VICTORY
Recovery Partners

Welcome to Victory Recovery Partners!

Simply put, it takes courage to face your addiction.

The Victory Recovery Partners staff is here to help guide, support, and encourage you on your journey to recovery. Our experienced team of caring and trusted professionals work together to ensure that each and every patient is given the best possible tools and support to be successful in reaching their goals. Everyone deserves the opportunity to regain control of his/her life and return to a productive and meaningful way of living.

Attached you will find our patient registration packet as well as various consents for treatment. Please fill out these forms in their entirety.

Victory Recovery Partners is currently certified by the New York State of Office of Addictions and Support Services. You will see several forms pertaining to "OASAS", please note that these are standard forms required by OASAS in order to engage in recovery services at Victory Recovery Partners.

Additionally, please return a copy of your photo ID and insurance card. Should you have any questions while filling this packet out, please feel free to reach out to one of our dedicated receptionists.

Packet Outline:

Pages 2-5 – Registration Forms – Required

Pages 6-9 – Consent for Alcohol/Drug Assessment & Treatment - Required

Pages 10-12 -- Treatment Contract/Patient Agreement – Required

Page 13 – Financial Agreement - Required

Page 14 – Consent for Medication History - Required

Page 15 – Confidentiality Agreement - Required

Page 16 – OASAS Justice Center Release – Required

Page 17 – LOCADTR Consent (for use in determining appropriate level of care) – *please enter your insurance name and ID number in the highlighted section, if you do not have insurance, you may leave this blank*. - Required

Pages 18-21 – Consent to send demographic/diagnostic information to our Laboratory for toxicology testing *(there is one form for each of the 4 different labs that we use)* - Required

Page 22 – OASAS Release of Insurance Benefits - Required

Page 23 – OASAS Release of Information - Required

Page 24 – Tele – Health Consent - Required

Page 25 – Criminal Justice Release - If you have legal involvement, please select the appropriate referring entity, this will allow Victory Recovery Partners to speak with them pertaining to your care.

Page 26 – Impaired Drivers System Release – Only applicable if you have been charged with a DUI/DWI

Page 27 – Patient Attestation Statement – Client Rights/Voluntary Basis /Experience Consent - Required

Page 28 – Emergency Consent - Please provide the name and relationship of your emergency contact - Required

Page 29 – PSYCKES Consent - Used to view your medical records from other Doctors/Hospitals (only applicable if you have Medicaid Insurance)

Patient Intake Form

VICTORY Recovery Partners

This form is completely confidential and will be a part of your medical record.

Demographic Information:

Patient Name:_____DOB: _____

Address:_____City:_____State:_____Zip:_____

Social Security #: _____ Gender: _____

Home Phone:_____ Is it okay to leave a message? ☐ Yes ☐ No

Cell Phone:_____ Is it okay to leave a message? ☐ Yes ☐ No

Race: ☐White ☐Black ☐Hispanic ☐Asian ☐Declined/Unknown ☐Other_____

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐OtherPreferred Language:_____

Email: _____ Can we text you appointment reminders?☐ Yes ☐No

Emergency Contact Name:_____Emergency Contact #: _____

Emergency Contact Relationship: _____

Mothers Name/Guardian (if under 21): _____

Fathers Name/Guardian (if under 21): _____

Name of Person filling out this form if not patient: _____

Current Occupation: _____

Current Occupation Status: ☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Disability

Pharmacy Information:

Pharmacy Name: _____ Address/City: _____

Health Insurance Information:

Primary Insurance Name:_____Policy #: _____

Policy Holder Name:_____Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Address:_____City:_____State:_____Zip:_____

Do you have a secondary insurance? ☐Yes ☐No

Name of Primary Care Physician:_____

How did you hear about us? ☐Walked/Drove By ☐Google Search ☐Family/Friend Referral ☐Social Media ☐ Newspaper ☐Doctor/Therapist Referral ☐Hospital/Detox ☐Legally Mandated ☐EAP/Employer ☐Other_____

Are you related to any member of the Victory team? No Yes, please list full name_____

Physical Health:

Medications:

List ALL Medications you CURRENTLY Take (Including Non-Prescription Medications and Herbal Supplements)		
Medication Name	**Dose**	**Times taken Daily**

Allergies: Please list all

1. Medication Allergies: _____
2. Food Allergies: _____
3. Environmental Allergies: _____
4. Latex Allergy: ☐Yes ☐No

Describe your physical health: ☐Good ☐Average ☐Poor

Are you currently under a doctor's care? ☐Yes ☐No

If yes, please provide doctor's full name: _____

Reason for care? _____

Have you been hospitalized in the past 6-12 months? If YES, please describe: _____

_____

Do you have any current concerns about your physical health? If YES, please specify: _____

_____

Do you have or have you ever had any of the following?

Aids or HIV	☐Yes ☐No	Epilepsy/Convulsions	☐Yes ☐No	Kidney Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting/Seizures	☐Yes ☐No	Liver Disease	☐Yes ☐No
Anorexia	☐Yes ☐No	Frequently Fatigued	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No
Arthritis	☐Yes ☐No	Glaucoma	☐Yes ☐No	Obesity	☐Yes ☐No
Asthma	☐Yes ☐No	Gonorrhea	☐Yes ☐No	Recent Weight Loss	☐Yes ☐No
Bulimia	☐Yes ☐No	Heart Attack	☐Yes ☐No	Stroke	☐Yes ☐No
Cancer	☐Yes ☐No	Heart Disease	☐Yes ☐No	Swollen Ankles	☐Yes ☐No
Chest Pain	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Syphilis	☐Yes ☐No
Chlamydia	☐Yes ☐No	Hepatitis	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Diabetes	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tuberculosis	☐Yes ☐No

Family History:

Check all that apply, Check here if history ☐Unknown

Present Health or Cause of Death	Present Age OR Age at Death		Relationship
Bleeding Disorder			☐ Mother ☐ Father ☐Sister ☐ Brother
Clotting Disorder			☐ Mother ☐ Father ☐Sister ☐ Brother
Diabetes			☐ Mother ☐ Father ☐Sister ☐ Brother
Stroke			☐ Mother ☐ Father ☐Sister ☐ Brother
Heart Disease			☐ Mother ☐ Father ☐Sister ☐ Brother
Hypertension			☐ Mother ☐ Father ☐Sister ☐ Brother
Cancer:_____			☐ Mother ☐ Father ☐Sister ☐ Brother
Drug Abuse			☐ Mother ☐ Father ☐Sister ☐ Brother
Alcohol Abuse			☐ Mother ☐ Father ☐Sister ☐ Brother

Mental Health Data:

Are you currently under the care of a Psychiatrist, Psychologist, Therapist, or Counselor? ☐Yes ☐No

If yes, please provider their name: _____

What mental health symptoms are you seeing the above for?_____

Substance Abuse Data:

What substances are you currently or do you have a history of using: _____

When was the last time you used? _____

When is your longest period of sobriety?_____

Have you ever overdosed on a substance(s)? ☐Yes ☐No If YES, Number of times you have overdosed: _____

From what substances(s) have you overdosed?_____

Do you consume alcohol? ☐Never ☐Occasionally ☐Heavily If yes, How many drinks per week_____

If former alcohol use, when was your quit date? _____

Tobacco Use:

Do you currently smoke cigarettes? ☐Yes ☐No

If YES, How many per day_____For how many years?_____

If a former smoker when was your quit date? _____

Do you currently use smokeless tobacco products? ☐Yes ☐No

Previous Substance Abuse Treatment:

Have you ever been in treatment for Substance Use Disorder? ☐Yes ☐No

If yes, when and where? _____

For what substances? _____

When is your longest period of sobriety?_____

Legal History Data:

In the past 12 months, have you been convicted? ☐Yes ☐No

If yes, was it a felony or misdemeanor? ☐Felony ☐Misdemeanor

Reason for conviction: _____

Have you ever had any drug or alcohol related arrests? ☐Yes ■No

Have you ever had a DWI/DUI (Driving While Intoxicated or Under the Influence)? ☐Yes ☐No

Are you currently on probation? ☐Yes ☐No Explain:_____

Do you currently have any pending charges? ☐Yes ☐No Explain: _____

CONFIDENTIALITY NOTICE: All intake information is protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR Pts 160 and 164 and cannot be disclosed without written consent unless otherwise provided for in the regulations. The Federal rules prohibit any further disclosure of this information unless a written consent is obtained from the person to whom it pertains. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

Consent for Alcohol and/or Drug Assessment & Treatment

VICTORY Recovery Partners

Name: _____ DOB: _____

I understand that as a patient of Victory Recovery Partners ("Victory") I am eligible to receive a range of services. 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 months.

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in an alcohol and/or drug assessment and/or treatment by staff from Victory. I understand that following the assessment and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable)
    e. Probable consequences of not receiving treatment.
2. **Benefits of Assessment & Treatment:** Assessment and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this assessment include diagnosis, assessment of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.
3. **Confidentiality:** Information from my assessment and/or treatment is contained in a confidential medical record at Victory, and I consent to disclosure for use by Victory staff for the purpose of continuity of my care. Per New York law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.
   I understand surveillance cameras are located throughout Victory for routine observation for the safety of our patients and staff.
   I understand that my alcohol and/or drug treatment records are protected under federal regulations 42 C.F.R. Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be disclosed without my written consent. I may revoke consents in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred.
   While information contained in substance use disorder patient's records is generally confidential under Federal law, reports of suspected child abuse or neglect are NOT protected and MUST be reported to the appropriate authorities.
4. **Right to Withdraw Consent**: I have the right to withdraw my consent for assessment and/or treatment at any time by providing a written request to the treating clinician. This consent for alcohol and/or drug assessment and treatment will expire 12 months from the date of signature, unless otherwise specified.
5. **Laboratory Testing and Reporting**: Laboratory testing, including, but not limited to blood work, may be requested. This testing may be to identify diagnosis of HIV, Hepatitis B or C or other bloodborne disease. Positive results from this lab work must be reported to the appropriate authorities. I authorize Victory to disclose any reportable infectious disease and information regarding that infectious disease to my local and

state health department for purposes of coordinating care. Only the minimum amount of protected health information needed to accomplish the intended purpose of the use is permitted for these disclosures.

6. **Toxicology Testing:** I understand that upon admission and throughout my course of treatment, I will be required to submit to a variety of toxicology tests, including urine drug testing, alcohol testing, pregnancy testing (if applicable), and blood/lab work testing. The treatment team and providers will determine the frequency of these tests. I give my consent to undergo all tests described above as they apply to me. I further give my consent to allow Victory to send my specimens to the laboratory for analysis.
7. **Informed Consent for Medically Assisted Treatment**: In accordance with evidence-based practices, Victory, upon assessment and evaluation and at the recommendation of a physician, physician assistant, or nurse practitioner may prescribe various medications to patients in recovery. These medications are used in conjunction with group counseling, individual counseling, and family counseling. Any medication I receive may have an adverse reaction and/or possible side effects, which I will be educated on at the time I am prescribed.
8. **Other Providers:** I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a substance use disorder treatment program, since the use of other medications in conjunction with medication assisted treatment prescribed by Victory may cause me harm.

Treatment with Buprenorphine (if applicable):

Buprenorphine is an FDA approved medication for the treatment of opioid addiction. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opiate addiction, including methadone, naltrexone, and some treatments without medications. The appropriate treatment plan for you will be determined by your medical provider.

Use of buprenorphine will maintain your physical dependence. If you discontinue it suddenly, you will likely experience withdrawal. If you are not already dependent, you should not take buprenorphine as it could eventually cause physical dependence. The medication you will be taking will likely contain both buprenorphine and an opiate blocker (naloxone). If the medication is abused by snorting or injection, the naloxone will cause severe withdrawal but when taken as directed, the naloxone has no effect.

If you are dependent on opioids you should be in as much withdrawal as possible when you take the first dose of buprenorphine/naloxone. If you are not in withdrawal, buprenorphine/naloxone can cause severe opiate withdrawal. We recommend that you arrange not to drive after your first dose, because some patients may experience drowsiness during the early phases of treatment. It may take several days to feel completely comfortable with the transition to buprenorphine/naloxone.

