****

**Please Fill out Form completely ON BOTH SIDES, mark N/A if not applicable:**

**We are a Smoke-Free Facility and Campus. Please smoke inside your vehicle. If you are in your INTAKE process, make sure to alert a staff that you are needing to smoke before leaving the building.**

**\*\*\*NO WEAPONS OF ANY KIND ARE ALLOWED\*\*\***

**Are you here for Methadone treatment Buprenorphine treatment Unsure Guest dosing Transfer? PLEASE CHECK THE APPROPRIATE BOX FOR YOUR VISIT TODAY.**

**Do you require any special accommodations (equipment or interpreting services)? YES NO**

**Have you had any suicidal thoughts in the last 72 hours? YES NO**

**Are you currently using Opioids? YES NO If Yes, How Long? \_\_\_\_\_\_\_\_\_\_\_**

**Are you currently enrolled in another Clinic? (even if your here for transfer) Yes No**

 **If Yes, Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*If you are Transferring from another clinic. You must sign a Release of Information form allowing us to access your records. Be prepared to follow the OMR treatment plan until we receive your records. This processing time is dependent on the cooperation of your current clinic. \*\***

**Do you smoke or use tobacco product: N/A-DO NOT SMOKE CIGARS CIGARETTES PIPE TOBACCO**

**SMOKELESS TOBACCO/CHEWING TOBACCO VAPE/ E-CIGARETTES**

**How long have you used tobacco? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**New Patient Information:**

* **Initial visit can last up to 4 hours. You are required to remain in the building for the entire process.**
* **You will be required to provide a Urine Drug Screen.**
* **We will discuss payment options during intake process. We have different costs for treatment depending how your treatment will be paid for. (Insurance, Grant, Financial assistance, Self-pay)**
* **If this is your first-time receiving methadone you will be subject to monitoring unless you have a driver.**
* **For Methadone- daily Attendance is REQUIRED for dosing, counseling, group etc.**
* **For Buprenorphine- attendance requirements are personalized individually.**
* **Take Home Doses are not guaranteed! You MUST follow the individual treatment plan set by the treatment team.**

**We require pre-payment on all patient accounts. Anything outside of pre-payment will require speaking with our billing team and creating a payment arrangement. Pre-payment helps create a quicker check-in/ visit for you! It also helps you remain compliant with our program. Provider appointments, Counseling appointments, proper medication use, and payment are all part of compliance. Not remaining compliant can result in administrative taper.**

**It is your responsibility to inform Overmountain Recovery of insurance changes AS WELL AS you are responsible to pay your balance as informed to you.**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_**

**Eye: \_\_\_\_\_\_\_\_\_\_ Hair Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How do you identify yourself (please circle one): MALE FEMALE TRANSGENDER NON-BINARY**

**Phone Number Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip-code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Size: \_\_\_\_\_\_\_\_\_\_\_\_ Marital status (please circle one):**

Married Separated Divorced Single

**Is there any chance you could be pregnant? YES NO If Yes, what is the expected DUE DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Race:** African American Asian **Ethnicity:** Hispanic **Education:** 6th 7th 8th 9th 10th 11th 12th

 White Hispanic Non-Hispanic

 Native American

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Income:** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(This includes Social Security, Disability, Military Pensions, etc.…)

**Status:**

Disabled Part Time Employment Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Full Time Employment Not Employed

Homemaker Retired

**Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral source (Please circle one):**

TV Social media (Facebook, Instagram, Twitter, etc.) Radio Word-of-mouth Medical Office Religious Facility Court Dept of Children services Shelter School Employer Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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