Please note that we do not call in prescription requests after hours, on weekends, or on holidays.

If you are due for a refill before your next clinic appointment, **please call and leave a voicemail 3-4 days before your refill is due**. We do not want any of our patients to run out of their medication and this process prevents that from happening.

Demographics

Name______________________ Address______________________

DOB______________________ Social Security#__________________

Insurance____________________

Phone #____________________ Employer______________________

Alt Phone #__________________ Email________________________

Emergency Contact________________ Contact #______________________

Cancellation Policy

In the event that an appointment needs to be rescheduled, a minimum of 24 hour notice must be given to avoid scheduling conflicts and potential cancellation fees.

If an appointment is missed with no prior notice, that appointment will be considered a "no-show" visit and a $40 no-show visit fee will be charged to the patient.

Repeated cancellations or no-show appointments may result in discharge from the clinic.

Medical Records

OVPI will provide one (1) complete copy of patient's medical records upon request. Please allow 5-7 business days for processing. After this request, any further copies will be charged $50 for the first 100 pages then $0.10 per page after that. Patients also have the option to unlimited access of their medical records for free via the online web portal that can be found by visiting the OVPI website at https://www.ovpimedical.com

By signing this form, you express understanding and agreement to the above policies.

Patient_________________________________ Date____________

Guardian________________________________ Date____________

Witness_________________________________ Date____________

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:________________________________ Date of Birth:______________

The information you may release subject to this signed release form is as follows:

☒ **Complete Records**	❑ **Lab Reports**
❑ **Care Plan**	❑ **Treatment Record**
❑ **Pathology Reports**	❑ **Medication Record**
❑ **Hospital Reports**	❑ **Progress Note**
❑ **History & Physical**	❑ **Radiology Reports**
❑ **Operative Reports**	❑ **Other (please specify)**

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: Ohio Valley Pain Institute

Address: 1169 Eastern Parkway Suite 400

City, State, Zip: Louisville, Ky 40217

Fax: 502-403-2065

The purpose/reason for this release of information is as follows:

____

_____________________________ **Signature**

_____________________________ **Date**

_____________________________ **Printed Name**

_____________________________ **Date of Birth or Social Security Number**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____________________________
(PRINT NAME PLEASE)

Signature: ____________________________ Date: ____________

Witness: ____________________________ Date: ____________

Brandon Sutton MD
Board Certified in Pain Medicine
Board Certified Anesthesiologist
Alexander Sinofsky MD
Board Certified in Pain Medicine
Board Certified Anesthesiologist

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

All other insurance companies and/or third party payers: I HEREBY AUTHORIZE Ohio Valley Pain Institute Alexander Sinofsky, M.D., Brandon Sutton, M.D., and/or any of their representatives to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to the physician(s) rendering the service. I authorize the release of any and all medical information to my insurance carrier or it intermediaries for services rendered.

Medicare: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of Medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, or its intermediaries or carriers any and all information needed for this or a related Medicare claim. I authorize and request that payment be made directly to Ohio Valley Pain Institute, or their representative.

Guarantee of Payment: I UNDERSTAND that filing a claim with my insurance company or other third party payor, under any circumstance, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Ohio Valley Pain Institute (Dr. Sinofsky, or Dr. Sutton) to me. I understand that it is ultimately my responsibility to verify my insurance benefits, eligibility and authorization requirements prior to any scheduled appointments. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to, claims filed for Worker's Compensation, automobile accidents and/or personal injuries. If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs even if there is a pending lawsuit. Payment must be made in full within 30 days of being billed unless prior arrangements have been made.

I AGREE that this authorization shall be valid until rescinded in writing or replaced on a later date.

______________________________________ ____________________
*Patient's signature (parent or Guardian if patient is a minor) Date of Signature

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice

______________________________________ ____________________
*Patient's signature (parent or Guardian if patient is a minor) Date of Signature

____
*Please print name

If Personal Representative's signature(s) appears above, please describe the relationship to the patient:

____

Ohio Valley
Pain Institute

Patient Consent for Electronic Prescribing

Ohio Valley Pain Institute has implemented e-prescribing as part of an on-going effort to improve your health care. E-prescribing refers to a system used to submit prescriptions electronically to a pharmacy of your choice. By eliminating paper, e-prescribing creates a more efficient and safer process for patients to access their medications. This electronic process helps to prevent, and in some cases eliminate, the top reasons for prescription errors—including illegible hand-writing, incorrect dosing, and missed drug/allergy reactions—which improves patient safety and helps to control ever increasing medication costs due to medication errors. E-prescribing systems also store and transmit your prescription information and medication history so that your health care providers and health insurers may quickly obtain information about the drugs covered under your benefit plan as well as the drugs you may already be taking to minimize the number of adverse drug events.

