

RHJ Medical Center, Inc

Thank you for allowing RHJ Medical Center, Inc to assist in your MAT recovery journey while attending Gateway Rehabilitation center. Your recovery and confidentiality are very important to us. During your stay at Gateway, we will need the following information prior to dosing at our facility:

- Release of information between RHJ Medical and your home clinic
- Release of information between Gateway and your home clinic
- Release of information between RHJ Medical and Gateway (Please use attached forms)
- Completed guest dosing form from your home facility to RHJ Medical Center, inc
- Letter guaranteeing your return to your home facility when discharged from Gateway
- Valid Photo ID upon first entry to our dosing facility
- Copy of all insurance information (front and back)
- Encounter form
- Consent to Treatment

Please submit completed packet to:

RHJ Medical Center, Inc. – Fax: 724-204-9003; or email: billing@rhjmedicalinc.com

Gateway Rehab Center: Phone- 724-378-4461; Fax: 724-375-3878; email: Cas@gatewayrehab.org

Thank you for choosing RHJ Medical Center, Inc. and Gateway Rehabilitation for your treatment needs!



Kerri Csikesz

Program Director

Re-disclosure Prohibited: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains to or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT suitable for this purpose.

1007 Old State Route 119, Hunker, PA 15639 Ph 724-696-9600 Fax 724-204-9003

Consent to Treatment

~~X~~ I _____, hereby consent to outpatient methadone maintenance treatment knowing that it is recommended for the treatment of my dependence on heroin or other narcotic drugs.

The treatment at RHJ Medical Center, Inc will encompass outpatient Methadone Maintenance Treatment, which includes both psychotherapeutic techniques and routine diagnostic procedures, as well as daily doses of methadone by RHJ Medical Center, Inc its medical director and his or her designees which will help control my dependence on heroin or other narcotic drugs.

I understand that I am not required to consent to outpatient treatment but I do so voluntarily under the terms specified above.

I understand that methadone is an addictive narcotic medication and that it may, like other narcotic drugs used in medical practices, produce adverse results, including death. The possible risks and complications of treatment as well as alternative treatments available have been explained to me.

I understand that one possible complication is that some clients in methadone maintenance alone or in combination with other drugs and/or cardiac (heart) risk factors can cause a change on an EKG heart evaluation (specifically a prolongation in the QT interval, which may contribute to the development of a serious and potentially fatal type of heart arrhythmia called "torsade de pointes" in susceptible clients.) You may be asked to get an EKG performed to check to see if your heart has this serious arrhythmia. It is important to disclose all medications used (prescribed/not prescribed/illicit) to determine if you are at risk for this heart arrhythmia. It is also important to disclose any prior heart conditions (known irregular heart beat, heart disease such as prior heart attacks or congestive heart failure), eating disorders such as bulimia or anorexia, electrolyte imbalances, unexplained seizures, exceptional chest pain/discomfort, breathlessness, unexplained fainting or dizzy near fainting feeling, heart palpitations, high blood pressure, or a family history of sudden or unexplained death at a young age (less than 50). This should not deter clients from entering methadone maintenance treatment as it is a relatively small potential risk and should be weighed against the more serious risks of withholding methadone

maintenance treatment; including a high likelihood of illicit of illicit drug use and its related morbidity, mortality, and public health ramifications.

I understand that I may withdraw from this treatment program and discontinue the use of methadone at any time, and I shall be afforded detoxification under medical supervision.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a narcotic treatment program, since the use of other drugs in conjunction with narcotic drugs prescribed by the treatment program may cause harm, including death.

I understand that during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me. I understand that these alternate procedures shall be used when, in the project medical director's professional judgement, it is considered advisable.

If I am currently pregnant or should become pregnant I understand that methadone is transmitted to the unborn child and will cause physical dependence.

I understand that failure to maintain regular contact with my primary counselor grants him/her the right to contact my home, by phone and/or mail requesting that I schedule an appointment.

X To the best of my knowledge, I am /am not (please circle one) pregnant at this time.

Besides the possible risks involved with the long-term use of methadone, I further understand that, like heroin and other narcotic drugs, information on its effects on pregnant women and on their unborn children is at present inadequate to guarantee that it may not produce significant or serious side effects.

It has been explained to me, and I understand that methadone is transmitted to the unborn child and will cause physical dependence. Thus, if I am pregnant and suddenly stop taking methadone, the unborn child or I may

show signs of withdrawal, which may adversely affect my pregnancy or the child. I shall use no other drugs without approval of the Medical Director or his authorized assistant, since these drugs, particularly as they might interact with methadone, may harm my unborn child or me. I shall inform any other physician who sees the child, after birth, of my current or past participation in a narcotic treatment program in order that he/she may properly care for my child and me.

It has been explained to me that after the birth of my child I should not nurse the baby, as this may cause physical dependence on methadone in the child. I understand that for a brief period following the birth, the child may show temporary irritability or other ill effects due to my use of methadone. It is essential for the child's physician to know of my participation in a narcotic treatment program so that he/she may provide appropriate medical treatment for the child.

