Northern Valley Indian Health, Inc.

Opioid Policy Explanation

What is NVIH's policy on opioid pain medications?

1) NVIH providers may prescribe opioid pain medications for short-term "acute" pain, such as a recent injury or accident or surgery, if other options for pain management are not sufficient. Also, NVIH providers may prescribe opioids for patients with active cancer and patients at the end of life.
2) NVIH providers will not prescribe opioid pain medications for chronic pain, lasting more than 3 months. On occasion, NVIH providers might prescribe a few days of opioids to patients who are experiencing a short-term flare up of their chronic pain, but this should not be routine.
3) Although generally avoided and only after all other alternatives have been explored, buprenorphine may be considered for chronic pain management in select cases with Pain Management specialty guidance.

The reasons for this change in policy are explained in more detail below. But in short, opioids for chronic pain are dangerous, lose their effectiveness in treating pain, and may cause even worse pain in the long-term. This change in policy has been made in the interests of your health and safety.

Background

What are opioids?

Opioids include Norco, Vicodin, Percocet, morphine, methadone, oxycodone, tramadol, and heroin, among others. Aside from heroin, most of these are prescribed to treat pain, particularly if it is severe.

How effective are opioids?

Opioids can be very effective in relieving short-term pain, such as from a broken bone, injury or accident, or pain after a surgical procedure.

It is much less clear whether opioids help with long-term pain, also known as chronic pain, from conditions like arthritis, chronic low back pain, fibromyalgia, frequent headaches, and irritable bowel syndrome. In fact, many newer studies seem to show that opioids do NOT help with long-term pain.

Why might opioids NOT help with chronic pain?

1) Tolerance: When you take an opioid medication for a longer time, your body becomes "used to it" and it stops being as helpful as it was in the past. In order to get the same effect, you have to take more and more of it.
2) Increased sensitivity to pain: When your body and brain's pain-sensing nerves are being suppressed by opioid pain medication, your body seems to compensate by growing more pain "receptors" on the nerves. As a result, you feel more pain from the same injury you had before. Also, you may develop pain in new places that you didn't have it before—such as abdominal pain or headaches—because your body produces new pain receptors EVERYWHERE, not just in the area where you had the original pain. This is frequently referred to as opioid hyperalgesia.

Why might it SEEM like opioids help with chronic pain?

Many people who have been taking opioids for a long time have the impression that opioids are the ONLY thing that helps their pain. It is true that people who take opioids chronically experience a short-

term decrease in their pain after they take a dose, usually for a few hours. However, when you look at the long-term picture, what you see is that many people who take chronic opioids have worse and worse pain over months and years. Many people don't realize that this slow increase in pain is happening. Even if they realize it, most people don't know that the opioids themselves might be the cause of their worsening pain. This explains why although opioid prescription rates have increased tremendously in the last couple decades, the reported pain levels have not decreased.

If I feel opioids DO help with my chronic pain, why can't I continue taking them?

In addition to the evidence that chronic opioids lose their effectiveness and the likelihood of increasing your pain over time, there are many other reasons to avoid chronic opioid use:

- Opioids often contribute to overdose deaths, even in patients who have taken them for a long time and think they are safe.
- Opioids are implicated in a large number of car crash deaths, falls, and other accidents.
- Opioids can cause sleep apnea, in which people stop breathing during sleep, which has many bad health consequences.
- Opioids cause constipation, depression, decreased sex drive, memory problems, lower hormone levels such as testosterone, and can sometimes cause fatal heart rhythm abnormalities.
- Opioids can be addictive for many people. Addiction means that people crave the drug, feel like they no longer have control over the drug, spend lots of time and energy trying to obtain it, and continue to use it despite bad consequences in their lives.

Due to the increasing evidence for serious risks and little evidence for benefit from long-term use, it is no longer evident that the benefits of long-term use outweigh the risks.

What are my options if I currently take opioids for chronic pain?

Your provider will work with you to decrease your dose of opioid gradually over a period of time so that you don't experience significant withdrawal symptoms from stopping suddenly.

