CENTER FOR EMOTIONAL HEALTH®

Identification - For the protection of our patients, and to reduce medical identity theft, all patients are required to present a valid insurance ID card AND a driver's license OR a valid photo ID at the time of service. You may email these items to info@cehcharlotte.com

Missed Appointments - There will be a $85.00 fee for any missed appointments unless the appointment was canceled or rescheduled at least 24 hours in advance. It is still considered a no show, even if you do not receive a courtesy call. If you incur this $85.00 fee, we cannot refill prescriptions, comply with requests for record transfers, or any other requests until this fee has been paid. Any balance must be paid prior to receiving any services. If you receive three (3) no shows, you are subject to being discharged.

Inappropriate Behavior - Patients may be discharged due to disruptive behavior or non-compliance of treatment.

Late Appointments - If a patient is 5 minutes late for a follow-up medication management appointment, OR 15 minutes late for an initial appointment, OR 15 minutes late for a follow up appointment with a therapist, the patient must reschedule.

Prescription Refills - It is the patient's responsibility to schedule a follow up appointment BEFORE the prescription runs out to ensure a continued supply of the prescription. If you are prescribed medication, you will be provided an initial prescription and refills to last until the suggested follow up visit. Medication refill requests will be denied if the patient fails to keep follow up appointments. Routine prescription refills will not be provided on the weekends.

Disability - As of Monday, April 4th, 2022, we will no longer be offering disability services to patients. However, we will continue to offer FMLA services as well as provide records for Disability cases that have been initiated outside of CEH. FMLA services will be subject to a fee that must be paid in advance.

Medical Records – Records can be released for a fee of $10.00. This fee must be paid in advance. All medical record requests are subject to be denied per office policy. Record requests may take up to 7-10 business days to be completed.

Custody: CEH does not participate in any type of custody preceding's or disputes. CEH has the right to discontinue services for custody related services.

Messages - Messages will be returned in the order of which they are received, however if it is an emergency, please call 911.

Parent/guardian(s) of children 12 and under must stay on the premises during the entire appointment. Patients 17 and under must be accompanied by a parent or legal guardian to all medication management appointments and other treatment services.

X _____ _____

Name of Patient (Please Print) Date

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

X_____ _____

Name of Parent/Legal Guardian (Please Print) Date

Above policies and procedures are not applicable to all CEH programs and services offered.

Compliance Assurance Notification

All health professionals and office staff continuously undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule.” We strive to achieve the highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of Personal Health Information (PHI) in accordance with HIPAA. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. We want to ensure our patients that our practice will not knowingly contribute in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implanted a Compliance Program that will help prevent any inappropriate use of PHI. Any questions regarding this policy may be directed to the Office Manager.

Patient’s Rights & Responsibilities

If you are or have been a patient of mental health services, you have the right to

● Access services that are appropriate to your disability, culture, language, gender, and age
● Be treated with respect and with due consideration for your dignity and privacy
● Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
● Participate in decisions regarding your health care, including the right to refuse treatment
● Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
● An individualized treatment plan to ensure quality care and coordination of care.

□ I acknowledge the above information and my patient rights and responsibilities. A copy of the patient rights and the consumer handbook for mental health from NC Department of Health and Human Services is available to me in each CEH office or by request.

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

Insurance Information

****We only bill primary insurance. No secondary insurance will be accepted****

Do you have Medicare? □ Yes/ □ No

Please be advised CEH does not accept Medicare as primary or secondary insurance. If at any time your insurance coverage changes to Medicare, you must inform the CEH billing department immediately. Patients who fail to inform the billing department may incur a balance, and/or are subject to discharge. Please sign below acknowledging that you do not have Medicare coverage and that you will inform CEH if there are any changes to your coverage.

Insurance Waiver and Authorization for Payment of Services

I understand that fees paid by my insurance company to CEH for specific services rendered are subject to change. All payments and balances must be paid in order to receive services. Upon receiving final accounting and payment from my insurance company, an additional payment may be required to settle my account with CEH.I understand it is my responsibility to inform the office if my insurance coverage changes at any point in time. I understand that I am financially responsible for any unpaid balance and/or charges not covered/paid by my insurance company. I authorize and request my insurance benefits be paid directly to CEH. This authorization will cover all treatment and services rendered until a written notice of cancellation is received.