All of the above possible effects of methadone have been explained to me, and I understand that at the present there have not been enough studies conducted on the long-term use of the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and promise to inform that Medical Director or one of his/her assistants immediately if I become pregnant.

I understand that this authorization will remain in effect for the entire duration of my treatment at RHJ Medical Center, Inc.

I certify that no guarantee or assurance has been made as the results that may be obtained from narcotic addiction treatment. With full knowledge of the potential benefits and possible risks involved, I consent to narcotic treatment, since I realize that I would otherwise continue to be dependent on heroin or other narcotic drugs.

X Client Signature _____ Date _____

Witness Signature _____ Date _____

RHJ Medical Center, Inc.

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Release of Information to RHJ

Client Name: _____ Client No: _____

Social Security No: _____ Date of Birth: _____

My signature on this statement acknowledges that I understand that my records are protected by law and cannot be disclosed without my written consent, unless otherwise provided by law. I have signed this request voluntarily and without coercion. I understand that I may revoke this consent at any time, it must be in writing and/or verbally and I understand that if action has been taken before the revocation, it will be validated by this release. This release will expire as described below. I may request a copy of this release for my records.

I give RHJ Medical Center, Inc. Hunker, PA permission to provide the information described to the agency listed.

Information to be released:

Client's name; Client's SSN; Client's Date of Birth; Client Enrolled in Said Program; Client's Admission Date; Client's Discharge Date; Client's Progress; client's Prognosis, Type of Services offered to Client; Client's follow up Instruction; Client's Aftercare Plan.

Reason for Request:

Coordination of care.

Information Released From:

Name: (Pt's inpatient Rehab)

Agency:

Address

Phone:

Fax:

Information Released To:

RHJ Medical Center, Inc.

1007 Old State Route 119

Hunker, PA 15639

Phone: 724-696-9600

Fax: 724-204-9033

This release expires **One Year** from date of signature.

Client signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Copy offered to Client: **Accepted** **Rejected**

RHJ Medical Center, Inc.

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Release of Information from RHJ

Client Name: _____ Client No: _____

Social Security No: _____ Date of Birth _____

My signature on this statement acknowledges that I understand that my records are protected by law and cannot be disclosed without my written consent, unless otherwise provided by law. I have signed this request voluntarily and without coercion. I understand that I may revoke this consent at any time, it must be in writing and/or verbally and I understand that if action has been taken before the revocation, it will be validated by this release. This release will expire as described below. I may request a copy of this release for my records.

I give RHJ Medical Center, Inc. Hunker, PA permission to provide the information described to the agency listed.

Information to be released:

Client's name; Client's Date of Birth; Client's ID number; Client's SS number; Client enrolled in RHJ Medical Center, Inc. – Hunker PA; Client's Admission Date; Client's Discharge Date; Client's Demographics; Client's Progress in Treatment; Client's Prognosis in Treatment; Client's Medications; Client's Dosing Schedule, Client's Dosage Amount, Client's ASAM; Client's Substance Use, Services offered to Client.

Reason for Request:

Coordination of Care; Transfer to Higher Level of Care.

Information Released From:

RHJ Medical Center, Inc.
1007 Old State Route 119
Hunker, PA 15639
Phone: 724-696-9600
Fax: 724-204-9033

Information Released To:

Name: (Pt's Inpatient Rehab)
Agency:
Address:

Phone:
Fax:

This release expires **One Year** from date of signature.

Client signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Copy offered to Client: **Accepted** **Rejected**

RHJ Medical Center, Inc.

Re-disclosure Prohibited: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains to or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT suitable for this purpose.

Release of Information to RHJ

Client Name: _____ Client No: _____

Social Security No: _____ Date of Birth: _____

My signature on this statement acknowledges that I understand that my records are protected by law and cannot be disclosed without my written consent, unless otherwise provided by law. I have signed this request voluntarily and without coercion. I understand that I may revoke this consent at any time, it must be in writing and/or verbally and I understand that if action has been taken before the revocation, it will be validated by this release. This release will expire as described below. I may request a copy of this release for my records.

I give RHJ Medical Center, Inc. Hunker, PA permission to provide the information described to the agency listed.

Information to be released:

Client's name, Client's SSN, Client's date of birth, Client's ID Number, Client's Demographics, Client's Dosage Information, Client's Appearance and Demeanor while Guest Dosing at facility, any Urine results at Guest-Dosing Facility, Last Day Client dosed at said facility, Any Take-Home Bottles given to Client, any Issues of Concerns while Guest-Dosing at said facility.

Reason for Request:

Verification that Client Attended Guest-Dosing Facility.

Information Released From:

Name:

Agency:

Address:

Phone:

Fax:

Information Released To:

RHJ Medical Center, Inc.