Your provider will work with you to implement all other pain-management tools that we have at our disposal, if you are interested in them. In many cases, we may not be able to eliminate your pain, but we can try to help decrease your pain to a tolerable level and help you learn to cope with it.

If you are thinking of obtaining opioids from a friend or neighbor—DON'T. Buying non-prescribed opioids carries a very high risk of overdose and death, as non-prescribed opioids are often contaminated with much stronger substances that you might be unaware of.

You might find that after a period of 3-6 months off opioid pain medications, your pain levels decrease significantly as your body's increased pain sensitivity, which develops as a result of opioid use, wears off. Many people who stop chronic opioids discover that after a while, they have less pain than they did when they were taking opioids.

One last note:

If you think you might be addicted to opioids, we want to help! Addiction is very common and can happen to anyone. Please discuss your concerns with your provider. There's no need to deal with it alone.

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Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

PATIENT REGISTRATION

PATIENT INFORMATION:	
Last Name: First Name: Middle Initial:	
Patient's Previous Name:	
Patient's Preferred Name:	
Patient's Home Phone: Cell Phone:	
Mailing Address: _____ City: _____ State: _____ Zip: _____ County:	Physical Address (If different than mailing address): _____ City: _____ State: _____ Zip: _____ County:
Email:	☐ Check if Homeless
Would you like to be Web enabled for the patient portal? *If yes, we will use your email above unless otherwise indicated.* ☐ Yes or ☐ No	
How would you like us to notify you for appointment reminders? PLEASE SELECT AT LEAST ONE OPTION: ☐ Voice: Number to call: _____ ☐ Text: Number to receive messages: _____ ☐ Do not send appointment reminders	
Patient's date of birth: / / Sex/Gender assigned at birth: ☐ Male ☐ Female	
Is the patient transgender?: ☐ Yes ☐No Gender Identity: ☐ Male ☐ Female ☐ Non-Binary/ Other ☐ Trans MTF ☐ Trans FTM Current Legal Gender: ☐ Male ☐ Female ☐ Non-Binary/ Other	
Patient's Social Security Number:	
Patient Marital Status: ☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Unknown ☐ Widowed ☐ Legally Separated	
Preferred Language: Interpretation Services Requested: Yes / No	
Patient's Race: ☐ American Indian ☐ Black or African American ☐ Declined to Specify ☐White or : _____ (Please fill in blank)	
Patient's Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic ☐ Declined to Specify or: _____ (Please fill in blank)	
Are you Native American: ☐ Yes or ☐ No	Tribe of Membership:

(NVIH Use Only) Patient Name:_____**HRN:**_____

PARENT/GUARDIAN INFORMATION IF PATIENT IS A MINOR OF DEPENDENT ADULT:

Name: Circle One: Father / Mother / Other Phone:

Name: Circle One: Father / Mother / Other Phone:

Guardian's Name: Phone:

PATIENT EMERGENCY CONTACT INFORMATION:

Relationship to patient: _____

First Name: _____ Last Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ EXT: _____

Cell Phone:

PATIENT EMPLOYER INFORMATION:

Employer name: _____

Employer Address: _____

City: State: Zip:

INSURANCE INFORMATION:

Please fill in information below and provide a copy of: Medicare, Medi-Cal, or Private Insurance Card(s)

#1 Primary Insurance:

Sub No: Group No:

Policy Holder Name: ☐ SELF Policy Holder's DOB:

Medicaid ID No:

#2 Secondary Insurance:

Policy Holder's Name: ☐SELF Policy Holder's DOB:

Group No:

#3 (Tertiary)- Third Policy:

GUARANTOR/ PERSON RESPONSIBLE FOR PAYMENT

☐ SELF ☐ Another patient or person *if so complete this portion. If not, mark SELF.*

Name: _____ DOB: _____

Address: _____

Phone: _____ Work: _____

Relationship to Patient:

TERMS AND CONDITIONS OF SERVICE
CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

1. NVIH: Northern Valley Indian Health, Inc. (NVIH) is a non-profit 501(c)(3) tribal organization and Tribal Federally Qualified Health Center (FQHC) system with federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. 25 U.S.C. 5301 et seq.

