Skiatook Family Clinic

201 East Second Street • Skiatook, OK 74070
Phone: (918) 306-1262 | Fax: (918) 306-4598

February 01, 2026

Re: Office-Based Opioid Treatment

Dear Prospective Patient,

Thank you for your interest in Skiatook Family Clinic's Office-Based Opioid Treatment program. We provide medication-assisted treatment for patients with Opioid Use Disorder using buprenorphine-based products and opioid antagonists. Our providers have nearly 20 years of combined experience caring for the unique needs of patients with Opioid Use Disorder. We accept new patients and are excited about the successes we have seen in the past and our current patients' progress towards recovery now.

We believe substance use disorders are chronic relapsing illnesses based on our biology and triggered by our unique social circumstances, not character flaws. Our treatment approach and practice philosophy builds on the American Society of Addiction Medicine's 2020 National Practice Guideline Update and is current. We understand what you are going through and are committed to providing the best care possible.

Our goal is to help our patients stabilize their health and life and then get back on their feet to be productive and enjoy their best life. Our program requires an initial assessment and examination that includes a drug test before considering any prescriptions. Our patients must also participate and demonstrate a commitment to recovery to remain in the program. Counseling and instruction are provided directly by our providers, and we also have a licensed drug and alcohol counselor available to see patients on-site for added support.

On a case-by-case basis, we accept new patients who are committed to recovery. If you would like to enter our program, please complete the attached documents and return them to the office at your earliest convenience for consideration and scheduling of your first appointment.

Sincerely,

Layne Subera, DO

**** *Electronic Signature Verified* ****

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New Patient Intake Form

Name: _____ Date of Birth: _____

Address: _____ City/State/ZIP: _____

Phone: _____ Type: [ ] Cell [ ] Work [ ] Home

Please answer these questions to help us understand your situation. Be sure to identify the circumstances and substances that cause problems. Provide enough detail to tell your story.

Substance: _____ How long using? _____

How much? _____ How often? _____

1. Have you ever tried to quit on your own? [ ] Yes [ ] No If yes, explain:

_____

2. Have you ever been treated for a substance use disorder? [ ] Yes [ ] No If yes, explain:

_____

3. Has your drug use ever resulted in medical or legal problems? [ ] Yes [ ] No If yes, explain:

_____

4. Have you ever used buprenorphine? [ ] Yes [ ] No If yes, explain:

_____

5. Are you able or willing to attend counseling? [ ] Yes [ ] No If yes, explain:

_____

6. Do you have any medical conditions (diabetes, HIV+, epilepsy, hepatitis)? [ ] Yes [ ] No If yes, list:

_____

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New Patient Intake Form (continued)

7. Are you currently taking any medications? [ ] Yes [ ] No If yes, list on medication flow sheet.

_____

8. Are you pregnant? [ ] N/A [ ] No [ ] Yes [ ] Not sure If yes, describe progress and prenatal care:

_____

_____

9. Is anyone in your family or home using substances now or have a history of substance use? [ ] Yes [ ] No If yes, explain:

_____

_____

10. Please describe your current living arrangement:

_____

_____

11. Are you currently employed? [ ] Yes [ ] No Occupation:

_____

Employer: _____

Hours per week: _____

At risk of losing your job? [ ] Yes [ ] No If yes, explain: _____

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Opioid Use and Safety Screener

INSTRUCTIONS: Place a checkmark in the box to the left of each statement that is true.

[ ] I am using opioids in larger amounts or for a longer period of time than I planned.

[ ] I have a persistent desire to cut down on my opioid use but have been unsuccessful.

[ ] I spend a lot of time trying to obtain opioids, use them, or recover from using them.

[ ] I crave opioids or have strong urges to keep using them.

[ ] My opioid use keeps causing me to fail to meet significant obligations at work, school, or home.

[ ] I continue to use opioids even though I know they are causing persistent social or interpersonal problems in my life.

[ ] I have given up important social, occupational, or recreational activities because of my opioid use.