1007 Old State Route 119

Hunker, PA 15639

Phone: 724-696-9600

Fax: 724-204-9003

This release expires **One Year** from date of signature.

Client signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Copy offered to Client: **Accepted** **Rejected**

RHJ Medical Center, Inc.

Re-disclosure Prohibited: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains to or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT suitable for this purpose.

Release of Information from RHJ

Client Name: _____ Client No: _____

Social Security No: _____ Date of Birth _____

My signature on this statement acknowledges that I understand that my records are protected by law and cannot be disclosed without my written consent, unless otherwise provided by law. I have signed this request voluntarily and without coercion. I understand that I may revoke this consent at any time, it must be in writing and/or verbally and I understand that if action has been taken before the revocation, it will be validated by this release. This release will expire as described below. I may request a copy of this release for my records.

I give RHJ Medical Center, Inc. Hunker, PA permission to provide the information described to the agency listed.

Information to be released:

Client's name, Client's SSN, Client's date of birth, Client's ID Number, Client's Demographics, Client's Dosage Information, Client's Appearance and Demeanor while Guest Dosing at facility, any Urine results at Guest-Dosing Facility, Last Day Client dosed at said facility, Any Take-Home Bottles given to Client, any Issues of Concerns while Guest-Dosing at said facility.

Reason for Request:

Setup Guest Dosing for Client

Information Released From:

RHJ Medical Center, Inc.
1007 Old State Route 119
Hunker, PA 15639
Phone: 724-696-9600
Fax: 724-204-9003

Information Released To:

Name:
Agency:
Address:

Phone:
Fax:

This release expires **One Year** from date of signature.

Client signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Copy offered to Client: **Accepted** **Rejected**

Release of Information from RHJ

Re-Disclosure Prohibited: This has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (CPR Part2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains to or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT suitable for this purpose.

Client Name: _____ ID#: _____

Social Security #: _____ Date of Birth: _____

My signature on this statement acknowledges that I understand my records are protected by law and cannot be disclosed without my written consent, unless otherwise provided by law. I have signed this request voluntarily and without coercion. I understand that I may revoke this consent at any time in writing and/or verbally. I understand that if action has been taken before revocation, it will be validated by this release. This release will expire as described below. I may request a copy of this release for my records.

I give RHJ Medical Center, Inc. permission to request and the agency listed permission to provide the information described.

Information to be Released:

Client's Name, Client's SS#, Client's DOB, Client's ID Number, client enrolled in RHJ Medical-Hunker, client's admission date, client's discharge date, client's progress in treatment, Client's prognosis in treatment, Client's medications, Client's dosing schedule, Client's 30 day dosing history, Client's dosage amount, Client's guest dosing forms, Client's Last 3 UDS Results, Client's ASAM, Client's Substances use, Services offered to client.

Reason for Request:

Continuation of care, Client attempting to receive and retain funding for treatment at RHJ.

Information Release From:

RHJ Medical Center, Inc.

1007 Old State Rte 119

Hunker, PA 15639

Phone: 724-696-9600

Fax: 724-204-9003

Information Release To:

This release of information expires when account is paid in full or 2 years after discharge.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Copy offered to Client: Accepted _____ Rejected _____

Revised: 09/14/2023

RHJ Medical Center, Inc.
1007 Old State Route 119, Hunker, PA 15639
Phone: (724) 696-9600 Fax: (724) 204-9003

CHAIN OF CUSTODY FOR CLIENT MEDICATION FORM

Client Name: _____ **Client #:** _____ **Date:** _____

RHJ Staff Signature: _____

Bottles Given: _____ **For Dates:** _____

Client Signature: _____

Medical Staff Signature(s): _____
(If Receiving Medication from Nursing)

*****Detach Here*****

CHAIN OF CUSTODY FOR OFF OF RHJ GROUNDS

Client Name: _____ **Client #:** _____ **Date:** _____

Transport Staff Name: _____

Medical Staff Signature: _____

DOSING SIGNATURES

Day 1. Client Signature: _____ **Date:** _____
Dosing staff: _____ **Date:** _____

Day 2. Client Signature: _____ **Date:** _____
Dosing staff: _____ **Date:** _____

Day 3. Client Signature: _____ **Date:** _____
Dosing staff: _____ **Date:** _____

Day 4. Client Signature: _____ **Date:** _____
Dosing staff: _____ **Date:** _____

Day 5. Client Signature: _____ **Date:** _____
Dosing staff: _____ **Date:** _____

Day 6. Client Signature: _____ **Date:** _____
Dosing staff: _____ **Date:** _____

ENCOUNTER FORM

[illegible]

RHJ Medical Center, Inc

METHADONE DISOPOSAL

If a patient should leave Gateway Rehabilitation Center, and have leftover methadone in their lock box, RHJ Medical Center, Inc. would like you to dispose of the methadone as per your policy of medication disposal. Please have your nurses document the disposal, and have a nurse witness the disposal.

Thank you,


Kerri Csikesz
Program Director