

MEDICATION-ASSISTED TREATMENT (MAT) INTAKE PACKET (CONFIDENTIAL MEDICAL DOCUMENT)

Full Name: *

Date of Birth: *

Primary Care Provider: *

Primary Care Provider's Address: *

Primary Care Provider's Phone Number: *

Primary Care Provider's Fax:

2. Telehealth Consent:

I consent to receive telehealth services from T Temple Family Health NP. I understand that telehealth visits are conducted using electronic communication and may have limitations compared to in-person medical visits. I acknowledge that there may be potential privacy risks when using video or phone communication, although reasonable steps will be taken to protect my confidentiality. I confirm that I am physically located in the state of New York or Delaware at the time of each telehealth visit, as required by state law. I understand that controlled substance prescribing requires appropriate monitoring, including follow-up visits, prescription monitoring program checks, and possible drug screening. I agree not to record telehealth visits without permission, and I understand that the provider may stop the visit if safety, legal, or medical concerns arise. By signing below, I confirm that I understand the information above and voluntarily agree to receive telehealth services.

Please sign your name below *

Signature

Date

I am the parent/guardian of this patient

3. Substance Use History:

Please provide a detailed history of your opioid and other substance use. Include the type of opioid you use, route, frequency, and last use. This information helps your provider assess your treatment needs and determine the appropriate phase of MAT. Additionally, note any prior treatment for substance use, including detox, counseling, or other medications.

Primary opioid used: *

Route of use: *

- Oral
- Snorted
- Injected
- Smoked
- Other

Please mention the route if "other" was checked: *

Duration of use: *

Frequency of use: *

- Daily
- Weekly
- Occasionally

Amount used per day: *

Last opioid use date/time: *

Have you overdosed before? * (select one)

- Yes
- No

Have you received Narcan before? * (select one)

- Yes
- No

Previous treatment for addiction: *

- None
- Suboxone
- Methadone
- Naltrexone
- Rehab
- Detox
- Counseling

Currently in treatment? * *(select one)*

- Yes
- No

DSM-5 Opioid Use Disorder Criteria:

The following criteria are used to assess the presence and severity of opioid use disorder over the past 12 months. They include patterns such as cravings, tolerance, withdrawal, inability to control use, time spent using, continued use despite negative consequences, and impact on daily functioning. Your responses help determine the severity of your disorder and guide your MAT plan.

*

- Cravings
- Tolerance
- Withdrawal
- Using more than intended
- Unable to cut down
- Spending lot of time using
- Problems at work/school
- Continued use despite harm
- Giving up activities
- Using in dangerous situations
- Legal problems related to use

Mental Health History:

Please describe any current or past psychiatric diagnoses, hospitalizations, or treatment. Include information about therapy, medications, and suicide or self-harm history. Understanding your mental health is essential to providing safe and effective MAT care.

Co-occurring psychiatric diagnoses: *

Psychiatric hospitalizations: * *(select one)*

- Yes
- No

Suicide attempts: * *(select one)*

- Yes
- No

Self-harm behavior: * *(select one)*

- Yes
- No

Current psychiatric medications: *

Past psychiatric medications: *

Therapist / psychiatrist: *

Therapist's / psychiatrist's Address: *

Therapist's / psychiatrist's Phone Number: *

Medical History:

Please provide your current medical conditions, medications, and history of surgeries, seizures, head injury, or communicable diseases. This ensures your MAT treatment is safe in the context of your overall health.

Current medical conditions: *

Current medications (non-psychiatric): *

Allergies: *

Past surgeries: *

History of seizures: * *(select one)*

- Yes
- No

History of head injury: * *(select one)*

- Yes
- No

Pregnant / possible pregnancy: * *(select one)*

- Yes
- No

HIV / Hepatitis / TB history: * *(select one)*

- Yes
- No

Social History:

Understanding your living situation, support system, employment, and history of abuse is critical to providing holistic care and planning MAT support.

Living situation: *

Employment status: *

Support system: *

Legal problems: * *(select one)*

- Yes
- No

Probation / parole: * *(select one)*

- Yes
- No

Access to weapons: * *(select one)*

- Yes
- No

History of abuse: *

- None
- Physical
- Emotional
- Sexual
- Domestic violence

MAT Treatment Agreement:

The following agreements are required to ensure safe and effective MAT treatment. By signing, you acknowledge your responsibilities while in the program.

I agree to:

- Take medication only as prescribed
- Not request early refills or share medication
- Use one pharmacy for all prescriptions
- Attend all scheduled follow-ups
- Submit to urine drug screenings as requested
- Allow PDMP checks
- Understand that lost or misused medication may not be replaced
- Follow telehealth rules and provide accurate information

Please sign your name below *

Signature

Date

I am the parent/guardian of this patient

Financial Agreement:

T Temple Family Health NP is a private-pay telehealth practice. All patients, including those with insurance coverage, are required to pay for services out-of-pocket at the time of the visit. Insurance may be billed for reimbursement at the patient's discretion, but the practice does not directly bill insurance for MAT services. Payment is required prior to receiving any treatment, including initial and follow-up visits.

Service Fees:

- Initial MAT Visit: **\$200**
- Follow-up Visit: **\$150**

By signing below, I acknowledge that I am responsible for all fees for services provided by T Temple Family Health NP, regardless of insurance coverage, and I agree to pay these fees at the time of service.

Please sign your name below *

Signature

Date

I am the parent/guardian of this patient

Provider Section (Office Use):

Diagnosis:

Phase: *(select one)*

- Induction
- Maintenance

UDS ordered: *(select one)*

- Yes
- No

PDMP checked: *(select one)*

- Yes
- No

PDMP Reference:

Medication prescribed:

Provider's Signature:

Date:

March 23, 2026