you CURRENTLY taking? (attach list if necessary)

Medication	Dose	Times per Day	Prescribed By	Do You need a refill today?

VACCINE History (provide approx.. date given)

Influenza (Flu) ____________ Tetanus ____________

Pneumonia ____________ Shingles ____________

Please check any symptoms (PROBLEMS) below that you are **currently experiencing:**

Constitutional
___Fever/Chills
___Feeling poorly
___Feeling Tired
___Recent weight gain/loss
___Night Sweats

EYES
___eye pain
___Red eyes/Discharge
___Vision Changes
___Dry eyes
___Itchy eyes

ENT
___Earache
___Sore Throat
___Nasal congestion/discharge
___Nosebleeds
___Hoarseness
___Hearing loss

Cardiovascular
___Chest pain
___Irregular heart beats
___Lower extremity edema
___Leg cramps
___Pain with exercise
___Slow heart rate
___Fast heart rate

Respiratory
___Shortness of breath
___Shortness of breath during exertion
___Cough
___Wheezing
___Shortness of breath lying down or at night

Gastrointestinal
___Nausea and/or vomiting
___Abdominal pain
___Diarrhea
___Constipation
___Heartburn
___Trouble swallowing

Endocrine
___Excessive thirst/urination
___Drooping of eyelid
___Hot or Cold Intolerance
___Hair loss
___Generalized weakness

Genitourinary
___Dark or bloody stool
___Pain with urination
___Frequency/urgency of urination
___Night time urination
___Hesitancy
___Incontinence (loss of urine/stool)
___Blood in urine
___Genital lesion
___Difficulty with menstrual periods
___Erectile dysfunction

Musculoskeletal
___Joint pain
___Muscle pain
___Joint swelling
___Joint stiffness
___Limb pain/swelling
___Muscle cramps/weakness

Integumentary
___Skin rash
___Itching
___Skin lesions
___Change in mole/lesion
___Breast lump/pain

Neurological
___Headache
___Dizziness
___Mental changes
___Fainting
___Limb weakness
___Difficulty walking
___Numbness
___Tremor
___Radiating pain

Psychiatric
___Anxiety
___Depression
___Suicidal/homicidal thoughts
___Personality changes/irritability
___Sleep disturbances

Blood/Lymph
___Easily bruising/bleeding
___Swollen glands

FAMILY History Have any members of your immediate family (**Parents, Siblings, Grandparents, Children**) ever had: (List Family Member)

Breast Cancer ____________________
Colon Cancer ____________________
Other Cancers ____________________
Thyroid Disease ____________________
Hypertension (high blood pressure) ____________________
Stroke ____________________
Heart Problems ____________________
Diabetes ____________________

SOCIAL HISTORY Circle Answer

Able to care for self Yes/No
Live alone or with others alone/with others
Advance Directive Yes/No
Are you currently employed? Yes/No
Occupation ____________________
General stress level? Low/Med/High
Number of Children ____________________
Alcohol intake Mild/Mod/Heavy
Caffeine intake Mild/Mod/Heavy
Illicit Drugs? Yes/No
List Drugs ____________________
____
Exercise level Mild/Mod/Heavy
Diet Regular/Healthy/Low Carb/Low Sugar
Hard of Hearing/deaf one/both ears Yes/No
Legally Blind Yes/No
Sexually active? Yes/No
Protected Sex? Yes/No
Smoking status Yes/No
Smoking how much? ____________________
Has smoked since age ____________________
Passive smoke exposure? Yes/No
Chewing Tobacco? Yes/No
Tobacco years of use ____________________

SURGICAL History

____
____
____
____
____
____

GYNECOLOGICAL History

Last PAP ____________________
Any Abnormal PAP Yes/No
OBGYN MD ____________________
Had HPV Vaccine? Yes/No
Sexually Active? Yes/No
Change in partner in last 6 mths? Yes/No
History of STI/STD's Yes/No
Age at first child birth ____________________
Current birth control method
____
Desired Birth Control Method
____
Last Menstrual Period
____
Date of last Mammogram
____
Total Births ____________________
Premature ____________________
Miscarriage ____________________
Full Term ____________________
Ectopic ____________________

Hysterectomy Partial/Full
Ovaries Remaining Left/Right
Approx. Year ____________________