Combining buprenorphine with alcohol or other sedating medications is dangerous. The combination of buprenorphine with benzodiazepines (such as Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) has resulted in deaths. Although sublingual buprenorphine has not been shown to be liver-damaging, your doctor will monitor your liver tests while you are taking buprenorphine. (This is a blood test.) Attempts to override the buprenorphine by taking more opioids could result in an opioid overdose. You should not take any other medication without discussing it with your medical provider first.

I understand that buprenorphine products and other medication assisted treatment medications may interact with other prescription medications, vitamins and nutritional supplements. Potential interactions include increasing or decreasing the level of buprenorphine products in my body or, in extremely rare instances, possibly causing an abnormal heart rhythm that has the potential to be lethal. I agree that it is my responsibility to provide documentation of all medication, vitamins and nutritional supplements I am taking on at least a monthly basis.

I understand that I may withdraw from this treatment and discontinue when indicated the use of the medication at any time, and I shall be afforded medical withdrawal under medical supervision. The medically supervised withdrawal could be either a short-term withdrawal or long-term withdrawal. This will be at the discretion of the Medical Director/Provider. I understand that once I complete a medically supervised withdrawal, I may be offered an aftercare program of counseling.

I have read and understand these details about buprenorphine treatment, including risks and benefits. I understand there are alternatives and wish to be treated with buprenorphine if that is medication that the medical provider deems medically appropriate.

Treatment with Methadone (if applicable):

I understand that I have been diagnosed as suffering from opioid dependence (i.e. that I am or have been addicted to an opiate drug, such as heroin or oxycodone) and that it has further been determined that an appropriate treatment is opioid maintenance therapy, which involves the daily use of medication (methadone), along with medical and rehabilitative (counseling) services, to alleviate the adverse medical, psychological, or physical effects incident to opiate addiction. The overall goal of opioid maintenance therapy is improved quality of life and freedom from illicit drugs.

I understand that methadone does not cure addiction, and is itself an opioid drug, which is addictive and can have serious, even fatal, side effects. The most commonly reported side effects are constipation and sweating/flushing. It may also cause dizziness, especially after sitting or lying down; drowsiness; mood changes; vision problems; difficulty falling or staying asleep; and sexual side effects. Serious and sometimes fatal side effects include seizures; severe allergic reaction; slowed or difficult breathing; and irregular heartbeat, especially in patients with certain existing heart conditions (known as prolonged QT interval).

I understand that mixing methadone with other depressants (such as alcohol or benzodiazepines) is especially dangerous and will refrain from doing so. I agree to take methadone only as prescribed, and to inform other healthcare providers that I take methadone to avoid potentially harmful interactions. Until I know how methadone will affect me, I will use caution when driving or operating machinery. I have made the Medical Director/Provider aware of all medical conditions I have and medications (prescription, over-the-counter, or illicit) I take, and will keep this information current throughout treatment.

I understand that methadone maintenance therapy generally takes place over an extended period of time, but that I am free to discontinue treatment at any time. I understand that if I stop taking methadone suddenly that it may produce severe withdrawal symptoms. I understand that at periodic intervals, and with my full consultation, the Program will discuss my present level of functioning, my course of treatment, and my future goals.

I understand that all medical decisions, including, but not limited to, diagnosis and treatment, are made by the Medical Director/ Provider, and hereby release the Program from any and all liability arising from such decisions.

I understand that other treatments are available, including, but not limited to, inpatient treatment, detoxification programs, buprenorphine treatment, and abstinence programs.

I agree that I am not currently enrolled in another methadone maintenance program at this time. I understand State and Federal law prohibits dual enrollment in opiate treatment programs. I therefore give my consent to allow Victory to disclose my enrollment status, via fax, verbal confirmation or electronic transfer, to all opiate treatment programs in accordance with state and federal law guidelines. I further give my consent to allow Victory to disclose my enrollment status, via fax, electronic transfer or verbal confirmation, to a statewide Central Registry in accordance with State and Federal law as well as any other OTP within a 100-mile radius.

FOR EKG/ECG TESTING: An electrocardiogram is a noninvasive procedure to obtain a graphical presentation of the heart's electrical activity derived by amplification of the minutely small electrical impulse normally generally by the heart. The tracing is obtained using 10 electrodes placed on the skin of the chest, arms, and legs. If any artifact (like static) occurs, some electrodes may need to be repositioned to ensure a clear recording of the heart. This test is used to identify and diagnose several different heart conditions. Risks include possible redness and itching at the sites of the electrode placement and possible minor skin irritation.

FOR WOMEN WHO ARE OR MAY BECOME PREGNANT: While methadone is approved by the FDA for medication-assisted treatment for opioid addiction in pregnant patients, there are no conclusive data regarding the safety of methadone in human pregnancy and it may be harmful to unborn babies. Tell your doctor and the Program's Medical Director/Provider if

you are pregnant or plan to become pregnant. After delivery, babies may experience withdrawal symptoms. A small amount of methadone is transmitted through breast-milk; therefore, discuss breastfeeding with your doctor.

Understanding the risks and benefits associated with methadone maintenance therapy, as well as alternatives to it, I hereby give my informed and voluntary consent to receive methadone maintenance therapy from Victory.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to assessment and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

VICTORY Recovery Partners

TREATMENT CONTRACT & PATIENT AGREEMENT

I, _____, understand that the goal of Medication-Assisted Treatment (MAT) is to suppress my withdrawal symptoms and cravings for my drug of choice. This assistance should allow me to regain a normal state of mind so that I can focus my efforts on making changes in my thoughts, behaviors and environment to better support my recovery.

