DANIEL FILENE, MD
178 MIDDLE STREET
PORTLAND, ME 04101
PHONE/FAX (207) 774-0046
WWW.DANFILENEMD.COM

DOCUMENT CHECKLIST – SUBOXONE TREAMENT

The following documents must be completed, signed, and returned to my office at least 2 days before your first appointment. They may be sent by Fax, mail, or hand delivered (there is a locked mailbox just outside the door to our suite, 178 Middle St., 3rd floor.) Please ensure that all documents are fully completed and signed:

- ☐ Client Registration form (4 pages)
- ☐ Symptom Checklist (2 pages)
- ☐ Psychiatrist – Client Service Agreement (3 pages)
- ☐ Privacy Policy (1 page)
- ☐ Suboxone Consent Form (2 pages)
- ☐ Controlled Substance Medication Agreement (3 pages)
- ☐ Medicare / MaineCare statement (1 page)
- ☐ If you have a current or recent Suboxone provider, you will also need to give him/her the Suboxone Provider Reference, to return to me before you begin Suboxone. This form is part of the Suboxone Treatment Information packet which you have already viewed/received (may be found on the Suboxone page of my website.)

DANIEL FILENE, MD
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CLIENT REGISTRATION

Date_____ Name _____

Preferred phone: _____ [ ] cell [ ] home [ ] work [ ] other
Alright to leave detailed messages on this phone? [ ] yes [ ] no

Other phone: _____ [ ] cell [ ] home [ ] work [ ] other
Alright to leave detailed messages on this phone? [ ] yes [ ] no

Email address (*optional – please provide if you would like emailed appointment reminders and access to the online self-scheduling system*)

_____

Mailing Address: _____

Street Address, if different: _____

Age _____ Date of Birth _____ Referred by: _____

Address & Phone of referrer, if another provider: _____

_____

Current therapist, if not referrer: _____ Therapist Phone _____

Primary care provider: _____ PCP Phone _____

PCP Address: _____

Pharmacy used, if applicable: _____ Pharmacy phone: _____

Client Employer: _____

Emergency contact (relationship & phone): _____

Person responsible for payment, if other than client (please give address & phone): _____

_____

FAMILY INFORMATION: Please note with an * if you are/were particularly close with a specific person.

	Name	Age	Living with you?	Serious Illnesses	Year deceased
Mother					
Father					
Siblings					
Children					
Spouse/partner					
Previous partner					
Other significant people					

Any experiences, deaths, or major losses in your life that have been particularly difficult for you?

_____

_____

_____

EDUCATION

Degree(s) earned _____

Any learning problems in school? _____

Any behavioral or hyperactivity problems in school? _____

_____

RECENT WORK HISTORY: _____

_____

MEDICAL HISTORY

Previously diagnosed medical conditions: _____

_____

Any history of head injury? _____

Allergies (indicate what sort of reaction to each medication): _____

_____

Prescribed medications you are currently taking, including dose and frequency

_____

_____

Other psychiatric medications you have taken in the past (indicate if any were especially helpful or caused problems):

_____

_____

SUBSTANCE USE

Describe history of opiod use (how long using, current type/amount of use, etc):

_____

_____

Describe any other past or present difficulties with substance abuse/dependence:

_____

_____

Describe any past or present treatment for substance abuse/dependence:

_____

_____

Do you have a family history of substance abuse/dependence? If yes, please describe:

_____

_____

How much alcohol do you drink each day? _____ Week? _____

How many caffeinated beverages (coffee, Coke/Pepsi/etc.) do you drink each day? _____

How much do you smoke each day? _____

PRIOR PSYCHIATRIC TREATMENT

Please describe any prior psychiatric treatment, including any hospitalizations: _____

_____

_____

_____

Why are you seeking help at this time? _____

_____

What are your goals for treatment? _____

_____

_____

Name _____ Date _____

Symptom Checklist

Please check the column that best describes how frequently you have experienced each of the symptoms below.

