Welcome Letter

Dear Valued Patient,

Welcome to Clear Horizons Recovery Clinic! Choosing to begin treatment is a brave decision, and we are honored that you chose to walk with us on this journey.

We know the pain that addiction can bring — the strain on relationships, health, and peace of mind. No one should have to face that alone. Addiction is a serious condition, but with the right care and support, recovery is possible. Our purpose is to help you heal and move toward the fulfilling life you deserve.

At Clear Horizons, we focus on making your recovery as smooth as possible. Together, we'll create a treatment plan that works for you, offering both medical and emotional support along the way.

Thank you for trusting us with your care. We look forward to helping you take the first steps toward a brighter, healthier future.

Warmly,

The Clear Horizons Recovery Team

Patient Rights & Responsibilities

Your Rights

- **Respect & Dignity** – Be treated courteously, with consideration for your values and culture.
- **Privacy & Confidentiality** – Your information is protected under HIPAA and 42 CFR Part 2.
- **Informed Care** – Receive clear explanations about your treatment and medications; participate in decisions.
- **Access to Care** – Timely, appropriate care without discrimination.
- **Refuse Treatment** – Choose to refuse or withdraw from treatment, with information on potential consequences.
- **Safe Environment** – Care in a clean, supportive, and safe setting.
- **Grievances** – Voice concerns or file complaints without fear of retaliation.

Your Responsibilities

- **Provide Accurate Information** – Give honest, complete details about your medical history, medications, and substance use.
- **Follow Your Treatment Plan** – Attend appointments and follow instructions from your care team.
- **Medication Compliance** – Take medications as prescribed; do not share, sell, or misuse them.
- **Communicate Openly** – Report concerns, side effects, or challenges to your provider.
- **Respect Others** – Treat staff and fellow patients courteously; follow clinic rules.
- **Financial Responsibilities** – Pay co-pays, deductibles, or self-pay fees; update insurance info as needed.

Clear Horizons Expectations for Recovery Participation

At Clear Horizons Recovery, we believe that successful recovery requires more than just medical treatment. Active engagement in recovery-based activities is a vital part of healing and building a strong foundation for long-term success. We encourage all patients to:

- **Attend Support Groups –** Participate in community-based recovery groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Celebrate Recovery, or other peer-support programs.
- **Work with Counselors –** Engage regularly with addiction counselors, therapists, or behavioral health specialists to address underlying issues and build coping strategies.
- **Develop a Recovery Network –** Build positive, supportive relationships with peers, mentors, and sober supports.
- **Stay Consistent –** Make recovery a daily priority by attending meetings, practicing coping skills, and following through with your treatment plan.
- **Set Goals for Growth –** Work toward rebuilding relationships, employment, education, or other areas of life that support your recovery journey.

Your active participation is a key part of your success. We will walk alongside you, but your commitment to engaging in recovery activities will help strengthen your progress and reduce the risk of relapse.

HIPAA Privacy Acknowledgment Form

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides patients with important rights regarding their personal health information (PHI).

At Clear Horizons Recovery, we are committed to protecting your privacy. Our Notice of Privacy Practices describes how your health information may be used and disclosed, and how you can access this information.

Examples of use and disclosure:

- **Treatment:** sharing necessary information with healthcare providers involved in your care.
- **Payment:** using information to process insurance claims and billing.
- **Healthcare Operations:** quality assessment, licensing, and training of staff.

Your Rights:

- Request restrictions on the use of your PHI.
- Request confidential communications.
- Inspect, copy, and request amendments to your health records.
- Receive a list of disclosures of your PHI.
- File a complaint if you believe your privacy rights have been violated.

Consent for Treatment / MAT Consent Form

Medication-Assisted Treatment (MAT) Patient Consent Form

Purpose: MAT combines FDA-approved medications with counseling and behavioral therapies to treat substance use disorders. This consent form provides information about available medications, their benefits, risks, and alternatives to help you make an informed decision.

Medications Used in MAT:

- **Suboxone® (Buprenorphine/Naloxone):** daily oral/sublingual medication that reduces cravings and withdrawal symptoms.
- **Sublocade® (Buprenorphine Extended-Release):** monthly injection that provides long-acting buprenorphine.
- **Naltrexone (Oral Revia®):** daily oral tablet that blocks the effects of opioids and alcohol.
- **Vivitrol® (Naltrexone Extended-Release):** monthly injection that blocks the effects of opioids and alcohol.