I freely and voluntarily agree to accept this treatment contract/patient agreement, as follows:

1. I agree to keep and be on time to all my scheduled appointments. If I am delayed or I must reschedule my appointment, I will call the office in a timely manner.
2. I agree to provide urine for the purpose of toxicology screens at any time during my treatment. The results of these tests will be used to assist me in my recovery goals.
3. I agree that my medication prescription can be given to me only at my office visits and only by the Doctor, PA or NP. If I miss scheduled office visits, I may not be able to get a prescription until the next scheduled visit.
4. I agree to take my medications exactly as prescribed. I understand that adjusting my own dosage may result in termination of treatment.
5. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place, away from children, pets or any person who could potentially abuse it.
6. I understand that lost medication will not be replaced.
7. I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated.
8. I agree not to obtain any medications from any physicians, pharmacies, or other sources without informing my treating physician, PA or NP. I understand that mixing some forms of MAT with other medications, especially benzodiazepines (Xanax, Ativan, Valium, Klonopin), alcohol or other drugs of abuse, can be dangerous.
9. I understand that medication alone is not sufficient treatment for my addiction, and I agree to participate in creating and carrying out a recovery treatment plan. This plan will be revised, with my input and as needed, to assist me in my recovery. The treatment plan will include patient education, referrals to relapse prevention programs and active involvement with those programs.
10. If I decide to stop MAT at any time, I will consult with my medical provider first and not do this on my own. I will work with the treatment provider to taper slowly (to reduce discomfort and relapse potential). Stopping MAT treatment in no way affects my relationship with my provider and I may return to the clinic if needed to discuss my addiction problems and reinitiating of medication as needed.
11. I agree to inform all doctors, dentists and hospitals that treat me while I am in the Victory MAT program that I am prescribed MAT or any other medications, and sign a release of information form so that a Victory physician can coordinate my care with any outside providers.
12. I agree to drug testing and random medication counts as often as requested.
13. I agree to accept referral to a higher level of care (i.e. detox, inpatient) if recommended.

I understand that I will be discharged and no further medication will be prescribed or administered to me if I engage in any of the following Unacceptable Behaviors:

1. If I use any rude, profane or threatening language with any Victory staff member at any time. This includes the receptionist, nurse, medical assistants, medical providers, and/or counselors.
2. If I provide any false or misleading information about my identity, my criminal history, or any reporting requirements for probation, parole or Children's Protective Services (CPS).
3. If I provide any false or misleading information about my medical history, any prior treatment for substance abuse including the prescribing of Suboxone or methadone, or any false information regarding the use or prescribing of benzodiazepines (Xanax, Valium, Librium, Serax, Klonopin etc.)
4. I attempt to give, buy, or sell medication or drugs to any other person.
5. I attempt to alter or falsify a prescription, or a urine drug screen.
6. I refuse to provide a drug screen, or come in for a medication count when requested.
7. My urine does not show the expected presence of MAT or other medication prescribed by Victory.
8. If I fail to tell a doctor or dentist that I am on any form of MAT or other medication and I attempt to obtain, or obtain a controlled substance from that doctor or dentist.
9. If I fail to promptly inform Victory staff that I have been prescribed a controlled substance by another doctor, dentist, hospital, urgent care or emergency department.
10. I fail to make satisfactory payment arrangements for an outstanding balance of $500 (five hundred dollars) or more which is more than 30 days past due.

I understand that if I engage in highly dangerous behavior, such as abusing benzodiazepine, a sedative or sleeping medication, or I consume a heavy amount of alcohol while on any form of MAT that I may be promptly referred to a higher level of care (hospital or residential) and no further medication will be prescribed to me.

I understand that Victory may terminate my treatment if:

1. I engage in any of the unacceptable behaviors described in the above section.
2. I have persistently not complied with my attendance requirements, treatment recommendations, or met my financial obligations to Victory as I agreed to do this in the treatment contract.
3. I have been referred to a higher level of care (detox of inpatient) but refuse to go.
4. I request a voluntary discharge.

Final Medication Prescription Guidelines, if I am discharged:

1. If I am discharged because of unacceptable or highly dangerous behaviors, as described above, no medications will be prescribed or administered to me.
2. If I am discharged for any reason during Detoxification/Induction, no medication will be prescribed.

OTHERWISE:

3. If I am discharged from Victory a final 30 day prescription may be provided (but is not guaranteed).

If I am discharged, I may be reinstated at the discretion of the medical director based on the recommendation from my clinical treatment team. I understand that re-instatement into the program is not a guarantee. The physician reserves the right to modify these prescription guidelines at his/her discretion.

The staff at Victory has reviewed each of the items contained in this Treatment Contract with me. I believe these terms and requirements are reasonable. I understand that they are meant to help support me in my recovery and I agree to abide by all guidelines.

_____ _____

Patient Name Date

_____

Patient Signature

VICTORY Recovery Partners

Patient Financial Responsibility Policy

Welcome to Victory Recovery Partners. We appreciate the opportunity to be of service to you. Our office is dedicated to excellence in patient care. To maintain our high standards, we believe that it is important that we communicate our policies to you. Please take a moment to read and become familiar with these policies. Should you have any questions, the office staff is happy to help answer them. By presenting these policies in advance, we can avoid any surprises or misunderstandings. We appreciate your time and your understanding.

Patient Financial Responsibility Agreement

- **Payment Responsibility:** I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment or co-payment is due at the time services are rendered unless special arrangements have been made. It is my responsibility to confirm coverage is provided by my insurance company or other provider.

- **Appointments & Cancellations:** I understand that, I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my family members. In the event that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment. Victory Recovery Partners may make exceptions and waive the fee, at its discretion, for emergency or unusual circumstances. I understand that insurance companies do not provide reimbursement for cancelled sessions. Repeated missed appointments may result in termination of treatment. There may be a time when my provider needs to cancel my appointment for an emergency; Victory Recovery Partners will make every effort to reschedule me/my family in an appropriate time frame. This will be at no charge to me.

- **Delinquent Accounts:** I understand that my account may be turned over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection and attorney fees. I further understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be charged a 1.5% service charge monthly on the remaining balance.

I fully understand and agree to these policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient Name_____

Patient/Parent/Guardian Signature_____

Printed Name: _____

Date: _____

Consent to Obtain Medication History

VICTORY Recovery Partners

Victory Recovery Partners uses an electronic health record system. This system allows us to collect and review your "medication history". Included in your medication history is a list of prescription medicines that we or other medical professionals have recently prescribed for you.

This list is collected from a variety of sources, including:

- Current and past pharmacies
- SureScripts
- Health Insurance Plan
- PMP (Prescription Monitoring Program)

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form, you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medications used to treat mental health conditions, such as depression. This information will become part of your medical record.