2. CONSENT FOR TREATMENT: I wish to receive health care services at NVIH. I consent to the medical treatments or procedures, X-ray examinations, drawing blood for tests, medications, injections, taking of treatment related photographs, videotaping, laboratory procedures, dental services, clinical services, behavioral health services, care and case management services or other services rendered to me under the general and special instructions of the provider or other health care professionals assisting in my care. I am aware that the practice of medicine, surgery, and therapy is not an exact science. I acknowledge that NVIH has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my provider or other health care professionals any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

3. TEACHING ACTIVITIES: I understand that residents, interns, medical students, associate behavioral health clinicians, students of ancillary health care professions (e.g., nursing, social work), post-graduate fellows, and other learners and trainees may observe, examine, treat, and participate in my care at NVIH under the supervision of the attending health care professional as part of an approved external education/training program. .

4. CONSENT FOR COMMUNICATIONS: I understand that I may receive messages and calls from or on behalf of NVIH, at the contact information provided, including my cell phone number and email address provided during my registration process. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I understand that if I email or text NVIH providers and others involved in my care that I am providing consent for them to respond to me using the same method I used, even if the messages contain confidential information. I understand that texting and email are not secure communication methods as unencrypted messages could be intercepted. I acknowledge that all such communications may become part of my medical records.

5. ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT: In consideration of the health care services provided, I the undersigned, whether signing as a patient or legal guardian, irrevocably (without the right to revoke) and expressly assigns and transfers to NVIH all insurance benefits including government programs, private insurance, and any other health plan otherwise payable to or on my behalf for NVIH services. I hereby authorize the release of all information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection

bear interest at the current legal rate.

6. TELEHEALTH CONSENT: Telehealth visits involve the use of telehealth technologies, including but not limited to two-way video, digital images, and other telehealth technologies to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering services. I understand that during my care at NVIH, I may be offered a telehealth visit if clinically appropriate. These services may include consultation, diagnosis, treatment recommendation, prescriptions, and/or referral to in-person care if further evaluation is needed. This service is offered to me as a convenience. I understand that I always maintain the option of choosing an in- person appointment if I prefer. If I am experiencing difficulty in accessing in person services due to transportation, Medi-Cal provides coverage to beneficiaries for transportation services to in-person services when other resources have been reasonably exhausted. I understand that not all services will be clinically appropriate to complete via a telehealth visit and the option may be limited as determined by my provider. Should I agree to a telehealth visit, I consent to have my insurance billed for the services and will pay any relevant copays, coinsurances or for services not covered by insurance. I understand that during the telehealth visit, sensitive personal health information may be discussed, and it will be my responsibility to locate myself in a location that ensures privacy. I will also be expected to participate in a location that will not cause danger to myself or those around me (such as while driving). If my provider is concerned about my safety, they may terminate the visit. Telehealth visits are not appropriate for medical emergencies. If I believe I am having an emergency, I will call 911 and/or go to my nearest emergency room.

7. BEHAVIOR: NVIH has a zero tolerance for abuse, intimidation, harassment, or violence in our facilities. For the safety and security of our patients, visitors and staff, weapons, knives, alcohol, illegal drugs and other dangerous materials are not allowed in our facilities. NVIH is committed to maintaining a safe workplace that is free from threats and acts that are disrespectful, discriminatory, hostile, or harassing. It is the expectation of NVIH that you and your visitors conduct yourselves in a respectful, non-violent, non-discriminatory, and non-abusive manner. I understand that any violation of NVIH's patient rights and responsibilities with unwelcome words or actions may lead to removal from NVIH premises and immediate termination as a patient of NVIH.
   I also understand that under California law I and my visitors cannot film, record, or disclose any images or sounds of our/my conversation with a NVIH employee or provider without the written consent of NVIH and all parties to the conversation, and that violation of this law may result in criminal and/or civil liability, and immediate removal/termination as a patient of NVIH.

