Jeff Blixt D.O., Inc.
1715 N. Weber Street
Suite 260
Colorado Springs, CO 80907

New Patient Intake Form

Full Name: _____

Address: _____ Apt#:_____

City: _____ State: _____ Zip:_____

Date of Birth: _____

Email Address:_____
(For Appointment Reminders Only)

☐ Consent to voice/text messaging
(For Appointment Reminders Only)

☐ Do not consent to voice/text messaging

Our office cares about our client's privacy and will protect the confidentiality of your medical information. Due to current State and Federal Laws regarding our office's responsibility to protect your information, you may request a copy of our Notice of Privacy Practices. Just ask our front desk for a copy.

Signature: _____ Date:_____

By signing on the above line, you agree to have been notified that our office has a privacy policy in place and have been allowed a copy of these policies. If you have any questions regarding our policies, please ask our office staff.

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Dear Client, Date:_____

Our office has adopted a policy that requires my office staff to obtain an authorization from you so we may contact you regarding appointments, test results, and account information. In an effort to protect your privacy and follow federal guidelines, please complete the following information:

I, _____, give permission for Dr. Blixt or his office
(Print name)
staff to leave a phone message regarding my medical care/account information. I fully

understand that this consent will remain valid unless revoked in writing by me.

Where can we leave a message for you?

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Is there anyone else we can leave this information with on your behalf?

Spouse/Partner: if yes, Name:_____
Phone Number:_____

Child: if yes, Name:_____
Phone Number:_____

Other: if yes, Name:_____
Relationship:_____
Phone Number:_____

Any special
instructions?_____
_____

Signature: _____ Date:_____

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Due to a high rate of clients not showing up for their scheduled appointments, I have found it necessary to charge a fee of $20.00 for these missed appointments. If you are unable to make your appointment, we require a 24-hour notice of your cancellation. We understand that unforeseen circumstances arise. However, we still need you to call as soon as possible. Clients that have 3 or more no-shows in a 12-month period will be dismissed.

Another concern I have is clients being late for their appointments. I understand that some of you drive a long distance. Unfortunately, when you are late for your appointment, the clients that arrive on time are not able to be seen at their scheduled time. Therefore, if you will be arriving late for your appointment, please notify my office staff at 719-896-4794. You may be informed that you need to wait until we can get you in, or you may need to be rescheduled.

I understand Dr. Blixt's Policy:

Signature: _____ Date:_____

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I, _____ (print name) have agreed to take urinary analysis (UA's) in Dr. Blixt's office.

I acknowledge that these UA's may be randomly sent out to a 3rd party laboratory for further analysis.

I may get a bill for these costs if insurance does not cover them, or I have no insurance at all.

Signature: _____ Date:_____

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Expectations and Costs For treatment

First Visit: Consult $200
Second Visit: Induction $150
First week follow up after induction visit $50
Second week follow up visit $50
First monthly visit one month after initial induction visit $150
Monthly visits thereafter will be $150 per visit. However, more frequent visits may be required if problems or need arises.

I agree to participate in random drug testing throughout my duration of treatment, and must be available for the drug test within 24 hours of notification. (Expect 2-4 random tests per month during the first 90 days).

To receive Suboxone or its equivalent such as Zubsolv (buprenorphine/naloxone) from Dr. Blixt, I must agree to and participate in behavioral treatment, which may include counselor, therapist, or professionally monitored group therapy. This must be immediately established and I agree to sign a records release so Dr. Blixt is able to communicate with this provider. Referrals can be provided.

(Please initial each line below)

_____Failure to follow through and establish behavioral treatment within 2 weeks of starting Suboxone Therapy will result in dismissal with Dr. Blixt and no further Suboxone treatment.

_____Failure to be compliant with behavioral professional's treatment recommendations may also result in dismissal from Dr. Blixt.

_____I am aware that I will only receive limited amounts of Suboxone initially (which will only be enough to get me through until my next appointment).

_____I understand that Suboxone is a highly regulated medication, and is followed closely by the DEA. Loss of medication, regardless of reason, will be my responsibility, and I will not receive an early refill.

_____I will keep my medication secure, in a lockbox, out of reach of other persons, especially children.
_____I understand that if I give my Suboxone to any other persons, for any reason, this will result in immediate dismissal from Dr. Blixt's office.

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_____I understand that I must bring all my medications to every office visit for accurate counts.

_____I agree to take my Suboxone only as prescribed. The indicated dose should be taken daily, and I must not adjust the dose on my own. If I wish to change the dose, I must call the office for an appointment to discuss this, and then Dr. Blixt can change the order.