[ ] I frequently use opioids in physically hazardous situations like driving or using tools.

[ ] I keep using opioids despite knowing they are causing me physical or psychological problems.

[ ] I keep increasing the amounts of opioids I use because I do not get the same effect from the lower doses I used to get.

[ ] If I run out of opioids, I get sick or have to find something else to take.

[ ] None of these statements are true.

Signature: _____ Date: _____

Adapted from the DSM-V criteria for Opioid Use Disorder.

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Explanation of Suboxone Induction Visit

SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet

Your induction visit is generally the longest, and may last anywhere from 1 to 4 hours. When preparing for your visit, there are a couple of logistical issues you may want to consider:

• You may not want to return to work after your visit—this is very normal, so just plan accordingly.

• Because SUBOXONE can cause drowsiness and slow reaction times, particularly during the first few weeks of treatment, driving yourself home after the visit is generally not recommended, so you may want to make arrangements for a ride home.

It is very important to arrive for your visit already experiencing mild to moderate opioid withdrawal symptoms. If you are in withdrawal, buprenorphine will help lessen the symptoms. However, if you are not in withdrawal, buprenorphine will "override" the opioids already in your system, which will cause severe withdrawal symptoms.

The following guidelines are provided to **ensure you are in withdrawal for the visit.** (If this concerns you, it may help to schedule your first visit in the morning; some patients find it easiest to skip what would normally be their first dose of the day.)

• No methadone or long-acting painkillers for at least 24 hours

• No heroin or short-acting painkillers for at least 4 to 6 hours

Bring **ALL** medication bottles with you to your appointment.

Before you can be seen by the doctor, all of your paperwork must be completed, so bring all your completed forms with you or arrive about 30 minutes early. In addition, you will need to pay the doctor's fees prior to treatment.

CHECKLIST FOR SUBOXONE INDUCTION VISIT:

[ ] Arrive experiencing mild to moderate opioid withdrawal symptoms

[ ] Bring completed forms

[ ] Fees due at time of visit (cash or check)

[ ] Arrive with a full bladder

[ ] Bring ALL medication bottles

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Consent to Release Records Containing Substance Use Information

42 CFR Part 2 Protected Information

I, _____ , authorize Skiatook Family Clinic to disclose the following information:

- [ ] Psychiatric/medical/alcohol/drug abuse records
- [ ] Progress notes
- [ ] Lab studies
- [ ] Medical tests/studies
- [ ] Psychological testing
- [ ] Other: _____

To (Name of recipient): _____

For the purpose of (be specific): _____

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows (describe date or circumstance):

_____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

[ ] I have been provided a copy of this form.

Signature of Patient: _____ Date: _____

Signature of person signing (if not patient): _____

Relationship: _____

Authority to sign on behalf of patient: _____

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Patient Information

Patient Demographics

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ SSN: _____ Sex: [ ] M [ ] F

Language: _____ Ethnicity: _____

Employer: _____ Work Phone: _____

Referred by: _____

Emergency Contact (someone NOT in your household)

Name: _____ Phone: _____

Relationship: _____

Insurance Information

	Primary Insurance	Secondary Insurance
Insurance Name:		
Address:		
Policy Holder:		
Holder DOB:		
Group/Plan #:		
Relationship:	[ ] Self [ ] Spouse [ ] Parent [ ] Child	[ ] Self [ ] Spouse [ ] Parent [ ] Child

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Authorization for Release of Medical Records

Patient Name: _____

Parent/Guardian (if minor): _____

I hereby authorize Skiatook Family Clinic to disclose health-related information from my (or my minor child's) medical records to the following individual or organization:

Name/Organization: _____

Address: _____

City/State/ZIP: _____

Information to be released:

[ ] Any and all medical records

[ ] Specific information (describe below):

_____

_____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization expires on the date listed below, or if no date is specified, one year from the date of signature.

Expiration Date: _____ [ ] Do not expire this authorization

Patient/Guardian Signature: _____ Date: _____

Witness: _____

* Parent or Legal Guardian if patient is a minor.