Intensive Health
a stepworks company

Patient Registration Form

Name: _____ Today's Date: _____ /_____ /_____

Social Security Number: _____ /_____ /_____ Date of Birth: _____ /_____ /_____

_____

Street Address City State Zip

Cell Phone: _____ Other Phone: _____

Email: _____

Preferred Language: ❒ English ❒ Spanish ❒ Other

Gender: ❒ male ❒ female ❒ other

Pronouns: ❒ he/him ❒ she/her ❒ them/they

Marital Status: ❒ single ❒ married ❒ separated ❒ divorced ❒ widowed

Ethnicity: ❒ Asian ❒ black ❒ Hispanic ❒ white ❒ North American native ❒ other ❒ unknown

Power of Attorney

Do you have a medical power of attorney, living will, or advance directive? ❒ yes ❒ no ❒ I don't know
If you have one of the above, please bring a copy for your records. If you have questions about this, ask your provider during your visit.

Primary Insurance

Insurance Name: _____

Member ID: _____

Group Number: _____

Insurance Holder: _____

Date of Birth: _____ /_____ /_____

Social Security number: _____ /_____ /_____

Relationship: ❒ spouse ❒ parent ❒ child ❒ other

Secondary Insurance

Insurance Name: _____

Member ID: _____

Group Number: _____

Insurance Holder: _____

Date of Birth: _____ /_____ /_____

Social Security number: _____ /_____ /_____

Relationship: ❒ spouse ❒ parent ❒ child ❒ other

I authorize the **release of any medical information** necessary to process all insurance claims. Further, I release **payment of medical benefits** to Stepworks Recovery Centers LLC.

I understand that I am fully responsible for **payment at the time of service** and any unpaid account balances including but not limited to, co-payments, co-insurance, and deductibles not paid by my insurance carrier. Accounts not paid in full within 30 days may be subject to a finance charge of up to 18% annually. In addition, should my account become delinquent and referred to a collection agency, I understand that I will be responsible for the balance owed on the account plus all costs incurred in collecting the balance.

_____ _____ _____ /_____ /_____

Patient Signature or Legal Representative Relationship to Patient Date

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Consent to Treat

Patient Name: _____ Date of Birth: _____ / _____ / _____

I consent to receive any necessary medical treatment, including assessment and evaluation, examinations, treatment/services such as diagnostic tests, medications, minor procedures, and psychotherapy, as deemed appropriate by my healthcare provider at Stepworks Intensive Health ("Intensive Health").

I understand:

- the potential benefits and risks associated with treatment;
- psychotherapy may elicit uncomfortable thoughts, feelings, and troubling memories;
- medications may have unwanted side effects;
- my responsibility to tell my provider about any unexpected or unwanted side effects; and
- that I am responsible for my personal safety.

Telemedicine Consent

I consent to receive treatment services via telemedicine. I understand:

- It is my responsibility to maintain adequate phone/computer/internet connectivity.
- There are inherent privacy and security risks associated with telemedicine and online data, though medical privacy/confidentiality laws also apply to telemedicine.
- I may withdraw my consent at any time without losing my right to future treatment.
- My healthcare provider may decide a traditional face-to-face encounter is more appropriate.
  - The provider may stop the telemedicine visit at any time and schedule a face-to-face visit.
  - Technical difficulties may also necessitate an in-person visit.
- While I may expect to benefit from telemedicine services, positive results cannot be guaranteed.
- I am responsible for telemedicine fees, including copays, coinsurance, and deductible amounts.
- If my visit ends prematurely, I must contact Intensive Health (270)765-5900 immediately to reschedule.

Release of Liability

- Intensive Health is not responsible for lost or stolen items.
- I hereby release, waive, and discharge from, and covenant not to sue Stepworks Recovery Centers, LLC (dba Intensive Health), its officers, servants, agents, and employees (hereinafter referred to as releases) on account of any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or relating to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, whether caused by the negligence of the releases or otherwise, while I am a patient at Intensive Health, or while in, on, or upon the premises where treatment is being conducted, while in transit to or from the premises, or in any place or places connected with Intensive Health.
- It is my express intent that this release shall bind the members of my family and spouse if I am alive, and my heirs, assigns, and personal representative if I am deceased, and shall be deemed as a release, waiver, discharge, and covenant to not sue the above-named releases.

Consent to Video Surveillance and Recording

I understand that Intensive Health uses video surveillance and recording of the following:

- waiting room, front desk, nurses station, group therapy areas, and most public areas.