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

Refund Policy

There are no refunds to services received for therapy, medication management, processing of forms, or completion of any paperwork, except where CEH is unable to provide services. In such case, the request for a refund must be reviewed by upper management. Patients that dispute charges for services rendered will be charged a $50 administration fee and will no longer be permitted to pay by credit card or debit card. All future payments must be paid in cash in order to receive services.

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

Patient Information

How did you hear about us? (circle one): Family/Friend/Internet/School/Other: _____
Reason for Visit:_____

Are you a veteran? Yes/No (If yes, please inform the provider you are seeing)

Patient's name (Last):_____ (First:) _____ MI: _____
Date of Birth: _____ Age: ____ Sex (circle one): M or F Marital Status: _____
Phone # (Home): _____ Cell #: _____

Home Address: _____
City: _____ State: _____ Zip Code: _____
Employer: _____ Occupation: _____
Emergency Contact (Full Name): _____ Relationship: _____
Phone #: _____ Alternate Phone #: _____

Current Symptoms Checklist

__ Depressed mood	__ Forgetfulness/concentration	__ Excessive guilt
__ Unable to enjoy activities	__ Increased risky behavior	__ Excessive worry
__ Sleep pattern disturbance	__ Racing thoughts	__ Loss of interest
__ Excessive energy	__ Impulsivity	__ Increased sex drive
__ Avoidance	__ Crying spells	__ Anxiety attacks
__ Decreased sex drive	__ Excessive drinking	__ Substance abuse
__ Fatigue	__ Change in appetite	__ Paranoia

General Questions
Local Pharmacy Name: _____ Phone #: _____
Specialist seen (other than CEH): _____ Phone #: _____
Current Therapist/Counselor: _____
Medication Allergies: _____
Other Allergies (foods, bees, soap, etc): _____
Current Medications (including over the counter):_____
Herbs, vitamins, supplements: _____
Your email address: _____
Primary Care Physician: _____
Primary Care Physician Contact Number: _____

□ **I authorize and consent for CEH to exchange/disclose my treatment or my child's treatment with the primary care physician listed above.**
□ **I do NOT authorize and consent for CEH to exchange or disclose my treatment or my child's treatment with the primary care physician listed above.**

X_____ _____
Signature of Patient (or Parent/Legal Guardian) Date

Consent to Treat for Adults

I, _____ do hereby consent to any medical care determined by Center for Emotional Health Medical Staff.

□ I consent to Outpatient Therapy □ I consent to Drug Testing

□ I consent to Medication Management □ I consent to any medical care determined by the CEH medical staff

X_____ _____

Name of Patient (Please Print) Date

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

Consent to Treat Minors

I, _____ (parent, or legal guardian), of _____, born _____, do hereby consent to any medical care determined by Center for Emotional Health Medical Staff for the welfare of my child.

□ I consent to Outpatient Therapy □ I consent to Drug Testing

□ I consent to Medication Management □ I consent to any medical care determined by the CEH medical staff

X_____ _____

Name of Patient (Please Print) Date

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

Urine Screen FAQ

Why do I need to provide a urine sample?

For your health and safety of our patients, CEH collects urine samples to comply with suggested federal guidelines. By monitoring urine samples CEH is able to:

• Understand the actual levels of drugs present in a patient

• Identify dangerous drug to drug cross-reactivity

• Monitor compliance with treatment plans

How often will I have to do this?

CEH complies with federal guidelines that require providers to limit patient drug diversion. Patients are subject to random drug testing.

How was I chosen?

This office will collect samples from ALL patients initially, as well as perform random collections for all patients who are prescribed medications

Who will see the results?

Our office staff and lab personnel are authorized to view your lab results.

** It is CEH policy that we cannot prescribe medication to patients that fail a drug test or have a prior history of substance abuse. We will be able to assist in alternative medications to treat patients.

_____ I consent to drug testing.

_____ I do not consent to drug testing. By checking this option, I will not receive any controlled medications. I have reviewed this form and agree to the CEH policy above.

