C.A.R.S.
CAYUGA ADDICTION RECOVERY SERVICES
OUTPATIENT CENTER

Outpatient Clinic
334 W. State Street
Ithaca, NY 14850

Phone: 607-273-5500
Fax: 607-273-1277

Request for Guest Dosing at Cayuga Addiction Recovery Services OTP

Referral Date: _____ **Dates of service:** _____ **to** _____

Client Name: _____ **DOB:** _____ **Phone:** _____

Client Address: _____

SSN: _____ **Hgt:** _____**Wgt:** _____ **Eye:** _____ **Hair:** _____

Name of Home Clinic: _____

Clinic Address: _____

Phone Number: _____ **Fax:** _____

Contact Person: _____ **Phone Number:** _____

Methadone dose: _____**mg** **Days of dosing/Privileges:** M T W Th F Sa Sun

Obtained ROI from home clinic: Yes No **Picture ID required**

Any behavioral concerns: _____

Reason for guest dosing: _____

_____, RN _____, MD

Please send an active/official methadone order with the doctor's name and signature, medication administration history, EKG, and any other pertinent information determined by the medical staff.

PLEASE NOTIFY THE CLIENT THAT THE REQUIRED GUEST DOSING FEE IS $40 FOR THE FIRST CLINIC VISIT AND $20 FOR EACH CLINIC VISIT THE SAME WEEK. THIS PAY STRUCTURE RESETS AT THE BEGINNING OF FOLLOWING WEEKS.

THE MISSION STATEMENT OF CAYUGA ADDICTION RECOVERY SERVICES

Cayuga Addiction Recovery Services transforms lives and the community with flexible and inclusive person-centered treatment.

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Guest Dosing Payment Agreement

Please note: Your first medication dose of each week will be $40 and $20 per clinic visit during the same week, resetting on Monday for subsequent weeks.

I _____ agree to pay for my medication dose throughout the days I guest dose at CARS Opioid Treatment Program. I understand that CARS does not accept insurance for guest dosing and the payment must be made in full at the time of my daily dose.

Signature: _____