Premier
Pain Treatment Institute

New Patient Information

Name:_____ Date:_____

Date of Birth:_____ Sex: □ M □ F SSN: _____

Street Address: _____

City:_____State:_____Zip Code: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Email: _____

Marital Status: □ Single □ Married □ Divorced □ Widow □ Other:_____

Primary Language: □ English □ Spanish □ Other: _____

Race:_____Ethnicity:_____

Primary Care Provider:_____ PCP Phone: (_____) _____

Referring Provider: _____ Referring Phone: (_____) _____

Emergency Contact Information

Contact Name:_____Relation: _____

Phone Number: (_____) _____Alternate Number: (_____) _____

Pharmacy Information

Pharmacy Name:_____Pharmacy Phone: (_____) _____

Pharmacy Address: _____

Premier
Pain Treatment Institute

Name:_____ Date of Birth: _____

Insurance Information

Primary Insurance:_____ Copay:_____

Policy Number:_____ Group Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth:_____ Policy Holder's SSN: _____

Policy Holder's Street Address: _____

City:_____ State:_____ Zip Code: _____

Policy Holder's Phone: (_____) _____ Relation to Patient: _____

Policy Holder's Employer:_____ Employer Phone: (_____) _____

Secondary Insurance:_____ Copay:_____

Policy Number:_____ Group Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth:_____ Policy Holder's SSN: _____

Policy Holder's Street Address: _____

City:_____ State:_____ Zip Code: _____

Policy Holder's Phone: (_____) _____ Relation to Patient: _____

Policy Holder's Employer: _____ Employer Phone: (_____) _____

Consent for Insurance Payment & Financial Responsibilities Acknowledgement

I hereby authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I authorize the assignment of benefits and payments, including Medicare, private insurance, and other health plans, directly to Premier Pain Treatment Institute for all of my insurance claims related to services received. It is my responsibility to pay any co-pay, deductible, co-insurance, denied charges, and non-covered services. I agree to pay any and all charges that exceed or are not covered by my insurance. I permit a copy of this authorization to be used in place of the original. This authorization will remain in place effect from the date of signing until it is revoked by me in writing.

Signature of Patient/Guardian: _____ Date: _____

Premier
Pain Treatment Institute

Pain Management Practice Agreement & Informed Consent

Premier Pain Treatment Institute strives to comply with all federal, state, and local guidelines and regulations. The State of Ohio requires that you, the patient, agrees to an informed consent prior to commencement of treatment. Please review and ***initial*** each line item below to establish your consent for treatment at our facilities. For the purposes of this document, Premier Pain Treatment Institute may also be referred to as PPTI.

_____I will notify PPTI of any change in name, phone number, or address. I agree to return any phone call from PPTI within 24 business hours.

_____I understand that PPTI employs nurse practitioners and physician assistants that work under the supervision of PPTI physicians. I understand that, due to schedule constraints, my physician may not be able to see me on every appointment. As such, I agree to scheduling my appointments with any nurse practitioner or physician assistant at PPTI as necessary to comply with scheduling demands of the practice. I understand that refusal to comply with this requirement may result in dismissal from the practice.

_____I understand that unprofessional or inappropriate behavior toward any PPTI staff, provider, or affiliate will not be tolerated and is grounds for dismissal from the practice. I agree to be respectful towards other patients of PPTI. I will not loiter on the grounds outside of the office suite or the parking lot. I will be respectful towards the businesses or patrons that reside near any PPTI facilities and I will not trespass on their property.

_____I understand that firearms and weapons of any kind are strictly prohibited inside any PPTI location. Upon request from any PPTI staff member, I agree to immediately comply with removal of any weapons from the premises. I understand that PPTI as a medical facility has the right to prohibit firearms and weapons on any of our premises and prosecute anyone who does not comply.