_____I understand that I will not, under any circumstances, receive a refill over the phone for Suboxone/buprenorphine products. I must be seen in the office to receive a new prescription for Suboxone.

_____I agree not to combine Suboxone with other sedatives, including but not limited to, alcohol, benzodiazepines (such a Valium, Xanax, Klonopin). Combining Suboxone with these substances can be hazardous to my health and may result in death. It may also result in dismissal from Dr. Blixt care.

_____I agree to immediately notify Dr. Blixt if I have a relapse. I understand a relapse in and of itself is not generally a reason for discharge, but failure to disclose relapses may be a reason for discharge.

_____Dr. Blixt has reviewed the medication guide, discussed this medication, how it works, side effects, interactions, etc. I have been given a copy of the medication guide. We discussed alternatives to Suboxone assisted therapy of opiate use disorder. Dr. Blixt has answered these questions to my satisfaction at my first office visit and I have elected to begin Suboxone therapy.

_____I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatments with Dr. Blixt may be ended immediately.

_____I understand that if the treatment team feels that I am not taking my medications in the prescribed manner or the medications have not improved my ability to function, then I will be weaned off the medications.

Printed Name: _____ Date:_____

Signature _____

Witness _____

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Pretreatment Screening for Substance Use Disorder

Name: _____
DOB: _____
Age: _____
Gender: _____
Reason and/or motivation for seeking treatment:

How long have you been using a substance? _____

How old were you when you first started using a substance? _____

How often do you use? _____

How much to use? _____

What route do you use (oral, intranasal, inhalation, IV)? _____

How much do you spend per week? _____

History of withdrawal symptoms? _____

History of frequent cravings? _____

What other mind altering substances do you currently use? (include prescription medication)

What consequences has your use of a substance caused you? Your own health? Physical problems? Mental problems? Relationship problems? Occupation problems? Legal Problems? Loss of self-esteem or self-worth? Other consequences?

Do you use alcohol, if so how much:

Do you use sedatives such as benzodiazepines? (Valium, Xanax, Klonopin?)

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Have you ever been treated for substance dependence or misuse (detox , in-patient substance abuse services, outpatient substance abuse services, Suboxone program, methadone program, and vivitrol):?

Have you ever tried to quit on your own? _____

Have you ever been treated by a psychiatrist? No
(If yes, please describe):

Current Psychiatric Symptoms include:

Current Physicians: _____

Current Therapists: _____

Current Support Groups: _____

Do you have any medical conditions?:

History of IV drug use? No
History of brain injuries? No
History of seizures? No
History of liver problems? No
History of cardiac problems? No
History of Hypertension? No
History of diabetes? No
History of chronic pain? No
History of Hepatitis C? No
History of Overdose? No Accidental? No Intentional? No
If you answered yes to any of the questions above, please explain:

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What current medications are you taking? please include over-the-counter medication such as ibuprofen, Tylenol, supplements, etc.

Any ALLERGIES to medications: _____

Past surgical history:

Last time had a complete physical exam: _____

History of psychiatric disorder before use of substance? No

History of psychiatric disorder during use of substance? No

History of psychiatric disorder after use of substance? No

Any thoughts of self-harm or suicidal thoughts? No

Any history of suicidal attempts?
No
Any history of violence?
No

(Females only)

Are you pregnant?: No
How many pregnancies?

Are you using birth control?: No
Result of pregnancies?:
Live births
Miscarriages
Elective abortions.

Are there any current legal issues we should be aware (e.g., probation and parole)?:

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Do you use tobacco or nicotine in any form? No
How much?
Are you a former tobacco user? No
When did you quit?

Employment status:
Occupation:
How many hours per week do you work?:

Please describe your current living arrangements, who do you live with and what is their relationship to you:

Do you have reliable transportation (If so, describe)?

Degree of Family support from family and significant others?

Do you have substance free friends?

Dependent children?

Highest level of education completed:

Marital status?
History of domestic violence? No
History of sexual abuse? No
Do you feel safe at home? No

Do you have meaningful interpersonal relationships?

History of trauma?

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Are there people with substance abuse in the household? No
When did they start?

What do they use?

Family History of substance abuse or mental health problems?

Father: _____
Mother: _____
Siblings: _____
Grandparents: _____
Extended Family: _____

Do you exercise? If so, what type?

Nutritional status:
Caffeine intake; how much?

Sugar intake; how much?

Sleeping problems?

Hours of sleep per night?

Do you feel rested after sleep? No

Do you have spiritual beliefs that help you cope? Are you part of a religious or spiritual community? Does your current situation affect your ability to do things that usually help you spiritually?