_____ _____

Patient Name Date

_____

Signature

Patient Confidentiality Agreement

Victory Recovery Partners is a confidential medical & counseling service. Victory Recovery Partners is bound by State and Federal laws of confidentiality of both mental health and substance abuse services. Once an appointment is made, no information can be disclosed to anyone without your written permission on a Release of Information Form. When you come to your first appointment, the policy on confidentiality and your rights as a patient will be discussed in detail.

What this means for you:

Victory Recovery Partners will not share your information with a third-party without your written consent. Victory Recovery Partners staff will work diligently to protect information provided in counseling sessions.

- Confidentiality does not apply to cases of reported or suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- In cases of medical or psychiatric emergency, information may be shared with medical personnel.
- On rare occasions, there will be a request by a court for your records. Victory Recovery Partners may be required to share that information. Victory Recovery Partners will make an effort to discuss with you any instances where your confidentiality may be breached. Victory Recovery Partners will make an effort to share only information which is deemed legally necessary.
- Information must be shared with your insurance provider, should you choose to use insurance. This information may be seen by various employees of the insurance provider. There is also the potential that certain members of your employer may see this information.

Your Responsibility:

It is also your responsibility to protect the confidentiality of other patients. Do not discuss other patients (names, diagnoses, etc.) outside of group therapy sessions. In order to protect your confidentiality, all patients must agree to honor this policy as well. If you are found to have breached this confidentiality policy, you may be discharged from the program.

By signing this form, you acknowledge that there may be instances where Victory Recovery Partners must share your confidential information and you recognize that you are responsible for helping maintain the confidentiality of other patients. Discussing other patients outside of the group sessions may result in your termination from the program.

Patient Name (Printed): _____

Patient Signature: _____ Date:_____

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

Revoked On:_____ Staff Initials:_____

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

Patient's Last Name	First	M.I.
Case Number		
Facility Victory Recovery Partners	Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED

All information necessary to investigate any alleged incident(s) of abuse or neglect, or other significant incidents, in which I may be named or am otherwise relevant.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION.

1) I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) including its Bureau of Special Hearings, and the NYS Justice Center for the Protection of People with Special Needs (JC) including its Vulnerable Persons Central Register (VPCR) for the purpose of investigating or making determinations regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

2) If I am a minor (under 18), I additionally consent to this program, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS) and the Justice Center for the Protection of Vulnerable Persons (JC) providing notification to my parent or legal guardian regarding any alleged incident(s) of abuse or neglect, or other significant incidents, in which I might be named or am otherwise relevant.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose and obtain such information as herein specified. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

Time period, event or condition extending period specified above: Completion of an investigation by the Justice Center into an allegation of abuse or neglect, or other significant incident, pursuant to Chapter 501 of the Laws of 2012 and determination of a proceeding under NY Social Services Law Article 6, title 6.

Time period, event or condition replacing period specified above: 1 year from signature and date below

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____	_____
(Signature of Patient)	(Signature of Parent/Guardian)
_____	_____
(Print Name of Patient)	(Print Name of Parent/Guardian)
_____	_____
(Date)	(Date)

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT

Revoked On: _____ Staff Initials: _____

Patient's Last Name	First	M.I.
Case Number		
Facility Victory Recovery Partners	Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above, and Payer / Managed Care Plan _____ _____ of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me, the OASAS treatment facility, and Payer / Plan identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: 1 year from signature and date below

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

REVOKED ON_____Staff Sig_____

CONSENT FOR RELEASE OF INFORMATION RREGARDING PERSONS WITH SUBSTANCE USE DISORDER

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY Victory Recovery Partners	UNIT	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE] / [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED (CIRCLE)

Demographic Information (including, but not limited Address, Date of Birth, Social Security #, Insurance name and identification number); Diagnosis; Medical History, Medication History

PURPOSE OR NEED FOR DISCLOSURE/RELEASE (CIRCLE)

Laboratory Results/ Treatment monitoring and planning

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
Between: Victory Recovery Partners	And: Aegis Laboratory / Aegis Sciences Corporation

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of patient records for persons with substance use disorder, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to aparty other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: 1 year from signature and date below

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Regarding Persons with Substance Use Disorder (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Signature of Patient)	(Signature of Parent/Guardian, when required)
(Print Name of Patient)	(Print Name of Parent/Guardian)
(Date)	(Date)

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

REVOKED ON_____Staff Sig_____

CONSENT FOR RELEASE OF INFORMATION RREGARDING PERSONS WITH SUBSTANCE USE DISORDER

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY Victory Recovery Partners	UNIT	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE] / [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED (CIRCLE)

Demographic Information (including, but not limited Address, Date of Birth, Social Security #, Insurance name and identification number); Diagnosis; Medical History, Medication History

PURPOSE OR NEED FOR DISCLOSURE/RELEASE (CIRCLE)

Laboratory Results/ Treatment monitoring and planning

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
Between: Victory Recovery Partners	And: Quality Laboratory

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of patient records for persons with substance use disorder, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to aparty other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: 1 year from signature and date below

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Regarding Persons with Substance Use Disorder (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Signature of Patient)	(Signature of Parent/Guardian, when required)
(Print Name of Patient)	(Print Name of Parent/Guardian)
(Date)	(Date)

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

REVOKED ON_____Staff Sig_____

CONSENT FOR RELEASE OF INFORMATION RREGARDING PERSONS WITH SUBSTANCE USE DISORDER

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY Victory Recovery Partners	UNIT	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE] / [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED (CIRCLE)

Demographic Information (including, but not limited Address, Date of Birth, Social Security #, Insurance name and identification number); Diagnosis; Medical History, Medication History

PURPOSE OR NEED FOR DISCLOSURE/RELEASE (CIRCLE)

Laboratory Results/ Treatment monitoring and planning

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
Between: Victory Recovery Partners	And: Acutis Diagnostics

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of patient records for persons with substance use disorder, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to aparty other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: 1 year from signature and date below