	Never	Rarely	Sometimes	Often
Depressed Mood				
Intense Fears (planes, heights, insects, etc.)				
Unwanted or intrusive thoughts				
Doing things over and over (compulsions)				
No memory for blocks of time				
Hearing things not there				
Seeing things not there				
Suspiciousness				
Difficulty sleeping				
Eating difficulties				
Difficulty concentrating				
Reduced/excessive sex drive				
Anxiety				
Feeling panicked				
Frequent nightmares				
Wanting to harm yourself				
Difficulty with memory				
Unusually high energy				
Sexual difficulties				
Excessive drug/alcohol use				
Tremors				

	Never	Rarely	Sometimes	Often
Fear of social situations				
Fear of being overweight				
Vomiting/purging				
Difficulty controlling temper				
Aggressive impulses				
Flashbacks				
Excessive risk-taking				
Self-injurious behaviors				
Wanting to harm others				
Disorientation				
Impulsivity				
Low energy				
Low self-esteem				
Mood swings				
Premenstrual symptoms				
Fear of leaving the house				
Problems with partner				
Fear of dying				
Physical pain				
Fear of being sick				
Feeling detached from others				
Addictive behavior				
Feeling uneasy in public				
Other:				

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PSYCHIATRIST – CLIENT SERVICES AGREEMENT

Thank you for your interest in my private psychiatric practice. This document contains important information about my professional services and business practices. Please read it carefully and return a signed copy to me at or prior to our first meeting.

SERVICES
I treat adults and older adolescents for a variety of psychiatric issues, including depression, anxiety, bipolar disorder, addictions, PTSD, grief, adjustment problems, and stress.

I provide both psychotherapy and medication management. Many clients find it advantageous to see the same individual for both therapy and medications. Other clients see me for medication management while continuing to work with a separate therapist. Either plan can work well.

PRACTICE STRUCTURE
I work in an office suite with other independently-practicing mental health professionals. While I share office space with them, I am independent of other professionals in providing you with clinical services.

OFFICE HOURS
I am generally at my office Monday 2pm-5pm and Tuesday to Thursday, 9am – 5pm. However, these days and times vary depending on my client and personal schedule. I also occasionally am out of the office to provide services at Riverview Psychiatric Center.

SUBOXONE TREATMENT
Please refer to the Suboxone Treatment Information document for details about how Suboxone treatment works in my practice.

CONTACTING ME
The best way to contact me is generally my office phone (774-0046). If I am unable to answer the phone, please leave a message. I do generally check messages daily when out of the office, but if the matter is not urgent I may not return your call until I am back at the office.

Email is often the most efficient way to reach me for very routine matters such as scheduling appointments and requesting medication refills. My email address is drfilene@gmail.com. You may also access email to me via the "Contact Me" page on my website, www.danfilenemd.com. Please consider that email may have a lower level of privacy than the telephone; if you choose to use email, please do not use it to communicate about sensitive clinical matters.

In an urgent situation, please see "Emergencies", below.

EMERGENCIES
As a private solo practitioner, I do not have continuous "crisis management" services other than myself. If you anticipate (or have had a history of) needing frequent crisis services, you may be better served by working with an agency that can provide more comprehensive coverage from a variety of practitioners; this is something we can discuss during your initial visit.

However, I do strive to be available to clients whenever there is an urgent situation, and encourage you to contact me whenever a crisis arises. Please take the following steps to reach me in an emergency:

Initials ___

1) First call my office (774-0046). If I do not answer, leave a brief message stating that you have an urgent problem.
2) If you did not reach me at the office, you may call my cell phone (329-3888). If I do not answer, leave a voice message.
3) If you still have not reached me, have not heard back from me quickly, and are in a hazardous situation, please do one or more of the following:

a) If you are in Cumberland County, call the Cumberland County Crisis line at 774-HELP (774-4357) or 1-888-568-1112
b) If you are outside of Cumberland County, call 1-888-568-1112
c) Go to the nearest hospital emergency room, or,
d) Call 911

Please know that having strong thoughts or impulses to harm yourself (or others) *is* a medical emergency; in such a situation it is completely appropriate to contact 911 or seek help at an emergency room. The personnel there will be able to get you help in a crisis.