_____I understand that missed appointments (no-shows) or cancelling/rescheduling with less than 24 hours advance notice may be considered as noncompliance with my treatment plan and it also takes away opportunities from other patients seeking treatment. I understand that the first offense is a $25 fee for a missed office visit and $50 for a missed procedure visit. Repeat offenses are subject to a $50 fee for office visits and $100 for procedure visits. I agree to pay any outstanding fees by cash or credit card prior to being seen for treatment again. I understand that my PPTI provider(s) may decide that such non-compliance with the treatment plan may necessitate cessation of the patient-provider relationship and my future appointment(s) at PPTI may be canceled as a result.

I have read and understand the terms of this agreement. I give my informed consent for treatment.

Print Name:_____ Date of Birth: _____

Signature:_____ Today's Date: _____

Opioid Treatment Agreement & Informed Consent

Premier Pain Treatment Institute strives to comply with all federal, state, and local guidelines and regulations. The State of Ohio requires that you, the patient, agrees to an informed consent prior to commencement of treatment. Please review and ***initial*** each line item below to establish your consent for treatment at our facilities. For the purposes of this document, Premier Pain Treatment Institute may also be referred to as PPTI.

_____I am presenting to PPTI for **interventional treatment only.** As such, drug testing may not be necessary for completion of my procedures. However, I agree to blood, urine, and/or saliva drug testing in the future if medication is necessary to treat my condition(s).

DO NOT continue completing agreement below if seeking ONLY interventional treatments

_____I consent to blood, urine, and/or saliva drug testing at any time interval necessary to establish or confirm compliance with my medication regimen.

_____I understand that I may be called at any time to bring all prescribed medications for a mandatory pill count within a specified time period. I understand that I will be held accountable if I am unable to be reached by a PPTI staff member for a mandatory pill count because my contact information is not up to date, the voicemail is full, telephone voicemails are not returned in a timely fashion, or another valid reason as determined by PPTI staff.

_____I agree to bring the medications prescribed to me by PPTI provider(s) in their original bottles to every appointment. I will bring in my bottles even if I am out of medication and they are empty.

_____I understand that prescription medications can be dangerous when they are not taken as prescribed. I agree to take my medications only as prescribed by my PPTI provider(s) and I will not take my medication in larger quantities or more frequently than prescribed. I understand that most changes to my medication regimen will require an office visit. Medication refills will not be made on weekends or evenings.

_____I understand that controlled substances may only be prescribed by one provider at a time. From the point that a PPTI provider starts prescribing my medication and going forward, I will not receive any prescriptions for controlled substances from any other provider(s). If I have surgery or a dental procedure, I must receive permission from my PPTI provider prior to filling any prescription from my surgeon for postoperative pain or my dentist for post-procedural pain.

_____I understand that I am able to go to an urgent care, the emergency room, or a hospital for treatment of any condition. However, I agree that I will not receive any prescriptions for controlled substances upon discharge from their care.

_____I agree to fill prescriptions from my PPTI provider(s) at the pharmacy that I have on file. I will not utilize any other pharmacies to fill prescriptions for controlled substances without prior approval from my PPTI provider(s).

_____I will not take any medications that are not prescribed to me and I will not use any illegal drugs, including marijuana, cocaine, heroin, etc.

_____I will not share, sell or trade my medication with anyone. I will not buy or borrow medication.

_____I will not alter the form of my medication or take the medication in a route other than as prescribed by my PPTI provider(s).

_____I understand that lost or stolen medication may not be replaced. I understand that presentation of a police report does not guarantee that the lost or stolen medication will be replaced. Due to the dangerous nature of these medications, I understand that it is my responsibility to ensure the proper and safe storage of medication. I understand that my PPTI provider may choose to stop prescribing the medication in severe or repetitive situations of medication loss or theft.

_____I authorize my PPTI provider(s) to investigate fully any possible overuse, misuse, or diversion of my prescribed medications. I understand that suspected overuse, misuse, or diversion may lead to cessation of medication therapy and/or corrective actions, including referral for an assessment with an addiction specialist or psychological specialist.

_____I understand that, in certain situations, my PPTI provider may decide that a psychological or addiction assessment may be required before prescribing certain medications, particularly controlled substances.

_____After a prescription has been filled, I agree to contact my pharmacy for all questions regarding that prescription. I understand that PPTI does not mail prescriptions under any circumstances.