This technology supports the security of our facility, the integrity of our programs, and our quality improvement efforts. Video recordings are stored at the sole discretion of Intensive Health. They are not a part of your health record and will not be released as part of any records release. In the event of alleged rule-breaking, video recordings may be used to assess actions and potential consequences. These video recordings will not be sold, distributed, displayed, or used for any unlawful purpose. By signing this document and consenting to the items herein, I hereby specifically acknowledge and approve the use of video surveillance and recording and release any personal rights to these recordings.

Non-Discrimination Policy

Intensive Health serves all patients regardless of inability to pay. We pledge to serve all patients; offer discounted fees for patients who qualify (based on family size and income); not deny services based on race, color, sex, age, national origin, disability, religion, gender identity, sexual orientation, or inability to pay; and to accept insurance, including Medicaid and Medicare.

Signature

By signing this document, I agree and consent to all of the above, and I have been given the opportunity to ask questions and have had them answered to my satisfaction.

Patient or Legal Guardian Signature: _____

Date: _____ / _____ / _____ Time: _____:_____ A. M. / P. M.

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HIPAA Authorization

Patient Name: _____ Date of Birth: _____ / _____ / _____

HIPAA Notice of Privacy Practices

By signing this form, you acknowledge you have received Stepworks Intensive Health ("Intensive Health") "HIPAA Notice of Privacy Practices." This describes how we might use or disclose your protected health information. It also discusses your rights and our duties with respect to your protected health information. You have the right to review the "HIPAA Notice of Privacy Practices" before signing this acknowledgment.

Authorization for Disclosure of Substance Use Information for Treatment, Payment, and Healthcare Operations (TPO)

By signing this form, you authorize Stepworks and/or Intensive Health and any past, present, or future provider with Stepworks and/or Intensive Health to disclose your health information, including records related to substance use, for the purposes below:

- **Treatment** - for example, we may disclose your records to a hospital for your continued treatment
- **Payment** - for example, your health information may be shared with your insurance company to allow Intensive Health to be paid and determine if you are eligible for services
- **Healthcare Operations -** for example, your information may be shared for administrative, financial, legal, and quality improvement activities necessary in healthcare operations

If your records are disclosed for the purposes above, your records may be redisclosed and no longer protected under the specific confidentiality rules for records related to substance use under 42 CFR Part 2 regulations.

Rights

You may revoke this authorization in writing at any time. You may also refuse to sign this authorization. However, if you do not sign this authorization or revoke your consent, you understand that you may be denied services as Intensive Health may not be paid for services. Your revocation does not apply to disclosures made before you chose to revoke this authorization. You have the right to receive a copy of this authorization.

Signature

By signing this document, I agree and consent to all of the above, and I have been allowed to ask questions and have had them answered to my satisfaction.

Patient or Legal Guardian Signature: _____

Date: _____ / _____ / _____ Time: _____:_____ A. M. / P. M.

OFFICE USE ONLY

Authorization Revoked: _____ /_____ /_____ Supervisor Signature: _____

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Controlled Substance Contract

Patient Name: _____ Date of Birth: _____ /_____ /_____

I agree to abide by the following guidelines for managing my prescriptions from Intensive Health.

1. All controlled substances must come from a provider at Intensive Health unless discussed beforehand.
2. I will inform any other providers (including dentists, specialists, ER physicians, etc.) of my agreement with Intensive Health. No changes will be made to my treatment plan without the other provider contacting this office.
3. If my medicines are lost or stolen, I understand they will not be refilled early.
4. I understand my provider will not provide extra medication if I use all of my medication before refills are due.
5. I understand that I may suffer withdrawal symptoms if I run out of my medication early.
6. If I have difficulty taking the medication as prescribed, I will discuss this with my provider at a scheduled office visit.
7. I understand that my provider may require monitored or unmonitored drug screenings and pill counts as part of my controlled substance contract.
8. If asked to complete a random drug screen or pill count, I understand that this must be completed within 24 hours of the request or by the time line indicated by the provider.
    a. If I do not adhere to this timeline, I understand my treatment plan could change.
9. When asked to provide a drug screen, I understand that I may not leave the office. If I leave the office, I fail my drug screen.
10. If I fail a drug screening at any time during my treatment, I understand my provider may stop prescribing controlled substances for me.

Initial the Following

_____ I will take my medication as instructed and prescribed. I will not take more medication than is prescribed.

_____ I will not abuse alcohol or other drugs, illicit or not.

_____ I will not sell or share controlled substance medications.

_____ I will use Stepworks Pharmacy to fill all of my controlled substance prescriptions. Should I need to change pharmacies, I will inform Intensive Health.