8. AUDIO/VIDEO RECORDING CONSENT: I hereby consent to the use and transcription of audio and video recordings by NVIH and its providers and staff for treatment and service purposes. I understand that NVIH uses recording technology to capture and record my visits and other communications with NVIH and its providers and staff for treatment and services. I understand that NVIH uses third-party vendor(s) to process the recordings to generate clinical documentation and related activities. I expressly consent to NVIH and its third-party vendor(s) to audio or video record my visits, transcribe and document my treatment and services, and permanently destroy the recordings. I understand that any use of my medical information will be in accordance with applicable law, including all applicable laws and regulations governing patient confidentiality, in the manner outlined in the NVIH Notice of Privacy Practices. I understand that I may request cessation

of recordings at any time by written request to NVIH. I understand that my withdrawal of consent will not affect recordings made prior to receipt of the written request to stop recording.

9. RELEASE OF MEDICAL INFORMATION: I understand that my medical information, photographs, and/or video in any form may be used for other NVIH purposes, such as quality improvement, patient safety and education. NVIH will obtain my written authorization to release information about my medical treatment, except in those circumstances when NVIH is permitted or required by law to release information (see NVIH Notice of Privacy Practices for a description of the specific circumstances under which NVIH may release this information). I understand that any use of my medical information will be in accordance with applicable state and federal law, including all applicable laws and regulations governing patient confidentiality, in the manner outlined in the NVIH Notice of Privacy Practices. I understand that NVIH providers are mandated to report to the appropriate authorities, as required by State and/or Federal laws, when (1) my provider believes I may hurt myself or someone else, (2) my provider suspects child, dependent adult, or elder abuse, (3) or by a specific order of the Courts.

10. NOTICE OF PRIVACY PRACTICES: I have received and reviewed a copy of the Notice of Privacy Practices of NVIH which is also available at https://nvih.org. I understand that NVIH reserves the right to change its practices and the terms of this Notice of Privacy Practices for all medical information that NVIH maintains. NVIH will make available the revised Notice of Privacy Practices by posting it in all patient registration areas, where copies will also be available. The revised Notice of Privacy Practices will also be posted on our website at https://nvih.org.

Signature of Agreement: I have read this Terms and Conditions of Service agreement. On my own behalf, or on behalf of the patient, I accept and agree to be bound by all of the terms in this agreement until I revoke my agreement, consent, or authorization in writing to NVIH.

_____ _____ _____ ☐ AM ☐ PM

Signature of Patient or Patient Representative Date Time

_____

Relationship of Representative to Patient

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Assignment of Benefits and Financial Agreement (Paragraph 5) set forth above.

_____ _____ _____ ☐ AM ☐ PM

Signature of Financially Responsible Party Date Time

_____

Print Name of Financially Responsible Party

Acct # _____ (office use only)

New Patient Health History Form

Name: _____ _____ _____
Last First Middle Date of birth Today's date

Preferred name, if different: _____

If you are completing this form for another person: _____ _____
Name of person completing form Relationship

Gender: □ Female □ Male □ Transfeminine □ Transmasculine □ Non-binary □ Other: _____

Sex assigned at birth: □ Female □ Male □ Intersex

Preferred pronouns: □ She/Her □ He/Him □ They/Them □ Other: _____

Health History

Have you been recently under the care of a primary care provider, surgeon or specialist? If so, please list:

Provider: _____
Name Phone number City, State

Provider: _____
Name Phone number City, State

Provider: _____
Name Phone number City, State

Check conditions you have, or have had in the past, or check if □ None

□ Anemia	□ COPD / Emphysema	□ Kidney disease	□ Prostate problems
□ Arthritis	□ Diabetes	□ Liver disease	□ Rheumatic fever
□ Asthma	□ Epilepsy	□ Low back pain	□ Scarlet fever
□ Bleeding disorders	□ Glaucoma	□ Measles	□ Sexually transmitted infections
□ Blood clots	□ Gout	□ Migraine headaches	□ Skin ulcers
□ Broken bones	□ Heart attack	□ Mononucleosis	□ Stomach ulcers
□ Bronchitis	□ Heart arrhythmia	□ Multiple sclerosis	□ Strep throat
□ Cancer	□ Hepatitis	□ Osteoporosis	□ Stroke
□ Cataracts	□ High cholesterol	□ Pacemaker	□ Thyroid problems
□ Chicken Pox	□ HIV	□ Pneumonia	□ TIA (transient ischemic attack)
□ Congestive heart failure	□ High blood pressure	□ Polio	□ Tuberculosis

Other health problems, please list: _____

What is your main goal in establishing care with NVIH, or what health issues would you like help with initially?

_____

Acct # _____ (office use only)

Obstetric and gynecologic history

Are you pregnant or do you think you might be pregnant? _____

Are you nursing/ breastfeeding? _____

Total number of pregnancies: _____

Number of: _____ _____ _____ _____ _____ _____

C-sections | Vaginal deliveries | Abortions | Miscarriages | Stillbirths | Living Children

Please check if any history of:

□ Endometriosis □ Fibroids □ Heavy /prolonged menstrual bleeding

□ Pre-eclampsia □ Pelvic pain □ Gestational diabetes

□ Infertility □ Post-menopausal bleeding □ PCOS or infrequent periods

If you are using contraception (birth control), please write which kind: _____

Behavioral health history

Check if you have currently, or in the past, or check if none: □ None

□ ADHD	□ Eating disorder	□ PTSD
□ Alcohol problem	□ History of trauma/ abuse	□ Schizophrenia or Schizoaffective disorder
□ Anxiety	□ Methamphetamine problem	□ Suicide attempt
□ Bipolar disorder	□ Opioid or heroin use problem	□ Other substance use or mental health problem: _____
□ Depression	□ Post-partum depression	

Health tests and screenings

Have you had any of the following? If not, please check □Have not had screenings

Check if you have had one	When was the last one?	Any abnormalities? Please describe
□ Colonoscopy, or stool test for colorectal cancer		
□ Mammogram		
□ Pap smear		
□ DEXA (bone density test)		
□ Lung cancer screening CT		
□ Abdominal aortic aneurysm ultrasound		

Surgical & hospitalization history

Please list any past surgeries, or check if: □ None	Date of surgery

Have you ever been admitted to the hospital? If yes, when, and what for? _____

_____

Acct # _____ (office use only)

Family health history (biological relatives)

	Are they living?	Medical problems or cause of death, please describe:
Mother		□ Unknown
Father		□ Unknown
Number of sisters _____		□ Unknown
Number of brothers ____		□ Unknown
Number of children ____		□ Unknown
Other family members, please list:		□ Unknown

Social history

Are you employed or in school? □ Yes □ No If yes, please describe your occupation: _____

Who do you live with? _____

What is your housing situation?

□ Rent a home or room □ Shelter □ Staying with family or friends, in their home
□ Own a home □ Unhoused

Do you have any cultural or spiritual beliefs or practices you think would be helpful to share or that you would like to incorporate into your healthcare?

_____

Please circle any substances you have used recently or in the past, and if used, when you last used them:

Tobacco / Vape / Chew _____ Alcohol _____
Marijuana / cannabis / THC _____ Methamphetamine _____
Non-prescribed pills _____ Heroin, fentanyl, or other opioids _____
Cocaine _____ Kratom _____
Other: _____ □ None

What is your relationship status?

□ Single □ Long-term relationship □ Married □ Separated □ Divorced □ Widowed

Are you sexually active with a partner?