_____I understand that any controlled substance prescribed to me has inherent risks, including loss of efficacy over time, withdrawal symptoms if stopped abruptly, addiction, sedation, respiratory depression or death when taken in excess or in combination with other medications with respiratory depressant effects, constipation, allergic reaction, itching, nausea, dry mouth, loss of function or impaired motor skills, immune system and hormone suppression.

I understand that opioid medications ("narcotics") may cause tolerance, dependence, and addiction. Withdrawal from opioids may cause nausea, vomiting, diarrhea, agitation, sweats, chills, irregular respirations, and/or elevated heart rate.

_____I agree not to drive or operate heavy machinery when under the influence of any prescribed controlled substance.

_____I understand that the combination of controlled substances and alcohol are contraindicated and that the combination may result in serious harm or death.

I agree to the central tenants of pain management at Premier Pain Treatment Institute as they have been detailed above. I do not have any further questions regarding these items and I give my informed consent to commence treatment with all providers at Premier Pain Treatment Institute. I understand that failure to comply with any of the information contained in this consent may result in the need for corrective actions to provide safe and effective treatment, up to and including cessation of treatment at Premier Pain Treatment Institute.

I have read and understand the terms of this agreement. I give my informed consent for treatment.

Print Name:_____ Date of Birth: _____

Signature:_____ Today's Date: _____

Premier
Pain Treatment Institute

Financial Policy

We appreciate the opportunity to be of service to you for your pain management needs. Our office is dedicated to excellence in patient care. To maintain our high standards, we believe that it is important to communicate our policies to you. Please take a moment to read and become familiar with these policies. Should you have any questions, the office staff is happy to help answer them. By presenting these policies in advance, we can avoid any surprises or misunderstandings. It is also important that you understand the details and terms of ***your*** personal medical plan. If you have any questions specific to your plan's coverage terms, we encourage you to call your insurance company directly.

Payment Responsibilities

- You are required to bring your insurance cards to **each and every** visit to our office.
- We participate in most major health plans and our billing service will submit claims for services rendered. It is the patient's responsibility to provide all necessary information to file the claims prior to leaving our office. Your primary and secondary insurance claims will be filed and we will work with the carrier to resolve any conflicts that may arise. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with this request.
- If you have an insurance plan that requires a referral to see a specialty provider, you must contact your primary care physician ***prior*** to receiving care from a PPTI provider because pain management from our providers is considered specialty care. Many insurers will not cover specialty services that are rendered without a referral and you may be held responsible for the costs. If we do not have a referral on file, we will not be able to render services.
- Your insurance company ***requires*** us to collect co-payments at the time services are rendered. Failure to collect or waiver of your co-payment may constitute fraud under state and federal law. Please be prepared to pay your co-payment on the date that services are rendered as this is a requirement per your insurance carrier. If you do not have your co-payment, we are not required to see you.
- You may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account following insurance processing will be billed to you.
- All patients of the practice are treated equally with regards to account balances. The practice will not waive or fail to collect any co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law as well as participating agreements with payers.
- Your insurance may pay you directly, if your clinic is out-of-network. As a patient, you are responsible for bringing in the payment and the Explanation of Benefits (EOB) from your insurance company.
- Payment for "self-pay" services is due in full prior to rendering services.

Appointments & Cancellations

- You are required to provide at least 24 hours advance notice if you are unable to keep a scheduled appointment because the scheduled time slot has been reserved exclusively for you. In the event that you do not provide 24 hours advance notice, you are financially responsible for the reserved appointment. PPTI may make exceptions and waive any associated fees, ***at its sole discretion***, for certain circumstances. You should understand that insurance companies do not

provide reimbursement for cancelled appointments. Repeated missed appointments may result in termination of the treatment agreement.

- There may be a time when your PPTI provider may need to cancel your appointment for an emergency; PPTI will make every effort to reschedule you in an appropriate time frame. This will be at no charge to you.