X _____ _____

Name of Patient (Please Print) Date

X_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

"The patient health questionnaires on the next page only need to be completed by patients 16 and older"

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PATIENT HEALTH QUESTIONNAIRE - 9
(PHQ - 9)

Over the last 2 weeks, 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 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 have been better off dead or of hurting yourself in some way	0	1	2	3

For office coding _____ _____ _____ _____

= total score _____

If you checked off any problems, how difficult 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

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MOOD DISORDER QUESTIONNAIRE

1. Has there been a period in time when you were not your usual self and...

... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? Yes ☐ No ☐

... you were so irritable that you shouted at people or started fights or arguments? Yes ☐ No ☐

... you felt much more self confident than usual? Yes ☐ No ☐

... you got much less sleep than usual and found you didn't really really miss it? Yes ☐ No ☐

... you were much more talkative or spoke much faster than usual? Yes ☐ No ☐

... thoughts raced through your head or you couldn't slow your mind down? Yes ☐ No ☐

... you were so easily distracted by things around you that you had trouble concentrating or staying on track? Yes ☐ No ☐

... you had much more energy than usual? Yes ☐ No ☐

... you were much more active or did many more things than usual? Yes ☐ No ☐

... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night Yes ☐ No ☐

... you were much more interested in sex than usual? Yes ☐ No ☐

...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky? Yes ☐ No ☐

...spending money got you or your family in trouble? Yes ☐ No ☐

2. If you have checked YES to more than one of the above, have several of these ever happened during the same period of time? Yes ☐ No ☐

3. How much of a problem did any of these cause you - like being unable to work; having family money or legal troubles; getting into arguments or fights?

No problem	Minor problem	Moderate problem	Serious problem
☐	☐	☐	☐

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunt, uncles) had manic-depressive illness or bipolar disorder? Yes ☐ No ☐

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? Yes ☐ No ☐

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VIVITROL AGREEMENT

I understand that Dr. Stoudmire is prescribing Vivitrol/Naltrexone to manage my alcohol dependence or opioid dependence. The risks, side effects and benefits of treatment have been explained to me, and I agree to the following instructions. Failure to follow these instructions may result in not having the medication prescribed.

1. I will participate in any other treatments recommended by my provider, including group therapy.

2. I will take my medications exactly as prescribed and will not change the medication or dosage without advance approval from any provider. I will provide my medication for pill counts at the provider's request. I will not request early refills.

3. I will keep regular appointments with my provider.

4. I will inform my provider within one business day if I am hospitalized for any reason, or if I have another condition that requires the prescription of a controlled drug (like narcotics, tranquilizers, barbiturates, or stimulants).

5. I will choose one pharmacy where all my prescriptions will be filled.
Pharmacy Name: _____
Phone Number: _____
Fax Number:_____
Address: _____

6. I understand that lost or stolen prescriptions will not be replaced, so I will keep my prescription and medication in a safe place or lock box. I will not under any circumstances sell, lend, or give my medication to others.
7. I agree to avoid all illegal and recreational drugs (including alcohol) and will provide urine or blood specimens at the doctor's request to monitor my compliance.

8. I agree to follow my doctor's recommendations regarding the operation of motor vehicles or heavy machinery while taking this medication.

9. Refills will be made only during regular office hours, which are Monday through Friday from 8:00 am to 5:00 pm. Refills will not be made at night, on weekends or during holidays. I am responsible for keeping track of my remaining medication, so that I can call for refills in advance. This way, I will not run out of medication.

Patient Name (print):_____
Patient Signature: _____ Date:_____
Provider Signature: Witness (optional):_____Date:_____

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Pregnancy Consent Form

The FDA has not approved suboxone/buprenorphine as completely safe for use during pregnancy. The decision on whether or not to continue the medication during pregnancy must be made after a full and open discussion of the risks and benefits of that decision.

It is important that you inform your doctor if you are now or intend to become pregnant.

Suboxone/buprenorphine can be a way to maintain pregnancy as healthfully as possible while also stopping use of the opiate of choice without triggering withdrawal symptoms that may cause a spontaneous abortion. Throughout the pregnancy your infant could become dependent on the drug. This can cause life threatening withdrawal symptoms in the infant after the infant is born. Adequate advance planning will allow for the greatest physical and mental well-being of mother and infant.

Signature:_____ Date:_____

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Footprints Program Patient Handbook

Welcome to the Footprints Treatment Program. We respect and support your decision to seek help in your recovery from addiction. We promise to recognize your strengths, respect you as a person, and help you develop skills for recovery.

Each part of the Footprints program has been designed to offer you a chance to make a new beginning for yourself and your family. Footprints invites you to work together with staff in a partnership to develop a plan to address your individual needs. We will help you set goals and work toward them. Communication is an important part of the Footprints program. We encourage you to share your needs, concerns, & opinions while taking time to listen.

The Footprints program strives to create an atmosphere where communication, caring and respect for oneself and others is recognized and appreciated. We seek to protect the health, security, and rights of all clients and staff. During your involvement as a Footprints patient, we promise to provide a safe and healthy environment. We know that discussions among a group of people can sometimes be difficult, however, group can also help you to develop important skills that will stay with you throughout your life. We hope that here you will learn to resolve conflicts, assert yourself appropriately and cooperate with others.