Benefits:

- Reduces cravings and withdrawal symptoms.
- Helps prevent relapse.
- Allows focus on counseling, recovery, and rebuilding life.
- Improves treatment retention and recovery success rates.

Risks and Side Effects:

- Nausea, constipation, fatigue, dizziness, headache, or mood changes

- Suboxone/Sublocade: respiratory depression if misused; Sublocade must be given by a healthcare professional.

- Naltrexone/Vivitrol: possible liver injury; injection site reactions; must be opioid-free 7–10 days before first dose.

Alternatives:

- Abstinence without medications.
- Counseling, behavioral therapy, or peer recovery support programs alone.
- Inpatient or residential treatment programs.
- Other FDA-approved medications as appropriate.

Patient Responsibilities:

- Take medication only as prescribed.
- Attend all appointments, including medical visits, counseling, and lab monitoring.
- Inform provider of all medications, supplements, alcohol, or drug use.
- Avoid misuse, diversion, or sharing of medication.
- Report side effects, mood changes, or relapse immediately.
- Carry a medical alert card/bracelet identifying MAT treatment if required.

Financial & Insurance Policy

Payment Responsibility: Payment is expected at the time of service unless prior arrangements are made. Patients are responsible for self-pay fees. Late payments may incur additional fees.

Insurance Information: Provide current insurance info at each visit.

Missed Appointments / Late Cancellations: Provide at least 24 hours' notice. Repeated missed or late appointments may result in fees or affect care.

Medication & MAT Fees: Costs for MAT medications may vary based on insurance coverage. Prior authorization may be required; patients are responsible for any out-of-pocket costs.

Refunds & Overpayments: Overpayments or credits will be refunded according to clinic procedures (up to 30 days).

New Patient Intake Form

Patient Name: _____ **Date of Birth:** _____

Primary Contact Information:

- Phone (Home): _____
- Phone (Cell): _____
- Email: _____
- Preferred Method of Contact: ☐ Phone ☐ Email ☐ Mail

Emergency Contact:

- Name: _____
- Relationship: _____
- Phone: _____
- Alternate Phone: _____

Address:

- Street Address: _____
- City/State/Zip: _____

Additional Contacts (Optional):

- Name: _____
- Relationship: _____
- Phone: _____

Insurance Provider: _____

- Policy Number: _____
- Subscriber Name/DOB**:** _____

Reason for Seeking Treatment

☐ Alcohol use
☐ Opioid use (heroin, pain pills, fentanyl)
☐ Other drug use _____

☐ Mental health support
☐ Other_____

Briefly describe your main

concerns:_____

Following up with Clear Horizons

Recovery Clinic after inpatient detox?

Please answer the following:

Anticipated Discharge from detox unit? _____

Anticipated new patient appt? _____

Substance Use History

Have you used any of the following substances? Check all that apply and note last

use:

- Alcohol ☐ Yes ☐ No | Last use: _____
- Opioids (heroin, oxycodone, fentanyl, etc.) ☐ Yes ☐ No | Last use: _____
- Methamphetamines ☐ Yes ☐ No | Last use: _____
- Cocaine ☐ Yes ☐ No | Last use: _____
- Marijuana ☐ Yes ☐ No | Last use: _____
- Benzodiazepines (Xanax, Valium, Klonopin) ☐ Yes ☐ No | Last use: _____ ● Prescription medications (not as prescribed) ☐ Yes ☐ No | Last use: _____ ● Tobacco/Nicotine ☐ Yes ☐ No | Last use: _____

- Other: _____

Age at first use: _____
Longest period of sobriety: _____
Prior treatment programs (detox, rehab, MAT, counseling):
_____
_____

Past Medical History

Please check any conditions you have been diagnosed with:

☐ High blood pressure
☐ Diabetes
☐ Heart disease
☐ Seizures
☐ Chronic Pain
☐ HIV/AID
☐ Kidney Disease
☐ Liver disease (Hepatitis, cirrhosis)

Other: _____

List Current Medications:
_____
_____

Surgeries / Hospitalizations:

Allergies: ☐ None | ☐ Yes → List: _____

Mental Health History

Have you ever been diagnosed with:

☐ Depression
☐ Anxiety
☐ PTSD
☐ Bipolar disorder
☐ Schizophrenia or psychosis
☐ ADHD
☐ Eating disorder
☐ Other: _____

Current mental health provider: ☐ None | Name: _____

Current psychiatric medications: _____

History of suicide attempts or self-harm? ☐ Yes ☐ No
If yes, when? _____

Social History

- **Housing situation:** ☐ Stable ☐ Unstable ☐ Homeless
- **Employment status:** ☐ Employed ☐ Unemployed ☐ Disabled ☐ Student
- **Marital/relationship status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced
- **Children:** ☐ Yes (#_____) ☐ No
- **Support system (friends/family/community):**

Legal History

- **Currently on probation/parole?** ☐ Yes ☐ No
- **Past arrests/charges related to substance use?** ☐ Yes ☐ No
  If yes, explain: _____

Treatment Goals

What do you hope to accomplish through treatment at Clear Horizons

Recovery?_____

Insurance Information:

Insurance Type: ☐Commercial ☐Medicaid ☐Medicare ☐Other _____
Insurance Name: _____
Policy Holder Name: _____
Policy Number: _____
Policy Type ☐HMO ☐PPO ☐Other: _____
RX Group Number:_____
RX BIN #:_____ RX PCN #:_____
Effective From Date:_____ Effective To Date: _____

Addiction Treatment Agreement

Clear Horizons Recovery is committed to providing evidence-based care for

individuals seeking recovery from substance use disorders. To ensure safety, accountability, and success in treatment, the following guidelines must be agreed upon by both the patient and the clinic.

1. Medication and Treatment Compliance

- I agree to take my medication exactly as prescribed by my provider.
- I will not share, sell, or misuse my medication.
- I understand that lost, stolen, or damaged prescriptions may not be replaced.
- I agree to attend all scheduled appointments and participate in recommended counseling or support services.

2. Drug and Alcohol Use

- I agree to abstain from all illicit drugs, unauthorized prescription medications, and alcohol.
- I understand that random urine drug screens and/or pill counts may be required.
- A positive drug screen, refusal to test, or evidence of diversion may result in changes to my treatment plan, including possible discharge.

3. Safe Use and Storage

- I will store my medication in a safe, secure location, away from children and others.
- I will bring my medication to the clinic if requested for a pill/film count.

4. Communication and Respect

- I agree to communicate honestly with my treatment team about my recovery and challenges.
- I will treat all staff, patients, and visitors with respect.
- Disruptive, threatening, or abusive behavior will not be tolerated.

5. Confidentiality and Recovery Support

- I understand my treatment is confidential and protected by law.
- I agree to engage in recovery-oriented activities such as support groups, therapy, or community resources, as recommended by my provider.

6. Consequences of Non-Compliance

I understand that failure to follow this agreement may result in:

- More frequent visits or testing
- Adjustment of medication
- Referral to a higher level of care
- Dismissal from the program

Patient Acknowledgement

I have read and understand this agreement. I agree to follow these guidelines as part of my treatment at Clear Horizons Recovery.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Emergency & After-Hours Instructions

- **Medical Emergency:** Call 911 immediately or go to the nearest ER.
- **Mental Health Crisis / Suicidal:** Call 988 or Crisis Center of Alabama 1-205-323-7777 (24/7); text HELLO to 741741.
- **Medication Questions (Non-Emergency):** Leave voicemail; call returned next business day.
- **Appointment Issues:** Leave message for cancellation/rescheduling; follow-up next business day.
- **Prescription Refills:** Must be requested during business hours.
- **Clinic Hours:** Friday: 8:00 AM – 4:00 PM; Saturday & Sunday: Closed.

Patient Acknowledgment

I acknowledge that I have received, read, and understand all materials provided by Clear Horizons Recovery, including Patient Rights & Responsibilities, HIPAA Notice, Financial & Insurance Policy, Consent for Treatment, MAT Agreement, and New Patient Intake Form. I understand my rights and responsibilities as a patient and agree to comply with the policies and procedures.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Staff/Witness Name: _____

Staff/Witness Signature: _____ **Date:** _____