If I violate the terms of this contract, I understand that the providers at Intensive Health may no longer prescribe controlled substance medications for me. If this occurs, I may continue with my current provider, but I will not receive controlled substance medications from Intensive Health. I agree that my provider has permission to discuss all diagnostic and treatment details with other healthcare providers, pharmacists, and professionals who provide my healthcare regarding my use of controlled substances for purposes of maintaining accountability.

Patient Signature: _____ Date: _____ /_____ /_____

Provider Signature: _____ Date: _____ /_____ /_____

❑ Tom Ingram, MD ❑ Greg Smith, MD ❑ Joyce Johnson, APRN ❑ Jen Cothern, APRN ❑ Sherri Bunch, APRN ❑ Cassie Baker, APRN

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Health History Questionnaire

Patient Name: _____ Date of Birth: ____ /____ /_____ Date: ____ /____ /_____

Allergies: ❑ Latex ❑ Food ❑ Medication

Explain: _____

Medical History

❑ heart disease ❑ heart attack ❑ lung disease ❑ infections (hepatitis, endocarditis, etc.)

❑ stroke ❑ diabetes ❑ thyroid disease ❑ genetic disease

❑ neurological problems ❑ stomach problems ❑ seizures ❑ kidney disease

❑ bone or joint problems ❑ ectopic pregnancies ❑ cirrhosis ❑ blood disease, clotting

other: _____

Surgical History

_____

_____

Mental Health History

❑ depression ❑ anxiety ❑ bipolar ❑ schizophrenia ❑ personality disorder ❑ other: _____

Family Medical History

❑ heart disease ❑ diabetes ❑ cancer ❑ substance use ❑ mental health

Preventative Care History

Item	Yes	No	Don't know	Approx. Date	Item	Yes	No	Don't know	Approx. Date
flu vaccine in past year	❑	❑	❑		colonoscopy	❑	❑	❑	
COVID vaccine	❑	❑	❑		mammogram	❑	❑	❑	
hepatitis B vaccine	❑	❑	❑		pap smear	❑	❑	❑	
physical exam	❑	❑	❑		prostate exam	❑	❑	❑	
TB skin test	❑	❑	❑		STD/HIV testing	❑	❑	❑	
hepatitis C test	❑	❑	❑		hepatitis B test	❑	❑	❑	

Do you see other medical or behavioral health providers? If so, list them below. ❑ no other providers

_____

_____

Social History

❑ in a relationship ❑ children (❑ in the home ❑ not in the home) ❑ high school diploma or GED

❑ employed (❑ full-time ❑ part-time)

❑ experienced trauma/abuse ❑ homeless within the past two years ❑ difficulty reading

Who do you live with? _____

Do you have trouble accessing any of the following? ❑ food ❑ housing ❑ transportation ❑ clothes ❑ employment ❑ none

Substance History

Tobacco use: ❑ never used ❑ do not currently use ❑ cigarettes ❑ vape ❑ chew ❑ snuff

Do you have a history of drug or alcohol abuse? ❑ yes ❑ no

If yes, explain: _____

Substance Use Treatment History ❑ not applicable

Type of Treatment	Currently	In the past	If in the past, approx. date
MAT: ❑ Suboxone ❑ Methadone	❑	❑	
Residential	❑	❑	
PHP	❑	❑	
IOP	❑	❑	
sober living	❑	❑	
support group meetings	❑	❑	
counselor	❑	❑	
case manager	❑	❑	

Patient Signature: _____ Date: ____ /____ /_____

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Sexual Health Questionnaire

Patient Name: _____ Date of Birth: ____ /____ /_____ Date: ____ /____ /_____

Part 1 - Preliminary Screening

These questions help us determine your risk of sexually transmitted infections (STIs), including viral hepatitis. **Please answer honestly.**

Have you ever had unprotected sex (sex without a condom) in the past year?

- ☐ yes
- ☐ no

Have you had multiple sexual partners in the last year or has your partner had multiple partners?

- ☐ yes
- ☐ no

Are you at high- risk for infections transmitted through the blood (sharing needles, a partner with hepatitis or HIV, traded sex for drugs, a blood transfusion before 1992)?

- ☐ yes
- ☐ no

Have you ever been diagnosed with an STI in the past?

- ☐ yes
- ☐ no

If you answered "yes" to anything above, proceed to Part 2.
If all of your answers were "no," your screening is complete.

Part 2: Detailed Screening

This section helps us gather more specific information about your potential risk factors.

How many sexual partners have you had in the last twelve months?