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Regarding Persons with Substance Use Disorder (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Signature of Patient)	(Signature of Parent/Guardian, when required)
(Print Name of Patient)	(Print Name of Parent/Guardian)
(Date)	(Date)

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

REVOKED ON_____Staff Sig_____

CONSENT FOR RELEASE OF INFORMATION RREGARDING PERSONS WITH SUBSTANCE USE DISORDER

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY Victory Recovery Partners	UNIT	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE] / [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED (CIRCLE)

Demographic Information (including, but not limited Address, Date of Birth, Social Security #, Insurance name and identification number); Diagnosis; Medical History, Medication History

PURPOSE OR NEED FOR DISCLOSURE/RELEASE (CIRCLE)

Laboratory Results/ Treatment monitoring and planning

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
Between: Victory Recovery Partners	And: Quest Diagnostics

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of patient records for persons with substance use disorder, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to aparty other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: 1 year from signature and date below

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Regarding Persons with Substance Use Disorder (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Signature of Patient)	(Signature of Parent/Guardian, when required)
(Print Name of Patient)	(Print Name of Parent/Guardian)
(Date)	(Date)

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

Revoked On:_____ Staff Initials:_____

Patient's Last Name	First	M.I.
CASE No.		
FACILITY Victory Recovery Partners	UNIT	

CONSENT TO RELEASE PERSONAL IDENTIFYING INFORMATION CONCERNING ALCOHOL/DRUG ABUSE TREATMENT HISTORY **FOR THE PURPOSE OF OBTAINING INSURANCE BENEFITS**

INSTRUCTIONS: **GIVE COPY OF FORM TO PATIENT.** Keep an original of this release.

PATIENT'S CONSENT TO DISCLOSE PERSONAL IDENTIFYING INFORMATION

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED

I _____hereby give Victory Recovery Partners , the New York State Office of Alcoholism and Substance Abuse Services, New York State Dept of Health, New York State Insurance Dept, New York State Attorney General's Office, and my insurance provider, permission to release information to, communicate with, and disclose among themselves information relating to insurance billing, benefits, and reimbursement, including the minimal clinical information necessary related to billing, benefits and reimbursement problems, for services I have received from this program.

PURPOSE OR NEED FOR DISCLOSURE

To permit the New York State Office of Alcoholism and Substance Services, New York State Dept of Health, New York State Insurance Dept, the New York State Attorney General, to assist both me and my drug treatment provider in obtaining access to insurance benefits and reimbursement for services rendered.

I, the undersigned, have read the above and authorize the staff of Victory Recovery Partners , New York State Office of Alcoholism and Substance Services, New York State Department of Health, New York State Insurance Department, New York State Attorney General's Office and my insurance provider to disclose and obtain such information as herein specified. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it, and that in any event this consent expires automatically as follows:

☐ When issues relating to billing, benefits and reimbursement have been resolved, or

☑ expires 1 year for signature date below.

(Specify other time when consent can be revoked and/or expires)

I also understand that any disclosure/release of any identifying information is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Pts. 160 &164; and that redisclosure of that information to a party other than the one designated above is forbidden without additional written authorization on my part

NOTE: Any information released through this form will be accompanied by the form Prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient

I further understand that my treatment will not be conditioned on whether I sign this consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian, when required)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)

Describe authority to sign on behalf of patient _____

NYS Office of Alcoholism and Substance Abuse Services
Authorization for Release of Behavioral Health Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment may be released and exchanged as set forth on this form. I understand that:

1. This authorization may include disclosure of all of my health information, including where applicable, my federal social security number (for record matching purposes only), any and all information relating to ALCOHOL and DRUG TREATMENT and HIV/AIDS-RELATED information. In the event the health information described below includes any of these types of information I specifically authorize release of such information to the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

   _____ If you initial this line, HIV-AIDS RELATED information can also be released to OASAS. You do not have to initial this line.

   _____ If you initial this line, your Social Security Number can also be released to OASAS. You do not have to initial this line.

2. With some exceptions, health information once disclosed may be redisclosed by the receiving entity. If I am authorizing the release of my federal social security number, HIV/AIDS-related, alcohol or drug treatment, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity Releasing and Exchanging this Information:
6. Name and Address of Entities to whom this Information will be Disclosed and Exchanged: NYS Office of Alcoholism and Substance Abuse Services, 1450 Western Avenue, Albany, New York 12203 I authorize the above listed Entity to inform the New York State Office of Alcoholism and Substance Abuse Services (OASAS) of my enrollment in this treatment program so that the quality of the services I receive may be evaluated, I also consent to all necessary communications between this facility and OASAS relative to my past alcohol and/or substance abuse treatment history; current and proposed treatment services.
7. The Purpose of this disclosure is to comply with implementation of New York's Medicaid redesign initiative and to comply with mandatory federal reporting requirements. By accepting the information covered by this consent into the NYS OASAS Client Data System, NYS OASAS acknowledges that this information may not be redisclosed per 42 CFR 2.32 – Prohibition on redisclosure.
8. My health information may be disclosed for a period of three (3) years from the last date of service, or until revoked.

9. If not the patient , name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

Alcohol/drug treatment related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

TRS-61 (03/31/17)

Revoked On: Staff Initials:

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

CONSENT TO THE USE OF TELEPRACTICE IN THE PROVISION OF ADDICTIONS TREATMENT

Patient's Last Name	First Name	M.I.
CASE No.		
FACILITY Victory Recovery Partners	UNIT	

INSTRUCTIONS: GIVE COPY OF FORM TO PATIENT. Keep an original of this consent

TELEPRACTICE INFORMED CONSENT

PURPOSE OR NEED FOR CONSENT: To permit the Substance Use Disorder (SUD) treatment to be provided via Telepractice as specified in OASAS Part 830 Regulations.

EXTENT OR NATURE OF INFORMATION

I_____provided information and understand the following regarding services delivered via Telepractice:

I. Description:

Telepractice is the delivery of Substance Use Disorder (SUD) treatment services provided by an OASAS certified program who is approved for the provision of Telepractice via Audio/Visual and when approved Telephonic mediums. Telepractice is a method of obtaining treatment and recovery support when in-person methods are not available and is subject to the same regulatory and clinical standards as in-person services. When applicable, reimbursable through both Medicaid and Commercial Insurance Plans.