PAST MEDICAL HISTORY

ADD/ADHD Yes/No
AIDS/HIV Yes/No
Abuse/Domestic Violence Yes/No
Acid Reflux (GERD) Yes/No
Acne Yes/No
Allergies (Food, Seasonal, Environment)
Yes/No ____________________
Allergies/Hayfever Yes/No
Anemia Yes/No
Anesthesia Complications Yes/No
Anxiety Disorder Yes/No
Arthritis Yes/No
Asthma Yes/No
Autism Spectrum Disorder(ASD) Yes/No
Autoimmune Disease Yes/No
Bedwetting Yes/No
Birth Defects or Inherited Disease Yes/No
Bladder/Kidney Problems Yes/No
Blood Diseases Yes/No
Blood Transfusion Yes/No
Breast Cancer Yes/No
Breast Problem Yes/No
COPD Yes/No
Cancer Yes/No
Cervical Cancer Yes/No
Chicken Pox Yes/No
Chronic Ear Infections Yes/No
Congestive Heart Failure Yes/No
Constipation Yes/No
Coronary Artery Disease Yes/No
Depression Yes/No
Depression/Postpartum Yes/No
Dermatologic Disorders Yes/No
Developmental or Behavioral Disorders
Yes/No
Diabetes Yes/No
Difficulty Swallowing Yes/No
Diverticulitis Yes/No
Drug/Latex Allergies Yes/No
Ear or Hearing Problems Yes/No
Eating Disorder Yes/No
Eczema Yes/No
Endometriosis Yes/No
Fibromyalgia Yes/No
GI Problems Yes/No

Gestational Diabetes Yes/No
Gout Yes/No
Headaches Yes/No
Heart Disease Yes/No
Heart Problems Yes/No
Hematologic Disorders Yes/No
Hepatitis Yes/No
Hepatitis/Liver Disease Yes/No
High Cholesterol Yes/No
History of STI/STD Yes/No
History of Abnormal PAP Yes/No
Hospitalizations ____________________
____
____
Hypertension Yes/No
Hyperthyroidism Yes/No
Hypothyroidism Yes/No
Infertility Yes/No
IV Drug Use Yes/No
Kidney Stones Yes/No
Kidney Disease Yes/No
Liver Disease Yes/No
Lung Disease Yes/No
MRSA Exposure Yes/No
Meniere's Disease Yes/No
Mental Disorder Yes/No
Muscle, Joint, Bone Problems Yes/No
Neurologic/Epilepsy Yes/No
Osteopenia Yes/No
Osteoporosis Yes/No
Ovarian Cancer Yes/No
Polycystic Ovaries Yes/No
Pre-Eclampsia Yes/No
Pulmonary (TB, Asthma) Yes/No
Reflux/GERD Yes/No
Seizures/Epilepsy Yes/No
Skin Problems Yes/No
Stroke Yes/No
Thrombophilias Yes/No
Trauma/Violence Yes/No
Tuberculosis Yes/No
Varicosities Yes/No
Vision/Eye Problems Yes/No

List ANY and ALL SPECIALISTS You Have Seen or Currently See

Provider Name	Specialty	Location	Phone Number

Dentist Name ______________________ Last Seen ______________________

Date of Last Colonoscopy? ______________________
Any abnormalities or polyps? ______________________

If **DIABETIC** Last Foot Exam ______________________
Last Eye Exam ______________________

Are you currently seen by a Pain Management Specialist? Yes/No
Name of MD ______________________

MALE PATIENTS

History of Testicular Cancer? Yes/No Family
History of Prostate Cancer? Yes/No Family

Office Policies

******Initial Each Line******

_____ If you are 15 mins late for your appointment, we ask that you reschedule. This is a courtesy to our patients and providers.

_____ There will be a $25 fee for **"No Show's" & Cancellations** that occur less than 24 hours prior to your appointment time. Insurance does NOT COVER this cost, it is an out of pocket expense.

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call **at least 24 hours in advance to cancel or reschedule your appointment.**

If for any reason you need to cancel an appointment, please notify our office as soon as possible.

After three consecutive no-show occurrences, the practice may elect to terminate our relationship with you.

_____ As a courtesy to all of our patients and providers, we ask that you be 15 mins early for your appointment to allow for check-in and paperwork.

_____ **Refill Requests**: Allow 48 hours for refill requests to be filled. DO NOT wait until you are out of a medication to request a refill.

_____ Refills & Appointment Requests will NOT be granted via the On-Call phone.

_____ If your **Deductible has not been met**, $100 PLUS your Co-Pay is due prior to seeing the Provider. This money will go toward your deductible and if there is an outstanding balance above this, you will receive a paper bill for the balance via the mail.

_____ **Co-Pays & Outstanding Balances** are due PRIOR to seeing the Provider.

Patient Name: ______________________________________

Signature: ____

Date: ____

Authorization for Disclosure of Medical Information

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed under this authorization may be subject to redisclosure by the recipient and no longer protected under federal privacy regulations.