PRIVACY

I believe privacy is a critical component of psychiatric treatment. Unless you are confident that the information you share with your psychiatrist is completely confidential, you will be held back from achieving your goals. I believe that operating as a solo private practitioner affords my clients the highest level of privacy protection. At larger clinics or agencies your personal information may be seen by receptionists, administrative assistants, dictation typists, billing clerks, etc. This is not the case in my practice; I am the only person with access to your file. As a rule, unless you provide specific authorization, I will release no information about you to anyone.

For details, including emergency exceptions to confidentiality, please see my full Privacy Policy. The policy is available on the "Privacy" and "Forms" pages of my website.

PAYMENT

My practice operates on a self-pay, fee-for service basis. This means that your fee for each meeting will be due at the session. As payment I accept personal checks (preferred) or cash. Please see the Suboxone Treatment Information document for details of current fees.

INSURANCE

I do not participate directly in any insurance networks or HMO panels. However, I can provide you with a detailed service receipt at each of our meetings. Many of my clients are able to obtain at least partial reimbursement for my services by submitting these receipts to their insurance companies. Many of my clients also now have insurance coverage with high annual deductibles or healthcare savings accounts; payments for my services may help count towards your deductible or be reimbursable to you from your HSA. You may wish to contact your insurance company to inquire about these matters prior to beginning treatment with me.

CANCELLATIONS

When you make an appointment with me, it is time that I reserve exclusively for you. Barring emergencies, I will be ready to see you at our scheduled time. I do not double-book or over-book my schedule.

Because of this, I ask that you provide me with as much notice as possible should you need to cancel or change an appointment, by calling my office phone at 774-0046 (please do *not* contact me on my cell phone for cancellations; cell phone is for urgent/emergency situations only.)

My cancellation policy is as follows:

Cancellation 24 hours or more before appointment: No charge

Initials ___

Cancellation less than 24 hours before appointment: $50.00
Cancellation without notice (no-show): $75.00

The associated fee must be paid prior to our rescheduling an appointment.

VACATIONS

I believe that changes of scenery, travel, and new experiences are beneficial to mental health. I encourage my clients to take vacation time away from their routine lives, and I do so myself from time to time. If I will be away for more than a short period of time, and/or if I will not be able to check messages or respond to my cell phone, I will leave information about my absence on my office telephone message, as well as on the homepage of my website. If I will be away and/or unavailable for an extended period, I will generally arrange clinical coverage with a colleague. Information on how to contact the covering colleague will also be found on my phone message and website. In certain cases, such as if you are experiencing acute problems at the time I am leaving for an absence, I may ask your permission to discuss your situation with my covering colleague prior to my departure. This will make it much easier for him or her to help you, if needed, while I am away.

LIMITS TO OUR RELATIONSHIP

When we negotiate a treatment plan, we will discuss the nature and scope of our relationship. Please understand that in following the standards of my profession and the ethical guidelines of the American Psychiatric Association, I can only be your psychiatrist. I cannot have other roles in your life, such as friend, romantic partner, or client of your work or services.

As we live in a relatively small community, it is entirely possible that we will encounter each other outside of the office setting, for example at a restaurant or theatre. To protect your privacy in such circumstances, it is my policy not to acknowledge you first; please do not misunderstand this as a lack of recognition or caring! If you wish to acknowledge me and exchange a brief greeting, that is perfectly fine.

STATEMENT OF PRINCIPLES

I strive to comply with the advisories and ethical principles of American Medical Association and the American Psychiatric Association. If you have concerns about our work together, please let me know. If you feel that I, or any other medical or mental health professional, has treated you unfairly or unethically, please tell me.

