

Luis Fajardo MR SIR2024-122 DOB: 09/02/1993 Male Blue Cross Blue Shield of Oklahoma
Package: full chart

Table of Contents

Facesheet 2

Pre-Admission-Assessment- 4

Assignment-of-Benefits-/-Release-of-Medical-Information- 9

Coordination-Of-Benefits-and-Pre-existing-Conditions 11

Golden Thread List 13

Insurance-Forms 14

Vitals 15

Glucose 16

Weight 17

Height 18

Orthostatic-Vitals 19

CIWA-AR 20

CIWA-B 21

COWS 22

Medications-Brought-In 23

Rounds 24

MAT-Orders 25

Luis Fajardo ♂ SIR2024-122

Birthdate: 09/02/1993

Allergies: No Known Allergies/NKA

Admission: 07/17/2024 Care Team

Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US & Canada)

Date 1st contact	Rep on intake call	1st contact name	1st contact phone	1st contact relationship
07/18/2024	Sandy Rosa	n/a	n/a	n/a

Location: Step Into Recovery Centers INC

Admission Date	Referrer	Contact?	Anticipated Discharge Date
07/17/2024 12:00 AM		No	
Discharge/Transition Date	Discharge/Transition to		
10/03/2024 12:18 PM			

PARTICIPANT INFORMATION HAS NOT BEEN VALIDATED - PLEASE VALIDATE

participant Information

Luis Fajardo

Current Address:
1115 S Urbana Ave
Tulsa, OK 74112 United States

Date of Birth: 09/02/1993 SSN: ***-**-9181

Birth Sex: Male

Pronouns:

Preferred Language:

Marital Status: Single

Race:

Ethnicity:

Payment Method

Insurance

Insurance Information

Insurance	Policy No.	Effective Date	Termination Date	Status	Insurance Type/Priority
Blue Cross Blue Shield of Oklahoma	YUQ94721844			Active	
Internal ID / External ID	Group Plan Name	Group ID	Plan Type	Payor Type	Insurance Phone
13123 /					
Rx Name	Rx Group	Rx BIN	Rx PCN	Rx Phone	Plan Period

Claims

Street Address 1	Street Address 2	Claims Fax					
City Subscriber	State	Relationship of Patient to Subscriber	SSN	ZIP Code	DOB	Country	Gender
Luis Fajardo		Self	***-**-9181		09/02/1993		Male
Subscriber Address Street		Subscriber Address Street 2			Subscriber City		
1115 S Urbana Ave					Tulsa		
Subscriber Address Zip	Subscriber Address State				Subscriber Address Country		
74112	OK				United States		

Concurrent Reviews

Contacts

Allergies and Food Restrictions

Allergies

No Known Allergies/NKA

Diets

Regular Diet

Lab Testing

Lab Bill To	Lab Guarantor Type	Lab Guarantor	Lab Guardian	Lab Patient Class
Unassigned	Unassigned	Unassigned	Unassigned	Not Applicable
Lab Primary Insurance	Lab Secondary Insurance			
Unassigned	Unassigned			

participant Record Source: N/A

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Location: Step Into Recovery Centers INC
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Pre-Admission Assessment 08/12/2024 12:26 PM

Date/Time of Assessment: 08/12/2024 12:26 PM

Race: Hispanic

Marital Status: Single

Number of Marriages:

0

Living Arrangements

With whom does the patient live:

self

Does the patient wish to return to current living situation? ☐ Yes ☒ No

Does the client have children? No children

Are you pregnant? N/A

Are you employed? No

Does your employer know you are here? No

If yes, when are you supposed to return to work? N/A

Do you have any mobility issues/concerns? Denied

Are you ambulatory? No

Heroin						
Suboxone/Zubsolv						
Oxycontin						
Methadone						
Other Opiates						
Benzodiazepines						
Hallucinagens						
Amphetamines						
Inhalants						
Ketamine (Special K)						
Triple C's						
Codeine						
Ecstasy						
Bath Salts						
Flakka						
MDMA/Molly						
Steroids						
K2Spice						
Kratom						
Kava						
Other OTC drugs						
Other						

Current Signs and Symptoms of Withdrawal

History of High Risk/Severe Withdrawal Symptoms:

Neurovegetative Signs and Symptoms

Sleep Patterns:

Good

Fair

Poor

☐

☐

☐

Hours per Night:

Sleep Interruptions:

Appetite:

Good

Fair

Poor

☐

☐

☐

Unanticipated weight gain?

Unanticipated weight loss?

Loss or gain over the following time
period?

Yes
☐

No
☐

Suicidal/Homicidal Lethality Risk Assessment

Suicidal Ideation:

How long has the client had these
thoughts?

Does the Client have a
plan?

Past history of suicide
attempts?

How was the attempt
made?

Homicidal Ideation?

History of Violent Behavior
(describe)

Self Abuse History

Does patient have a history of self
mutilation?

How and where does client typically disfigure
him/herself?