By signing below, you provide your consent for Ohio Valley Pain Institute and its providers to electronically submit your prescriptions through the e-prescribing system described above and to request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

This consent will remain in effect until you withdraw it. You may withdraw your consent at any time except to the extent it has already been relied upon. Your decision not to sign this form will not affect your ability to receive medical care or your ability to receive your prescriptions through alternative means.

____________________________ ____________________________
Signature of Patient (or Guardian) Date of Birth

____________________________ ____________________________
Print Patient Name Relationship to Patient

If you choose to participate in E-Prescribing, please list your preferred pharmacy information below.

____________________ ________________________ __________________
Pharmacy Name Location-(City and Street Name) Pharmacy Telephone #

Informed Consent for Opioid Treatment for Non-Cancer/Cancer Pain

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/health care provider comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I have agreed to use opioids (morphine-like drugs) as part of my treatment for chronic pain. I understand that these drugs can be very useful, but hide a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

1. I am responsible for my pain medications. I agree to take the medication only as prescribed.
   a. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.
   b. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/health care provider at the Pain Center.

3. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).

   It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant.

4. I understand that the opioid medication is strictly for my own use. The opioid should **never** be given or sold to others because it may endanger that person's health and is **against the law**.

5. I should inform my physician of all medications I am taking, including herbal remedies. Medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects.

6. During the time that my dose is being adjusted, I will be expected to return to the clinic as instructed by my clinic physician. After I have been placed on a stable dose, I may receive opioids from my primary care physician and will return to the pain clinic for a medical evaluation at least once every six months.

7. I understand that opioid prescriptions will **not be** mailed. If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions with consultations from my pain physician.

8. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

9. I will communicate fully with my physician to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medications. This information allows my physician to adjust my treatment plan accordingly.

10. You should not use any illicit substances, such as cocaine, marijuana, amphetamines, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.

11. The use of alcohol together with opioid medications is contraindicated.

12. I am responsible for my opioid prescriptions. I understand that:
    a. Refill prescriptions can be written for a maximum of one month supply and will be filled at the **same pharmacy.**
    Pharmacy: ____________________ Phone number: ____________________

    b. **It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.**
    c. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. If my medications are lost, misplaced, or stolen my physician may choose not to replace the medications or to taper and discontinue the medications.
    d. Refills will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow".
    e. Refills can only be filled by a pharmacy in the State of Kentucky even if I am a resident of another state.
    f. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends.
    g. **You must bring back all opioid medications and adjunctive medications prescribed by your physician**
    in the original containers/bottles at every visit.
    h. Prescriptions will not be written in advance due to vacations, meetings, or other commitments.

i. If an appointment for a prescription refill is missed, another appointment will be made as soon as possible. *Immediate* or *emergency* appointments will not be granted.
j. **No "walk-in" appointments for opioid refills will be granted.**

13. While physical dependence is to be expected after long-term use of opioids, **signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.**

    a. **Physical dependence** is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

    b. **Addiction** is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/she will be referred to an addiction medicine specialist.

    c. **Tolerance** means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

14. If it appears to the physician/health care provider that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

15. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity**.

16. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, and sometimes two to three days extra **if** the prescription ends on a weekend or holiday. This extra medication is **not** to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.
17. I agree and understand that my physician reserves the right to perform random or unannounced urine and/or blood drug testing. If requested to provide a urine or blood sample, I agree to cooperate. If I decide not to provide a urine or blood sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug (s) or illicit drug (s) in the urine and/or blood can be grounds for termination of the doctor/patient relationship. Urine and/or blood drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

18. I agree to allow my physician/health care provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if the physician feels it is necessary.
19. I agree to a family conference or a conference with a close friend or significant other *if the physician feels it is necessary.*

20. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

I, ________________________ have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

Patient's Signature (Print):

________________________________ **Date:** __________________

Patient's Signature (Sign):

________________________________ **Date:** __________________

Witness Signature:

________________________________ **Date:** __________________