Patient Balances

- Any patient balances that remain delinquent after 90 days, with no response to requests for payment, may be referred to a collection agency. You will be responsible for any and all costs associated with the collection agency up to and including all legal costs.
- Patients with account balances in excess of 120 days with no payment arrangements or hardship request may be discharged from the practice. If this occurs, you will have 30 days to seek alternative medical care. During the 30-day period our providers will only be able to treat you on an emergency basis.
- A fee of $40.00 will be added to your account for any check returned by your financial institution regardless of reason. Should a check be returned, you will not be permitted to write a check again for a period of six (6) months.

Patient Acknowledgement

I, the undersigned, understand the financial policies of Premier Pain Treatment Institute and agree to abide by the financial policy I have signed. In addition, I understand and agree to the following:

- To pay the amount charged by Premier Pain Treatment Institute for all professional treatment and services to the undersigned.
- I understand that I am financially responsible for any and all charges whether or not they are covered by insurance. In the event that I do not pay these charges, I am financially responsible for all costs of collection and reasonable legal fees in addition to the amount originally owed.

Patient Name (Print) _____

Patient or Guardian Signature _____

Guardian Name (Print) _____

Date _____

Signature of Witness _____

Date _____

Premier
Pain Treatment Institute

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I was offered a copy of the Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my PHI. I understand that there are risks with email communication and conditions for appropriate use. I was offered a copy of the Electronic Mail Consent Form that contains a more complete description of the risks and conditions for email use. I agree to abide by the conditions and instructions for appropriate email communication with PPTI.

I understand that this organization has the right to change its Notice of Privacy Practices and Electronic Mail Consent Form from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name (Print) _____

Patient or Guardian Signature _____

Guardian Name (Print) _____

Date _____

Authorization to Discuss Medical Information

In accordance with the HIPAA guidelines, this practice is authorized to discuss my medical information with the following individuals (Please list up to 3 people we may leave messages with in the event we are unable to contact you. **We will use the 1st person listed as your emergency contact person.**)

HIPAA Authorized Person's Name	Relationship to Patient	Phone Number

By signing below, I authorize PPTI to give appointment information (dates and times) to any transportation services I may use. If I have a medical Power of Attorney, I also agree to provide a copy of medical POA documentation for PPTI records.

Patient or Guardian Signature _____ **Date** _____

Premier
Pain Treatment Institute

Authorization for Release of Information

I,_____, consent to and authorize

_____

to release all medical information relating to my treatment to Premier Pain Treatment Institute, LLC., including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment. ***I understand that I need to indicate any portion of my medical record that I do not want released. I do not want the following information released:*** _____

Purpose of disclosure: Continuity of care

Treatment period requested: ☐ Entire course ☐ Last 3 months ☐ Date(s): _____

Records requested: ☐ All ☐ Last 3 office notes ☐ Discharge letter Operative report

☐ X-ray of _____ ☐ CT scan of _____ ☐ MRI of _____

☐ Other _____

Premier Pain Treatment Institute is hereby released from all legal liability that may arise from the release of the information requested. I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the ability of PPTI or its physicians, employees or agents to use or disclose my information for treatment, payment, healthcare operations or as otherwise permitted by law.

I understand that this consent is subject to revocation by me, in writing, at any time and, unless an earlier date is specified, that it automatically expires one (1) year after the date below.

Patient or Authorized Representative's Signature Relationship to Patient

_____ _____

Patient or Authorized Representative's Signature Date

_____ _____

Relationship to Patient Staff Witness

PLEASE FAX RECORDS TO: 513-438-0202

Patient Name: _____

Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Phone No.: _____

Name_____Date _____

OPIOID RISK TOOL

		Patient Use Only	Staff Use Only	
		Mark each That applies	Circle if Female	Circle if Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16-45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	-Attention Deficit Disorder	[ ]	2	2
	-Obsessive Compulsive Disorder	[ ]		
	-Bipoloar	[ ]		
	-Schizophrenia	[ ]		
	-Depression	[ ]	1	1

TOTAL **[ ]**

AUDIT-C QUESTIONNAIRE

Patient Name:_____ Date of Visit: _____

For each question, CIRCLE THE LETTER next to the most appropriate response.