Your signature below indicates that you have read this agreement and agree to abide by its terms. You have the right to revoke this agreement in writing at any time.

_____ _____
Signature of Client / Parent / Guardian Date

_____
Printed Name

_____ _____
Daniel R Filene, MD Date

DANIEL FILENE, MD
178 MIDDLE STREET, SUITE 300
PORTLAND, ME 04101

PRIVACY POLICY

This notice describes the privacy procedures of my private psychiatry practice.

It is of the utmost importance to me that information about you, my client, remains absolutely confidential whenever possible. I believe that this is a critical element in developing the trust and openness essential in the process of addressing mental health issues. Unless you explicitly notify me otherwise, I will generally assume that you wish your personal information to remain strictly confidential. In any situation where I believe that release of information would be beneficial, it is my usual practice to request your written consent via a Release of Information (ROI).

To maximize your privacy, I do not involve other individuals or agencies in billing, scheduling, or other administrative aspects of my practice. I feel this provides you with a higher level of confidentiality than would be possible in a larger clinic or group practice. In the routine course of my practice, no one but me will access any of your demographic or clinical information.

If you are seeing a psychotherapist in addition to me, I will generally request your permission to remain in touch with that person. I may also ask your permission to allow contact with your primary care physician or others whose care may interact critically with our work. It is of course your choice whether to permit such contact or not.

The greatest level of privacy can be obtained by not involving insurance companies in your mental health care. However, if you request, I will supply you with invoices for our sessions, which you may submit to your insurance company seeking reimbursement. This allows you the greatest control over where and when any information about you is released. Please know that insurance companies *require* a diagnosis and description of the service rendered in order to cover any costs; this information will be indicated on my invoice.

There are unusual circumstances in which the law may require a health professional to release information about you without your authorization. These situations are very rare and I will work relentlessly to avoid them. Such situations include: (1) If I have reason to believe that you pose a direct threat of imminent harm to any individual (including yourself), and (2) If I have reason to believe that abuse or neglect of a child, elder, dependent or disabled person is taking place.

Finally, although client/psychiatrist communications are generally protected as confidential under the law, I may be required to use or disclose information about you in the course of a judicial or legal proceeding if I am ordered by a court to do so. I also reserve the right to use and disclose information about you if doing so is necessary to defend myself in legal action brought against me in relation to your care.

By signing, I acknowledge that I have received and reviewed a copy of this Notice of Privacy Practices.

_____
Client (or Parent/Guardian, if applicable)

_____
Date

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Consent for Treatment with Buprenorphine

Buprenorphine is a medication approved by the Food and Drug Administration (FDA) for treatment of people with opioid dependence. Qualified physicians can treat up to 30 patients for opiate dependence. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary.

Buprenorphine itself is an opioid, but it is not as strong an opioid as heroin or morphine. Buprenorphine treatment can result in physical dependence of the opiate type. Buprenorphine withdrawal is generally less intense than with other opiates. If buprenorphine is suddenly discontinued, some patients have no withdrawal symptoms; others have symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opiate withdrawal, buprenorphine should be discontinued gradually, usually over several weeks or more.

If you are dependent on opiates, you should be in as much withdrawal as possible when you take the first dose of buprenorphine. It you are not in withdrawal, buprenorphine may cause significant opioid withdrawal. For that reason, you should take the first dose under supervision and return to the office for observation and assessment.

Some patients find that it takes several days to get used to the transition from the opioid they had been using to buprenorphine. During that time, any use of other opioids may cause an increase in symptoms. After you become stabilized on buprenorphine, it is expected that other opioids will have less effect. 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 me first.

Combining buprenorphine with alcohol or some other medications may also be hazardous. The combination of buprenorphine with benzodiazepine medications such as (Ativan, Xanax, Valium, Librium, and Klonopin) has resulted in deaths.