While participating in our program there will be some demands made of you and your time. We promise to always do what is in your best interest. You may not always agree with us or like our decisions, but your full cooperation and participation is vital for your success.

By enrolling in the Footprints program, you are making a commitment to yourself and your family and you are agreeing to abide by the guidelines of our program. We look forward to working with you in your recovery process.

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What can I expect when I start the Footprints program?

Footprints utilizes Medication-Assisted Treatment (MAT) in the treatment process. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery.

MAT is primarily used for the treatment of addiction to opioids such as heroin and prescription pain relievers that contain opiates. The prescribed medication operates to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative effects of the abused drug. Medications used in MAT are approved by the Food and Drug Administration (FDA), and MAT programs are clinically driven and tailored to meet each patient’s needs. Combining medications used in MAT with anxiety treatment medications and/or alcohol can be fatal. Types of anxiety treatment medications include derivatives of Benzodiazepine, such as Xanax or valium.

Recovery from addiction is a process. The first few weeks and months of treatment can be difficult, this is completely normal! Urges and cravings for your drug of choice can still be present and learning to adapt to a new lifestyle will take some time, so be patient with yourself. We will help you through the transition into recovery. Every patient will receive an initial psychological assessment and medication management consultation upon starting the program. At this time, we will work collaboratively with you to create an individualized treatment plan to address your specific needs and goals in recovery. Medication management, group and individual therapy sessions will be utilized to facilitate your treatment. Through this process you will learn coping tools that will aid in preventing relapse. Group therapy is exceptionally beneficial as you develop trust and accountability among group members as well as sharing courage, inspiration and hope.

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Rules and Procedures

In order to provide the best care for our patients, we utilize a level system where more intensive treatment is provided early in recovery. As goals are met for each level the patient will graduate to a less intensive level of care. All levels are formulated to help patients achieve and maintain their goals while utilizing medicated assisted treatment to improve quality of life. In order to graduate to each successive level, patients are required to adhere to program rules including negative drug/alcohol screens and punctual attendance.

Suboxone

Level 1: Introduction (first 2 months)

1. Once a week medication management
2. Once a week group or individual therapy session
3. Maintain negative alcohol/drug screens and punctual attendance

Level 2: Stabilization (month 6)

1. Once every two weeks medication management
2. Once every two weeks group or individual therapy sessions
3. Maintain negative alcohol/drug screens and punctual attendance

Level 3: Maintenance (month 6+)

1. Once a month medication management
2. Once a month group or individual therapy session
3. Maintain negative alcohol/drug screens and punctual attendance
4. Relapse prevention plan / Titration plan

Vivitrol

1. Once a month medication management
2. Once a month group or individual therapy session
3. Maintain negative alcohol/drug screens and punctual attendance
4. Relapse prevention plan

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Rules and Procedures

*** A positive drug screen includes any alcohol or illicit drugs including non-prescribed medications. Positive drug/alcohol screens will be considered program non-compliance and will require a mandatory individual therapy session in addition to current level requirements.

*** Individual, group, and medication management attendance/appointments must be maintained. Multiple late, missed, canceled, or rescheduled appointments will be considered program non-compliance.

*** Group and individual therapy attendance must be maintained per level requirements. Missed group and individual therapy appointments will require a make-up session prior to medication appointment. Three or more no shows for appointments or cancellations within a month period will be considered program non-compliance.

*** Medication management appointments not scheduled for seven (7) consecutive days will be considered program non-compliance. No medication management appointment can be missed unless approved by the program director. Missed medication management appointments will be considered program non-compliance.

***All level changes will be staffed by the Footprints staff and medical director. Patients must meet all level change criteria to be considered for a level change.

***PROGRAM NON-COMPLIANCE WILL RESULT IN PRE-ADMINISTRATIVE DISCHARGE OR DISCHARGE. FOOTPRINTS RESERVES THE RIGHT FOR IMMEDIATE DISCHARGE FOR ANY PROGRAM NON-COMPLIANCE.