Eating Disorders:

Preadmission Mental Status

Speech:

Judgment:

Insight:

Thought
Process:

Memory:

Attention:

Affect:

Family History

Father:

Mother:

Siblings:

Spouse:

Children:

Other:

**Rationale for Treatment
Admission:**

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Location: Step Into Recovery Centers INC
(GMT-08:00) Pacific Time (US &
Canada)

Step Into Recovery Centers INC

Assignment of Benefits / Release of Medical Information

I hereby authorize and request that payment of benefits by my Insurance Company(s), Blue Cross Blue Shield of Oklahoma, be made directly to Step Into Recovery Centers INC for services furnished to me or my dependent. I understand that my Insurance Company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Step Into Recovery Centers INC to disclose any and all written information from the above named to my above named Insurance Company and/or its designated representatives, or other financially responsible parties; at the determination of Step Into Recovery Centers INC. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release Step Into Recovery Centers INC and its officers, agents, employees, and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the above named Insurance Company(s) or their designated representatives.

By signing this Assignment of Benefits and Release of Information, I acknowledge:

- I am aware and understand that this authorization will not be used unless the above-named Insurance Company(s) or their designated representatives request records of information for reimbursement purposes, or seek to take action for the referred payment for treatment services.
- I agree to participate and assist Step Into Recovery Centers INC or its designated representatives with any appeal process necessary to collect payment for the services rendered.
- I am aware and have been advised of the provisions of Federal and State Statutes, rules, and regulations that provide for my right to the confidentiality of these records.
- I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon. In any event, this authorization will expire once reimbursement for services rendered is complete.
- Step Into Recovery Centers INC is acting in filing for insurance benefits assigned to Step Into Recovery Centers INC and it can assume no responsibility for guaranteeing payment of any charges from the Insurance Company(s).
- Billing may be done by a firm contracted by Step Into Recovery Centers INC for billing and collection purposes.
- Step Into Recovery Centers INC is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier.
- Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
- Step Into Recovery Centers INC shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form:

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Luis Fajardo (participant), 08/12/2024 12:27 PM
Staff present: Jennifer Rosa, Administrator



Jennifer Rosa, Administrator (Staff), 08/12/2024 12:27 PM

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Step Into Recovery Centers INC
Coordination of Benefits and Pre-existing Conditions

Date of Admission: 07/17/2024

This will confirm that upon admission to Step Into Recovery Centers INC, I, Luis Fajardo:

- ☐ Have been employed for the past eighteen months and do not have Cobra coverage;
- ☐ Am presently unemployed, but did not work within the past eighteen months for the company identified below, but do not have Cobra coverage;
- ☐ Am presently employed with n/a (employer), but DO NOT have any hospital/medical/health insurance coverage;
- ☐ The only benefits available to me during my stay at Step Into Recovery Centers INC is from n/a , (Name of Insurance);
- ☐ I have never been treated for this condition prior to my admission to Step Into Recovery Centers INC;
- ☐ Enrolled as a dependent of n/a , who is my n/a (Relationship).

IN WITNESS WHEREOF I have here executed this agreement as dated below.

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Luis Fajardo (participant), 08/12/2024 12:28 PM
Staff present: Jennifer Rosa, Administrator



Jennifer Rosa, Administrator (Staff), 08/12/2024 12:28 PM

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Internal ID / External ID	Group Plan Name	Group ID	Plan Type	Payor Type	Insurance Phone
13123 /					
Rx Name	Rx Group	Rx BIN	Rx PCN	Rx Phone	Plan Period

Claims

Street Address 1		Street Address 2		Claims Fax			
City Subscriber	State	Relationship of Patient to Subscriber	SSN	ZIP Code	DOB	Country	Gender
Luis Fajardo		Self	***-**-9181		09/02/1993		Male
Subscriber Address Street		Subscriber Address Street 2			Subscriber City		
1115 S Urbana Ave					Tulsa		
Subscriber Address Zip		Subscriber Address State			Subscriber Address Country		
74112		OK			United States		

Vital Signs

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Location: Step Into Recovery Centers INC
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Blood Pressure		Blood Pressure		Temperature	Oxygen Saturation	Pulse	Respiration	Comments	Logged By	Logged At
Date	Systolic	Diastolic								

Glucose Logs

No records available.

Weights

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No height/weight records.

Heights

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Location: Step Into Recovery Centers INC
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Date Height Logged By Logged At

Orthostatic Vital Signs

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Lying		Sitting		Standing					
Date	BP	HR	BP	HR	BP	HR	Resp.	Temp.	O2 Comments Logged At Logged By

CIWA-Ar

No CIWA-Ar assessment logged

CIWA-B

No CIWA-B assessment logged

COWS

No COWS assessment logged

Medications Brought In

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No Medications Brought In Logged.

Rounds

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MAT Orders

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Location: Step Into Recovery Centers INC
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Current/Active Order *No Current/Active Order.*

Order History

Start Date	End Date	Phase	Order Type	Medication	Dose	Instructions	Ordered By	Entered By	Discontinued By	Status
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