II. Confidentiality:

Telepractice is subject to the confidentiality requirements of 42 CFR Section and HIPAA for the protection of individual's privacy and confidentiality while providing services via Telepractice. Telepractice should be delivered using telecommunication technology that is compliant with confidentiality standards of state and federal law. Provider using Telepractice will make every reasonable effort to decrease the risks associated with the use of Telepractice. I further understand that my confidential information will not be redisclosed without my consent.

III. Patient Rights:

Telepractice is also subject to the requirements of the OASAS Part 815 Patient Rights Regulations. Concerns regarding my treatment can be sent to PatientAdvocacy@oasas.ny.gov I understand that I can decline services via Telepractice at any time.

I, the undersigned, have read the above and authorize the staff of Victory Recovery Partners , to provide my SUD treatment services via Telepractice. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it, and that in any event this consent expires automatically as follows:

(Signature of Patient) (Signature of Parent/Guardian, when required)

(Print Name of Patient) (Print Name of Parent/Guardian)

(Date) (Date)

Describe authority to sign on behalf of Patient:

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

CONSENT TO RELEASE OF INFORMATION CONCERNING SUBSTANCE USE DISORDER TREATMENT

FOR CRIMINAL JUSTICE CLIENTS

Client's Last Name	First	MI

Client's New York State Identification Number (**NYSID**)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Referring Entity's Staff Member's Name:

Referring Entity's Name & Address

Referring Entity Type

- ☐ District Attorney
- ☐ Court
- ☐ Probation
- ☐ Parole - General
- ☐ Parole - Release Shock
- ☐ Parole - Release Willard
- ☐ Parole - Release Resentence

INSTRUCTIONS:

1) SEND A COPY OF THIS COMPLETED FORM TO THE CLIENT'S TREATMENT PROVIDER;
2) ADD A COPY OF THIS COMPLETED FORM TO THE CLIENT'S CRIMINAL JUSTICE FILE; AND
3) PROVIDE A COPY OF THIS COMPLETED FORM TO THE CLIENT/DEFENDANT

1) I, the undersigned, Client/Defendant, hereby **CONSENT** and authorize communication between the above named **Referring Entity**, my Substance Use Disorder Treatment Provider: Victory Recovery Partners

and the following: _____

I **CONSENT** to **DISCLOSURE OF INFORMATION** concerning my current and past individual assessment or evaluation, intake summary, diagnosis, treatment recommendation, date of admission, and status as a patient including course and level of treatment (i.e. residential, community based, individual, or group), my progress and adherence including but not limited to: my attendance at treatment, dates and results of toxicology testing, cooperation with my treatment program, prognosis, treatment completion or reason(s) for termination, date of discharge, discharge status, and discharge plan.

Such disclosure is for the **PURPOSE** of enabling the entities listed above to communicate as to my treatment needs, activities, history and adherence with my evaluation and treatment for purposes of monitoring the terms and conditions of treatment, release, care management purposes, and for carrying out other official duties; **AND**

2) I further **CONSENT** and authorize communication between and among the above named **Referring Entity** and the New York State Office of Addiction Services and Supports (**OASAS**); and OASAS to **DISCLOSE INFORMATION** to the New York State Division of Criminal Justice Services (**DCJS**), concerning admission and discharge data for the **PURPOSE** of research and program evaluation activities. I understand that any reports or studies compiled from my records disclosed pursuant to this release will not include personally identifiable information which will remain confidential and protected from further re-disclosure.

I, the undersigned, have read the above and authorize the staff of the above named disclosing entities to disclose, obtain and share such information as herein specified. I understand that, unless otherwise specified, this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, interim probation supervision, probation, parole, post-release supervision, or local conditional release or other proceeding or determination by a releasing authority under which I was referred to or otherwise agreed to treatment.

I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations 42 CFR Part 2, governing the confidentiality of substance use disorder treatment records for patients, as well as the Health Insurance Portability and AccountabilityAct of 1996 (HIPAA) 45 C.F.R. Pts. 160 &164; and that redisclosure of such information to a party other than those designated above isforbidden without additional written authorization on my part.

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Print Name of Client)

_____ (Signature of Client)

_____ (Date)

NEW YORK STATE | Office of Addiction Services and Supports

Consent To Release Of Information Concerning Subject Charged with Impaired Driving **IMPAIRED DRIVER SYSTEM (IDS)**			Individual's Last Name, First Name and MI
			Individual's DMV Client ID (Driver's License Number)
Individual's Case Number or File Reference			Referring Entity's Name and Address
Referring Entity Type			
☐ Court	☐ IDP Provider	☐ Motorist	
☐ DMV	☐ OASAS Approved Provider		

INSTRUCTIONS

1) Give a completed copy of this form to the individual; and

2) Add a completed copy of this form to the individual's case record

I, the undersigned, hereby **CONSENT** and authorize communication between and among the above named **Referring Entity** and the following agencies:

- My OASAS approved provider: Victory Recovery Partners
  (Enter Name of Provider or N/A if Non-Applicable)
- My Impaired Driver Program (**IDP**): _____
  (Enter Name of Program or N/A if Non-Applicable)
- The New York State Office of Addiction Services and Supports (**OASAS**), NYS Department of Motor Vehicles (**DMV**), NYS Office of Court Administration (**OCA**) and the NYS Division of Criminal Justice Services (**DCJS**) (DCJS will receive non-personally identifying information for research purposes only);

to **DISCLOSE INFORMATION** concerning any current and/or past data pertaining to my impaired driving offense including prior conviction(s) related to impaired driving and other traffic infractions noted on my driver's abstract and the following data elements:

- **Motorist**: DMV client ID, first two characters of current last name and last name at birth, sex, birth date and last four digits of my SSN.
- **Violation**: violation date, court name, violation, first two characters of current last name, BAC level, indication of chemical test refusal, if any, and an indication of out of state license, if any.
- **Screening**: provider/program name, screening date, indication of assessment referral, if any, and indication of screening tool used.
- **Assessment**: referral source, provider/program name, assessment start and end dates and assessment status.
- **Treatment**: provider/program name, admission date, discharge date, number of sessions and discharge status.
- **IDP**: program name, start and status dates, indication of assessment referral, if any, and IDP enrollment status.