Patient Name: ______________________________ **Date of Birth:** ______/______/__________

Address: ________________________________ **Phone Number:** (   )______-__________

____

Facility/Provider to Release: ____

Covering the period (s) of health care: ______/_________ to ______/_________

INFORMATION TO BE DISCLOSED: ____Complete Health Record

OR ONLY THE FOLLOWING: ____History & Physical ____Progress Notes ____Billing/Financial

____Labs/Imaging ____Consult Reports ____Other:__________

Facility/Provider to Receive:

____ Maltman Medical Center 9051 Executive Park Dr Suite 500 Knoxville, TN 37923

P: 865-337-7793 F: 865-240-3539

____Victory Treatment Program 9051 Executive Park Dr Suite 202 Knoxville, TN 37923

P: 865-337-7812 F: 865-240-3539

For the purposes of: Continuing Patient Care at the request of the patient.

I understand I have the right to refuse to sign this form and that my refusal will not result in the medical provider(s) limiting or not providing healthcare to me with the following exceptions: 1. Refusal to sign authorization if it is for disclosure of information created for research that includes treatment, may result in the medical provider declining to provide the research-related treatment. 2. Refusal to sign this authorization, if its disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. I also understand this authorization will expire one year from the date it is signed. I further understand that I may revoke in writing at any time.

I understand by signing below that I am giving specific consent to release information related to testing and treatment for HIV, AIDS, STI, mental/psychiatric care, or alcohol/drug abuse if such is contained in the medical record.

Patient Signature: ________________________________ **Date:** ______/______/__________

Witness: ____ **Date:** ______/______/__________

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol) =

8-9 oz. of malt liquor (about 7% alcohol) =

5 oz. of wine (about 12% alcohol) =

1.5 oz. of hard liquor (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at *www.who.org*.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING <u>0</u> + ______ + ______ + ______

=Total Score: ______

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

RELEASE OF LIABILITY

READ CAREFULLY - THIS AFFECTS YOUR LEGAL RIGHTS

In exchange for participation in the activity of Outpatient Detoxification from Opiates or Alcohol organized by Victory Treatment Program, of 9051 Executive Park Drive Suite 202, Knoxville, Tennessee, 37923 and/or use of the property, facilities and services of Victory Treatment Program, I,

____agree for myself and (if applicable) for the members of my family, to the following:

1. AGREEMENT TO FOLLOW DIRECTIONS. I agree to take prescribed medications only as instructed. I agree to not take more than the prescribed dosage or amount, and further agree to follow any oral instructions or directions given by Victory Treatment Program, or the employees, representatives or agents of Victory Treatment Program.

2. ASSUMPTION OF THE RISKS AND RELEASE. I recognize that there are certain inherent risks associated with the above described activity and I assume full responsibility for personal injury to myself and (if applicable) my family members, and further release and discharge Victory Treatment Program for injury, loss or damage arising out of my or my family's use of or presence upon the facilities of Victory Treatment Program, whether caused by the fault of myself, my family, Victory Treatment Program or other third parties. I have been informed of all risks involved, including respiratory depression/arrest, cardiac arrhythmias/arrest, and/or death and agree to release and discharge Victory Treatment Program from all responsibility.

3. INDEMNIFICATION. I agree to indemnify and defend Victory Treatment Program against all claims, causes of action, damages, judgments, costs or expenses, including attorney fees and other litigation costs, which may in any way arise from my or my family's use of or presence upon the facilities of Victory Treatment Program.

4. APPLICABLE LAW. Any legal or equitable claim that may arise from participation in the above shall be resolved under Tennessee law and all costs will be paid by myself in regards to all legal, court fees.

5. NO DURESS. I agree and acknowledge that I am under no pressure or duress to sign this Agreement and that I have been given a reasonable opportunity to review it before signing. I further agree and acknowledge that I am free to have my own legal counsel review this Agreement if I so desire prior to signing this document. I further agree and acknowledge that Victory Treatment Program has offered other forms of treatment (inpatient detoxification) as an alternative treatment option if I choose not to sign this Agreement.

8. ENFORCEABILITY. The invalidity or unenforceability of any provision of this Agreement, whether standing alone or as applied to a particular occurrence or circumstance, shall not affect the

validity or enforceability of any other provision of this Agreement or of any other applications of such provision, as the case may be, and such invalid or unenforceable provision shall be deemed not to be a part of this Agreement.