Pre-Administrative Discharge

1. Once a week medication management
2. Once a week group or individual therapy session
3. Once a week mandatory individual therapy session
4. Maintain negative alcohol/drug screens and punctual attendance

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Group Expectations

1. Confidentiality - “what is said here stays here."
2. Use of "I" statements.
3. Talk about "what" rather than "why."
4. Stay in the “here and now”.
5. Honesty - try to be honest with yourself and others.
6. Try hard to practice good eye contact while speaking with others.
7. Share feelings.
8. Don't rescue. We grow by learning to work through the pain.
9. Try to be open to the experiences and feelings of others.
10. Don't interrupt while another group member is sharing.
11. Don't monopolize the group - all members have equal power.
12. Be on time!
13. No extended war stories.
14. Do not Personalize – “are they talking about me”.

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Program Expectations

1. All sessions will begin promptly
2. Attendance at all sessions is mandatory. Each absence will be noncompliance unless advance arrangements have been made with staff. Make-up sessions must be approved by staff.
3. Patients need to contact CEH 24 hours prior to your appointment time. Same day cancellations are considered no shows. No partial medications will be called in if appointments must be rescheduled.
4. As a courtesy to others, we reserve the right to reschedule your appointment if you are more than five minutes late for medication appointments or fifteen minutes late for therapy/group appointments. Same rules apply if you check in and then go outside to smoke or sit in your vehicle at the time of your appointment.
5. Total abstinence from mood altering drugs including alcohol is a requirement. You can expect to be given a random Breathalyzer or drug screen (observed or unobserved) at any time during treatment and if the result is positive you may be decreased a level or administratively discharged from the treatment program.
6. Treat all persons with respect while in or around Footprints/Center for Emotional Health. Physical or verbal abuse of other patients or staff will lead to administrative discharge.
7. Dress appropriately, no low-cut blouses or inappropriate shirts.
8. CEH is not responsible for child care, children should be accompanied by an adult or guardian at all times. Children under the age of 12 will not be allowed to be left alone in the lobby/waiting area. Children are not allowed to attend group, unless group is kid friendly ages 10 years and under. Regarding therapy sessions, the only exception is if children are in an infant carrier.
9. Random pill counts are an expectation in this treatment program. You must present with all medications that are prescribed as informed by the nurse/PA. You are responsible to provide current phone numbers to CEH. If you are unable to be reached for a pill count after multiple attempts this is considered program non-compliance.
10. Any hospitalizations, procedures, or ED visits, please bring in the discharge paperwork or a physician’s note for documentation.
11. Bring in all prescription bottles or vitamins/supplements that are new or currently prescribed for documentation, medication list will not be accepted.
12. I understand that lost or stolen prescriptions will not be replaced, so I will keep my prescription/medication in a safe place or lock box. I will not under any circumstances sell, lend, or give my medication to others.
13. Respect the confidentiality of peers and staff.

Patient's Right

All patients will be given equal treatment regardless of sex, race, religion, age or handicap.

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Footprints Program Patient Handbook

By signing this document, you understand and agree to the rules and expectations of the Footprints Treatment Program:

_____Print Name

_____Signature

_____ Date

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Footprints Program Telepsych Group Therapy Rules

Due to COVID in order to provide quality service, individual therapy sessions and all groups are currently being held via telepsych/zoom for the safety of our patients and staff of CEH. The following rules are being implemented to maintain a therapeutic learning experience.

1. Patients will need to confirm their appointment via the secure video invitation/link that is sent to your email at least 24 hours prior to the scheduled group/individual therapy session. If you do not receive your invitation/link via email, then you will need to contact CEH no later than 4 hours prior to your scheduled group/individual therapy session to have the link re-sent.

2. Patients will be required to participate in a setting that is preferably in a quiet room with no other people present. No participation while in a public space/outside, in a moving car, or any area where there is no privacy due to HIPPA regulations, unless approval is granted by the therapist prior to your scheduled group/individual therapy session.

3. Regarding children, have a family member or friend provide child care while the member is in the group/individual therapy session, unless you are in the scheduled kid friendly group session.

4. TV's, radios, or other personal electronic devices will need to be turned off or set in airplane mode if that feature is available.

5. Patients will need to ensure that you have a stable internet connection and that audio and video settings are properly operating.

6. Patients must be able to be seen and heard at all times.

7. Patients must actively participate in the group/individual therapy session by paying attention, listening, and responding when addressed. If a patient is sleeping or under the influence in a group/individual therapy session, you will be asked to reschedule your appointment and will not receive credit for the group/individual therapy session.

8. Failure to comply with any of the rules will result in removal from the group/individual therapy session and loss of credit. Consistent failure to follow group/individual therapy session rules will result in loss of telepsych group/individual therapy session privileges.