Such disclosure is for the **PURPOSE** of enabling the entities listed above to share the indicated data elements for purposes of data collection, tracking, monitoring activities of providers and programs. The specific data elements disclosed to each entity will be limited to the minimum necessary for that entity to carry out its official duties related to my impaired driving offense in compliance with the NYS Vehicle and Traffic Law (VTL).

I, the undersigned, have read the above and authorize the staff of the disclosing entities named to disclose, obtain and share such information as herein specified. I further understand that, unless otherwise specified, this consent will authorize the use of data to support research and quality assurance measures for OASAS, OCA, DCJS and DMV and will remain in effect for this purpose and cannot be revoked by me for a period of ten (10) years as consistent with the record retention period in NYS VTL §201(1)(i) and the DWI offense level determination clauses of NYS VTL §1192.

I understand that disclosure of my personal information by DMV is controlled by the Federal Driver's Privacy Protection Act, 18 USC §2721 and that my signature below constitutes my authorization for DMV to disclose my personal information to the entities indicated above.

I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations 42 CFR Part 2; governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Pts. 160 & 164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part

.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Chemical Dependence Treatment Patient** (TRS-1).

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment and/or determined ineligible for the Impaired Driver Program if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

Print Name of the Individual	Signature of the Individual
Date of Signature	Signature of Parent or Guardian of Individual (If applicable)

Patient Attestation Statement Rules/Regulations

Client Rights and Voluntary Basis

- I have been provided with a copy of the Patient Handbook which contains Program Rules and Regulations, Patient Rights and Responsibilities and a summary of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR Pts 160 and 164A. I have been given the opportunity to discuss these documents and to have my questions answered. By signing this form, I am indicating that I understand these rules, rights and regulations.

- I also understand that all treatment services are provided on a voluntary basis and that I have the right to discharge myself from treatment at any time. If I have been mandated to treatment, there may be consequences for leaving treatment prematurely, but my participation remains a voluntary choice.

- I acknowledge and agree that I have had the right to review a copy of CS Medical Associates, P.C.'s (the "Practice") dba Victory Recovery Partners Notice of Privacy Practices prior to signing this consent, which provided me a more complete description of uses and disclosures of my Protected Health Information (PHI) and how I can obtain access to this information. I hereby consent to the Practice using the disclosing my PHI to carry out treatment, payment, and healthcare operations. I am aware that the Practice disclaims any liability or harm resulting from my incorrect or incomplete provision of my primary care physicians contact information, and the Practice reserves the right to revise its Notice of Privacy Practices at any time. I am also aware that an updated copy of the Practice's Notice of Privacy Practices is available on the Practice's website.

_____ _____

Patient Signature Date

Consent for Feedback on Your Experience

As part of your visit it is especially important for us to understand your experience so that we can make your next visit better. By agreeing to this consent, you are agreeing to receive text messages from our organization via Well iQ so that we may receive feedback on your appointment. The Well iQ survey is your voice as a patient, and we want to hear from you.

By signing below, I hereby give my consent and state my preference to provide my feedback as described. I may choose to stop participating at any time by texting the word "STOP" in response to any text message sent by Well iQ. I understand that message and data rates may apply, and that I will receive a maximum of 1 message per visit to share my experience and feedback.

_____ _____

Patient Signature Date

29

NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

REVOKED ON_____Staff Sig_____

CONSENT FOR RELEASE OF INFORMATION RREGARDING PERSONS WITH SUBSTANCE USE DISORDER

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY Victory Recovery Partners	UNIT	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE] / [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED (CIRCLE)

Emergencies Only

PURPOSE OR NEED FOR DISCLOSURE/RELEASE (CIRCLE)

Emergency contact only.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
Between: Victory Recovery Partners	And:

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of patient records for persons with substance use disorder, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to aparty other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: 1 year from date signed

NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Regarding Persons with Substance Use Disorder (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian, when required)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)

NEW YORK STATE | Office of Mental Health | PSYCKES

Consent Form

CS MEDICAL ASSOCIATES, P.C.

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to **www.psyckes.org,** and click on **About PSYCKES,** to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.[1] For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. *Please check 1 box only.*

I GIVE CONSENT for the provider, and their staff involved in my care, to access my health information in connection with my health care services.

I DON'T GIVE CONSENT for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

_____ _____

Print Name of Patient | Patient's Date of Birth

_____

Patient's Medicaid ID Number

_____ _____

Signature of Patient or Patient's Legal Representative | Date

_____ _____

Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27- F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

1. **How providers can use your health information.** They can use it only to:

   - Provide medical treatment, care coordination, and related services.
   - Evaluate and improve the quality of medical care.
   - Notify your treatment providers in an emergency (e.g., you go to an emergency room).

2. **What information they can access** If you give consent, CS MEDICAL ASSOCIATES, P.C. can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (Xrays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advance directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:

   - Mental health conditions
   - Alcohol or drug use
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Sexually transmitted diseases

3. **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see “About PSYCKES”, or ask your provider to print the list for you.
4. **Who can access your information, with your consent.** CS MEDICAL ASSOCIATES, P.C.’s doctors and other staff involved in your care, as well as health care providers who are covering or on call for CS MEDICAL ASSOCIATES, P.C.. Staff members who perform the duties listed in #1 above also can access your information.
5. **Improper access or use of your information.**There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn’t have – call:

   - Tracey Wallace / VP Operations at 6316964357, or
   - the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **Sharing of your information.** CS MEDICAL ASSOCIATES, P.C. may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.[1]
7. **Effective period.**This Consent Form is in effect for 3 years after the last date you received services from CS MEDICAL ASSOCIATES, P.C.,or until the day you withdraw your consent, whichever comes first.
8. **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at www.psyckes.org or from provider by calling 631-696-4357. Please note, providers who get your health information through CS MEDICAL ASSOCIATES,P.C. while this consent form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.
9. **Copy of form.**You can receive a copy of this Consent Form after you sign it.

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27- F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as “HIPAA”).