9. EMERGENCY CONTACT. In case of an emergency, please call ________________ (Relationship: ________________) at ________________ (Day), or ________________ (Evening).

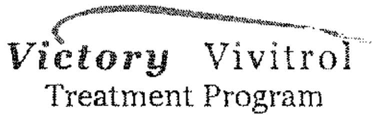
I HAVE READ THIS DOCUMENT AND UNDERSTAND IT. I FURTHER UNDERSTAND THAT BY SIGNING THIS RELEASE, I VOLUNTARILY SURRENDER CERTAIN LEGAL RIGHTS.

Dated: ____________________

Signature: ____

Witness

____

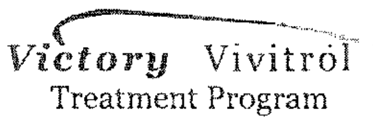


Treatment Program

9051 Executive Park Dr.
Suite 202
Knoxville, Tn 37923
(865)337-7812 Fax (865)240-3539
www.victoryvivitrolclinic.com

Victory Vivitrol Treatment Program Informed Consent

I understand that Vivitrol is an injection that is given once a month and is NOT a narcotic.	
I understand that I need to be opiate free for 5-7 days from all opiate drugs including hydrocodone, oxycontin, morphine, and heroin before taking the Vivitrol injection.	
I understand that I may have opiate withdrawal symptoms if I have opiates in my system, even if I have not taken any opiates in two weeks. Opiate withdrawal symptoms include anxiety, nausea, vomiting, abdominal pain, diarrhea, muscle aches and pain, and runny nose. These symptoms may be severe in some cases.	
I understand that if I take opiates or alcohol after having the Vivitrol injection, I will NOT feel the effects by getting high or having pain control, but it **COULD RESULT IN OVERDOSE OR DEATH**.	
I understand that if I attempt to override the blocking mechanism of opiate receptors (how the Vivitrol injection works) by taking opiates, **IT IS POSSIBLE TO OVERDOSE AND DIE**.	
I understand if I take even a small amount of opioids after I receive the Vivitrol injection **OVERDOSE OR DEATH IS POSSIBLE**.	
I understand that I will be more sensitive to opioids, thus putting me at risk for overdose or death: after detoxification, during Vivitrol treatment, and after Vivitrol treatment.	
I understand that I should be free from using Suboxone or Methadone for **AT LEAST 14 days** before starting the Vivitrol injection due to the increased **risk of sudden opioid withdrawal and possible death.**	
I understand that it is at the discretion of my provider whether or not I am a candidate for Vivitrol treatment. If advised to complete an inpatient detoxification program by my provider, arrangements will be made for me to do so by my provider. If I choose to go against my provider's medical advice and not complete inpatient treatment; my provider, the staff at Victory Vivitrol Treatment Program (DBA Maltman Medical Center), and Maltman Medical Center are not responsible for any adverse effects I may experience.	
I understand that I must complete counseling as designated by my provider as part of the treatment program to obtain maximum benefit from the Vivitrol injection. Failure to do so can result in dismissal from the program. I may be asked to provide proof of such counseling to my provider or the staff at any time.	
I understand that I should not take Vivitrol if I have acute infectious hepatitis.	
I understand that I will have blood tests to screen for certain diseases and damage done by use of opiates. These test include Hepatitis panel, HIV, Lipid panel, etc.	



Maltman Medical Center
9051 Executive Park Dr.
Suite 202
Knoxville, Tn 37923
(865)337-7812 Fax (865)240-3539
www.victoryvivitrolclinic.com

I understand that Vivitrol is not recommended during pregnancy and that the effects are unknown. I understand it is my responsibility to have an adequate birth control method. One can be prescribed by my provider at Victory Vivitrol Treatment Program if needed.	
I understand potential side effects from the injection are redness, swelling, discomfort or pain at the injection site. Other side effects may include nausea, vomiting, fatigue, dizziness, or headache.	
I understand that Vivitrol is FDA approved for alcohol and opioid dependency.	
I understand risks involved with Vivitrol and have had an opportunity to have my questions answered.	

I,____, have been educated on all of the above information related to Vivitrol treatment and given the opportunity to have my questions answered.

Patient Signature____Date ____________________

Staff Signature ____Date ____________________

Maltman Medical
Center
9051 Executive Park
Dr.
Suite 202
Knoxville, Tn 37923
(865)337-7812
Fax (865)240-3539

I,____, give permission for the staff and providers at Victory Vivitrol Treatment Program to discuss my care with my counselor at anytime.

Patient Signature____Date ____________________

Staff Signature ____Date ____________________