9. We reserve the right to reschedule your appointment if you are more than fifteen minutes late for group/individual therapy session appointments.

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Footprints Program Telepsych Group Therapy Rules

By signing this document, you understand and agree to the rules and expectations of the Footprints Treatment Program:

_____Print Name

_____Signature

_____ Date

PATIENT HIPPA AUTHORIZATION CONSENT FORM

This form authorizes release of your medical information for patient support services.

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

By signing and printing my name below, I authorize 1. my prescribing healthcare provider, 2. the healthcare provider who will administer VIVITROL to me, 3. the pharmacy(ies) to which my VIVITROL prescription is sent for fulfillment (the "Pharmacy"), and 4. my health plans and insurers (collectively, my "Healthcare Entities") to use and disclose to: 1. Alkermes, Inc. and the companies working with Alkermes, Inc. to provide the VIVITROL patient support services I request, which are United BioSource Corporation, IQVIA, Inc., (collectively, "Alkermes") and 2. my Contact(s) listed above (together with Alkermes, the "Recipients") health
information related to my medical condition, including information about my drug or alcohol addiction, my mental health condition(s), my treatment with VIVITROL, my insurance coverage, as well as the information requested in this form (taken together, "Information") for the specific purposes of allowing Alkermes to facilitate: 1. ordering, delivering and administering VIVITROL, 2. conducting reimbursement verification and obtaining payment from my health plan(s) and insurer(s), 3. providing me with educational and therapy support services by mail, text-messaging, e-mail, and/or telephone, which may include sending me product information materials, treatment reminders, and motivational messages, 4. referring me to, or determining my eligibility for, other programs, foundations or alternative sources of funding or coverage to help me with the costs of VIVITROL and 5. reviewing and analyzing fulfillment of VIVITROL prescriptions. Information May Be Further Disclosed: I understand that Information disclosed pursuant to this authorization could be re-disclosed by a Recipient and may no longer be protected by federal privacy law (HIPAA).

I understand that signing this authorization is voluntary and if I do not sign this authorization it will not affect my ability to obtain treatment, insurance, or insurance benefits from my Healthcare Entities. I understand, however, that if I do not sign this authorization, I will not be eligible to receive the educational, patient support, or other services described above, which are being provided by, or on behalf of, Alkermes. I will consult with my healthcare provider before making any treatment decisions. I understand I have the right to receive a copy of this authorization after I sign. I understand that the Pharmacy may receive payment from Alkermes, Inc. in exchange for Information.

I may withdraw this authorization at any time by mailing or faxing a written request to Vivitrol2gether, 852 Winter Street, Waltham, MA 02451, 1-877-329-8484.

☐ I Agree

By signing below, I authorize my Contact(s), listed below, to receive logistical and administrative information related to my treatment, such as appointment reminders, and to make decisions on my behalf—for which I will remain liable—regarding the delivery of VIVITROL® (naltrexone for extended-release injectable suspension). Alkermes is not liable for any decision(s) made by the Contact(s) or actions taken in reliance on such Contact(s) decisions.

☐ I Agree

By signing below, I authorize my Contact(s), listed below, to receive logistical and administrative information related to my treatment, such as appointment reminders, and to make decisions on my behalf—for which I will remain liable—regarding delivery of VIVITROL® (naltrexone for extended-release injectable suspension). Alkermes is not liable for any decision(s) made by the Contact(s) or actions taken in reliance on such Contact(s) decisions.

Please list any contacts authorized as set forth above:

Designee Name (1) _____ Designee Name (2) _____

Relationship (1) _____ Relationship (2) _____

Phone (1) _____ Phone (2) _____

CO-PAY SAVINGS PROGRAM INFORMATION FOR ELIGIBLE PATIENTS

By signing below, I certify that: I am at least 18 years old, and I am being treated for opioid dependence or alcohol dependence.

I am not enrolled in, or covered by, any local, state, federal, or other government programs that pays for any portion of medication costs, including but not limited to:

•Medicare, including Medicare Part D and Medicare Advantage plans
•Medicaid, including Medicaid Managed Care and Alternative Benefit Plans ("ABPs") under the Affordable Care Act
•Medigap

If my insurance changes, I will promptly notify Vivitrol2gether at 800-848-4876
eligibility. I understand the eligibility requirements described above.

☐ I Agree (Optional)

_____ _____

Patient Signature (or Authorized Representative) Date (MM/DD/YYYY)

_____ _____

Patient Printed Name Patient Date of Birth (MM/DD/YYYY)