The form of buprenorphine you will be taking (Suboxone) is a combination of buprenorphine with a short-acting opiate blocker (Naloxone). If the Suboxone tablet were dissolved and injected by someone taking heroin or another strong opioid, it could cause severe opiate withdrawal.

Buprenorphine tablets or films must be held under the tongue until they dissolve completely. Buprenorphine is then absorbed over the next 30 to 120 minutes from the tissue under the tongue. Buprenorphine will not be absorbed from the stomach if it is swallowed.

Buprenorphine may cost $10+/day for the medication. If you have medical insurance, you should find out whether or not buprenorphine is a benefit. In any case, my office fees must be kept current.

Alternatives to buprenorphine

Some hospitals that have specialized drug abuse treatment units can provide detoxification and intensive counseling for drug abuse. Some outpatient drug abuse treatment services also provide individual and group therapy, which may emphasize treatment that does not include maintenance on buprenorphine or other opiate-like medications. Other forms of opioid maintenance therapy include methadone maintenance. Some opioid treatment programs use naltrexone, a medication that blocks the effects of opioids, but has no opioid effects of its own.

_____

Signature

_____

Print Name

_____

Date

DANIEL FILENE, MD
178 MIDDLE STREET
PORTLAND, ME 04101
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Client: _____

CONTROLLED SUBSTANCE MEDICATION AGREEMENT

Controlled substances prescribed in my practice may include the following:

1) Stimulants, for ADHD and other indications (Ritalin, Adderall, Concerta, etc.) DEA Schedule II
2) Sedative/hyptonics, for anxiety and/or insomnia (Klonopin, Ativan, Ambien, etc.) DEA Schedule IV
3) Suboxone, for opiate dependence. DEA Schedule IV.

The particular purpose, nature, risks, and benefits of each medication will be discussed with you prior to prescription. Certain common elements are reviewed in this document:

Tolerance, Dependence, & Abuse

These medications have the potential to induce tolerance and dependence. *Tolerance* means that the effect can "wear off" over time, and higher doses may be needed to produce the same effect as previously. *Dependence* means that withdrawal symptoms may develop if a person has developed tolerance and stops the medication. The risk of tolerance and dependence increases with the dose, duration, and consistency of the medication use, and also depends on individual factors that may be hard to predict. *Abuse* is use of the medication in any way other than as prescribed (in higher doses, more frequently, for "recreational" purposes, or by any means other than oral ingestion.)

Diversion

These medications may be sought after by individuals who are dependent on them or wish to abuse them. Giving or selling your medications to others is a violation of Federal law, as well as of this agreement, and may carry severe legal consequences.

Multiple Sources

It is essential, both for your safety and for a trusting professional relationship, that you **not** obtain controlled medications similar to those I prescribe for you from any other source without my knowledge. This includes medication prescribed by other doctors, "borrowed" from friends, or "off the street".

Renewals

Renewals for controlled substance prescriptions will typically be handled in person at regularly-scheduled appointments. If necessary, renewalls for Schedule IV medications may be called in between appointments, assuming use has been appropriate. As with all medication refills, please call or email *at least several days in advance* of running out of your medication, so that I will have time to take care of the refill.

Schedule II medications (stimulants) cannot be called in, and require a paper prescription. Typically I will not re-prescribe Schedule II medications except at an office visit. If for some reason we do make a plan that involves a new prescription between visits, extra time will be needed to mail the prescription, or to have you pick it up. Please plan accordingly.

Lost, misplaced, or overused medication.

A controlled substance prescription or medication supply that is lost, misplaced, accidentally destroyed, used up early, or otherwise missing **will not be replaced** until the time it was due for renewal. At my discretion, depending on the clinical situation, I *may* authorize a limited supply of a lost medication, only in order to provide a "taper" to prevent serious medical or psychiatric effects of withdrawal. **Due to extra work and investigation required in such situations, an additional fee of $50.00 will be charged.**

Stolen Medication

It is extremely important that you protect your medication from theft. However, if your controlled medication is stolen *you must report this to the police immediately*. Supply the police with the name, dose, and approximate number of pills of each medication stolen. Tell the police that your physician requires that a written report be completed. Typically, this document will not be available for 5 business days.