- ☐ 1-2
- ☐ 3-5
- ☐ 6 or more

Do you know the STI status of your current or recent sexual partners?

- ☐ yes
- ☐ no
- ☐ unsure

Have you ever been vaccinated for hepatitis B?

- ☐ yes
- ☐ no
- ☐ unsure

When were you last tested for a STI or Hepatitis?

- ☐ 1-3 months
- ☐ 4-6 months
- ☐ more than 6 months ago
- ☐ unsure

In the past year, have you noticed any unusual symptoms (like sores, itching, or unusual discharge) in your genital area?

- ☐ yes
- ☐ no
- ☐ unsure

Do any of your close family members have a history of viral hepatitis?

- ☐ yes
- ☐ no
- ☐ unsure

If you answered "yes" or "unsure" to anything above, your provider will discuss whether more information or further actions are necessary.

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Authorization to Release Health Information to Significant Other or Emergency Contact

If you wish us to be able to speak to your family member or friend, complete this form. Without this signed form, we cannot even confirm you are a patient at Intensive Health if your loved one calls. This form is optional.

Patient Name: _____ Date of Birth: _____ / _____ / _____

I authorize Stepworks Recovery Centers (dba Intensive Health) to release the indicated information to the individuals listed below. I understand that I can revoke my consent at any time except when disclosure has already taken place.

Individual One

Full Name: _____ Phone Number: _____

Relationship: ▢ spouse ▢ parent ▢ child ▢ other_____

Is this person your emergency contact? ▢ yes ▢ no

Type of Information to be Released: (check all that apply)
▢ appointment ▢ financial ▢ medical ▢ mental health ▢ drug and alcohol use
▢ information related to HIV/STDs/hepatitis

Individual Two

Full Name: _____ Phone Number: _____

Relationship: ▢ spouse ▢ parent ▢ child ▢ other_____

Is this person your emergency contact? ▢ yes ▢ no

Type of Information to be Released: (check all that apply)
▢ appointment ▢ financial ▢ medical ▢ behavioral health ▢ drug and alcohol use
▢ information related to HIV/STDs/hepatitis

▢ **Decline**

This information has been disclosed for records protected by federal confidentiality rules (42 CFR Part 2). Federal rules prohibit anyone from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

Patient/Legal Representative Signature: _____ Date: _____ / _____ / _____

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Consent to Individual One Revoked

Date: _____ / _____ / _____ Team Member Name: _____ Initials: _____

Consent to Individual Two Revoked

Date: _____ / _____ / _____ Team Member Name: _____ Initials: _____

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Authorization for Release of Protected Health Information

Complete this form to have your previous medical records forwarded to Intensive Health. If you need extra copies for more providers, let the front desk know. This form is optional, but it is helpful to our providers to have your most recent medical records.

Patient Name: _____ Date of Birth: _____ / _____ / _____

Social Security Number: _____-_____-_____ Phone Number: _____

I authorize the following medical/behavioral health provider or entity:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

to release the following medical records:

▢ **ALL MEDICAL RECORDS** including any information related to the diagnosis and treatment of alcohol or drug abuse (SUD), mental health, hepatitis, STD, and/or HIV/AIDs

▢ **SPECIFIED Medical Records:**

- ▢ **ALL** records from _____ / _____ / _____ to _____ / _____ / _____ (including SUD, mental health, HIV, STD, & hepatitis records)
- ▢ progress notes (including SUD, mental health, HIV, STD, or hepatitis)
- ▢ progress notes (nothing related to SUD, mental health, HIV, STD, or hepatitis)
- ▢ lab results (except HIV/hepatitis/STD)
- ▢ HIV/hepatitis/STD lab results
- ▢ radiology and other diagnostic testing
- ▢ treatment plan
- ▢ discharge summary
- ▢ biopsychosocial evaluation
- ▢ other _____

If requesting a specific date range for these specified records, please provide that here: _____ / _____ / _____ to _____ / _____ / _____

for continuity of care to:

Intensive Health
201 Peterson Drive
Elizabethtown, KY 42701

FAX: 270-982-1284
PHONE: 270-765-5900

I understand I can revoke my consent at any time except when disclosure has already taken place, in which case consent will expire 90 days from the date on which this form was signed.

This information has been disclosed for records protected by federal confidentiality rules (42 CFR Part 2). Federal rules prohibit anyone from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

Patient/Legal Representative Signature: _____ Date: _____ / _____ / _____

OFFICE USE ONLY

Release Sent: _____ / _____ / _____ Team Member Name: _____ Initials: _____

Records Received: _____ / _____ / _____ Team Member Name: _____ Initials: _____