□ No □ Yes, one recent partner □ Yes, more than one recent partner

If yes, what is/are your partner's gender (circle all that apply):

Male Female Transmasculine Transfeminine Nonbinary Other

How would you describe your sexual orientation? (circle all that apply)

Straight / Heterosexual Gay Homosexual Lesbian Bisexual Other Unsure

Acct # _____ (office use only)

Allergies

Please list any allergies you have to medications, food, latex, substances, or insects, or check if □ None

_____

Vaccines

Do you have a vaccine record you can share with us? Yes / No

If not, please check if you think you've had any of the following vaccines, or check if □ None

□ Tetanus or Tdap
□ Pneumonia (PCV13, PPSV23, PCV15 or PCV20)
□ COVID-19 initial vaccines
□ COVID-19 bivalent booster
□ Hepatitis B
□ Varicella (chicken pox)
□ Influenza vaccine
□ HPV (human papillomavirus)
□ Shingrix
□ MMR (Measles, mumps and rubella)
□ Hepatitis A
□ Other vaccines: _____

Medications

Please list all medications, supplements, herbs, or over-the-counter medications, you take, or check if □ None

Name of medication	Purpose of medication	Dose	How often do you take it?	If prescribed, who prescribes this to you?

Northern Valley Indian Health

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Clinic Appointment Policy

PURPOSE

In order to maintain quality patient care and timely access to care, the following established guidelines regarding appointments with NVIH healthcare clinics are to be followed:

POLICY

New Patient Appointments:

1. New patients unable to keep their scheduled initial appointment must notify the clinic staff. Notification must be made by no later than one business day in advance of the intended cancellation. Failure to do so is considered a missed (no-show) appointment.

2. New patients who miss their scheduled initial appointment twice will not be rescheduled.*(Exceptions may be authorized by the Lead Provider or Department Director.)

Established Patient Appointments:

1. Patients unable to keep a scheduled appointment must notify the clinic staff no later than one business day in advance of the scheduled appointment of the intended cancellation. Failure to do so is considered a missed (no-showed) appointment.

2. Arriving more than ten minutes late for a scheduled appointment may result in the Clinic Site Manager determining the patient has missed (no-showed) the scheduled appointment.

3. Late arrival for any same day appointment scheduled for 15 minutes or less will not be seen by the provider due to limited length of time and will be considered a no-show.

4. Patients will be considered a high risk no-show patient if patient misses two appointments within a 12-month period and may receive a notification from NVIH with information of future inability to reserve individual scheduled appointments time slots. Notification will inform patient the option of being seen as a stand-by or same-day patient appointment as available.

5. If after three missed appointments in a 6-month period a patient continues to miss appointments, the patient may be dismissed from the associated clinical services altogether as a direct result of being "noncompliant to treatment," at the Clinic Provider's discretion. A stand-by or same-day work-in option will be considered for Native American patients. **

6. If patient is allowed to continue after three missed appointments in a 6-month period and continues to miss future appointments, patient will be dismissed from the associated clinical services at the discretion of the Department Director. A stand-by or same-day work-in option will be considered for Native American patients. **

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Clinic Appointment Policy

DEFINITIONS

New Patient: A person who has not previously been registered within the NVIH system; or, a patient who has been registered within the NVIH system but has not had an established care visit; or, a patient who has been registered within the NVIH system but has not been an active patient for at least three years.

Stand-by: Patient will be scheduled in a time slot that would be considered a double-booked space. Staff will work efficiently to seat/room the patient in a timely fashion. Patient should expect to have some delay in seeing the provider. Visit type will likely be limited in focus depending on available time (e.g.: Dental treatment may be limited to limited exam/minor treatment).

Same-day: Patient will call in the same day and be advised on availability/arrival time for a same-day work in appointment as available at associated site. Staff will work efficiently to seat/room the patient in a timely fashion but minor delays may occur.

* Native American patients will be placed on a stand-by or same day work-in option.
**Dismissal of patients will be considered, in accordance with the Patient Termination Policy.

Patient Acknowledgement:

I hereby acknowledge that I have been given the opportunity to review the Clinic Appointment Policy and receive a copy if requested.

Patient Printed Name: _____Patient DOB:_____

Patient/Parent Signature:_____Date:_____

****

NVIH Use Only:

HRN: _____