1. How often do you have a drink containing alcohol?
    a. Never (do not answer question #2 or #3)
    b. Monthly or less
    c. 2-4 times a month
    d. 2-3 times a week
    e. 4 or more times a week

2. On a day that you do have a drink containing alcohol, how many standard drinks do you typically consume?
    a. 1 or 2 b. 3 or 4 c. 5 or 6 d. 7 to 9 e. 10 or more

3. How often do you have 6 or more drinks on one occasion?
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

STAFF USE ONLY:

Score: _____

Premier
Pain Treatment Institute

Advanced Directives

Patient Name: _____

Date of Birth: _____

Date: _____

Please circle the following advanced directives that apply to you currently:

A. Living Will
B. Durable Power of Attorney
C. Do Not Resuscitate Order
D. Organ Donor
E. Body donated to Science
F. None

If an advanced directive was circled, are you able to provide us a copy for your medical records?

A. Yes
B. No

Please circle the following advanced directives that you would like information on:

A. Living Will
B. Durable Power of Attorney
C. Do Not Resuscitate Order
D. Organ Donor
E. Body donated to Science
F. None

Premier
Pain Treatment Institute

MARKETING AUTHORIZATION FORM

Practice Name: ___Premier Pain Treatment Institute_____

Patient Name: _____ Date: _____

1. Authorizing marketing communication from this practice means I may:

A. Receive treatment communications concerning treatment alternatives or other health related products or services

B. Be contacted for appointment reminders or information about treatment alternatives or other health-related benefits and services that may interest me.

*I understand that I have the right to "opt out" of receiving such communications.

*I understand that this practice may receive financial remuneration for communications.

Other communications for such purposes that do not involve financial remuneration are adequately captured in this practice's notice of privacy practices (NPP).

2. Marketing Authorization Options:

☐ I wish to receive Marketing Communications from this Practice Only

☐ I wish to receive Marketing Communications from this Practice, and this Practice's Business Associates.

☐ I do NOT wish to receive any Marketing Communications

Patient Signature: _____

Communication that encourages you to use our services is considered marketing. If we intent to use, or sell PHI for personal gain or commercial advantage, we must first obtain written authorization. Authorization is required for all treatment and health care operations communications where the covered entity receives financial remuneration for making the communications from a third party whose product or service is being marketed. Such a policy will ensure that all such communications are treated as marketing communications, instead of requiring covered entities to have two processes in place based on whether the communication provided to individuals is for a treatment or a health care operations purpose. We MAY receive financial remuneration from a third party due to marketing.

HIPAA states the term "financial remuneration" does not include non-financial benefits, such as in-kind benefits, provided to a covered entity in exchange for making a communication about a product or service. Rather, financial remuneration includes only payments made in exchange for making such communications.

In addition, HIPAA emphasizes that the financial remuneration a covered entity receives from a third party must be for the purpose of making a communication and such communication must encourage individuals to purchase or use the third party's product or service. If the financial remuneration received by the covered entity is for any purpose other than for making the communication, then this marketing provision does not apply.

Premier
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Patient Consent to Leave Detailed Message/Information

Dear Patient:

Premier Pain Treatment Institute has adopted a policy that requires our staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and to also protect our staff from violating the patient's confidentiality. If we do not have a signed consent on file, the staff may only leave their name and a phone number on an answering machine or with another person answering your phone.

By completing the consent form below, you hereby authorize the staff to call and leave their name, doctor's name, and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will be renewed annually.

[ ] I give consent to my doctor and/or staff of Premier Pain Treatment Institute to leave a message regarding treatment, test results or other necessary information at the following numbers:
Please print phone number on the line(s)

1. _____ on answering machine at home
   Home Phone
2. _____ on cell phone voicemail
   Cell Phone
3. _____ on voicemail at work
   Work Phone

You may communicate information regarding my care only to [ ] Myself and/or [ ]_____

_____
Patients' Name

_____
Patients' Signature

[ ]I do **NOT** consent any messages being left on my machine other than office name and phone number.

_____
Patients Name

_____
Patients Signature Date