After reporting the theft to the police, contact me. If you do not reach me in person, leave detailed information about the theft, the date you filed the police report, the phone # of the police department reported to, and the name of the officer who took the report.

When I am able, during normal office hours, I will then contact the police to confirm that a report was filed. If confirmed, I *may*, at my discretion, authorize up to a 7-day interim supply of medication. You will then need to obtain and forward to me a copy of the police report as soon as it is available. After I have the police report, I *may*, at my discretion, authorize additional supply of medication to replace that which was stolen. **Due to extra work and investigation required in such situations, an additional fee of $100.00 will be charged**.

Note that contact with police will not be made nights, weekends, and at times when I am on vacation. Colleagues covering for me when I am away will *not* be authorized to replace lost or stolen medications.

Medication Containers / Travelling

Although it is common sense that it is safer not to travel to work, vacation, etc. with one's entire supply of medication, State law requires that *all* prescription drugs remain in the original containers in which they were dispensed, except "when in use". "When in use" is defined to include "reasonable repackaging for more convenient legitimate medical use." On occasion, patients have been confronted by law enforcement officers if medications are not in their original bottle (e.g., when a car is searched at a traffic stop.) While I cannot offer an interpretation of the law on this matter, if you do chose to carry any of your medication outside its original container, it would be advisable to carry your pharmacy paperwork showing the details of the prescription, so that its legitimacy can easily be confirmed if necessary. If you have further questions about this, you may wish to consult an attorney for advice.

Prescription Monitoring Program

The Prescription Monitoring Program (PMP) is a tool created by the Maine Department of Health and Human Services to prevent and detect prescription drug misuse and diversion. The PMP maintains a database of all transactions for controlled substances dispensed in the State of Maine. This database is available to all prescribers and dispensers. I intermittently monitor the database for any unexpected prescriptions to my patients who take controlled substances. You may expect that other physicians who you see may also monitor the database, and will be aware of any controlled medications prescribed by me.

Agreement

I agree that I understand the risks of controlled substance tolerance and dependence. I agree that I will not in any way abuse the medication prescribed to me.

I agree to maintain strict and careful control over my medication supply and unfilled written prescriptions. I agree that under no circumstances will I give away, share, sell, or trade my medications, or leave my medications or prescriptions in a place that is likely to result in loss, theft, or diversion. I agree that I will report any theft of controlled substance medications to police immediately.

I agree that I will not seek or fill additional prescriptions for controlled substances similar to those I am prescribed by Dr. Filene without first informing Dr. Filene. If controlled substance medications are prescribed to me by another clinician, I agree to notify Dr. Filene immediately (or as soon as feasible following an emergency situation.) I agree not to obtain or consume controlled substance medications from friends or "street" sources.

I understand that all prescriptions for controlled substances dispensed in Maine are entered into the PMP database and may be reviewed by pharmacists and other physicians in order to prevent drug misuse and diversion.

I understand that state law requires that all prescription medications remain in their original (pharmacy) containers, except "when in use".

I understand that any violation of the above agreements could result in termination of some or all of my controlled substance prescriptions and/or termination of my status as a patient in Dr. Filene's practice. I further understand that violation of the above agreements may result in abruptly being without my controlled medication, which may cause unpleasant or hazardous withdrawal effects.

_____ _____

Client Date

_____ _____

Daniel R. Filene, MD Date

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178 MIDDLE STREET
PORTLAND, ME 04101
PHONE/FAX (207) 774-0046
WWW.DANFILENEMD.COM

MEDICARE / MAINECARE STATEMENT

I certify that I do not have healthcare coverage under Medicare Part B or Medicaid (MaineCare). Should I obtain such coverage in the future, I agree to notify Dr. Filene prior to the coverage becoming active.

_____
Client name

_____ _____
Signature Date