Omega Interventional Pain Clinic

"The end is just the beginning"

3838 South 700 East, Suite 300a
Salt Lake City, UT 84106
Phone: (801) 261-4988
Fax: (801) 269-9425

Date:_____

Dear:_____

You have been scheduled for a New Patient Appointment on _____,
at _____am/pm with _____.

Please arrive no later than _____am/pm.

WELCOME

Omega Interventional Pain Clinic is committed to partnering with you to make a difference.

Pain Management Hours:

Monday - Thursday: 7:30 AM – 5:00 PM
Friday - Sunday: Closed

Please fill out the packet completely and make sure to bring with you: the packet, photo ID, your insurance card(s) and your copay (if applicable). **Please be advised, that if your new patient packet is not fully completed by your appointment time you will be rescheduled.**

You will have 40 minutes to 1 hour with the provider. In order to discuss multiple issues, it is recommended to write down all questions you want to discuss during your appointment.

If you need to change or cancel your appointment for any reason, please be sure to give a 24-hour notice or you will be charged a missed appointment fee. ***If you miss 2 appointments without calling or canceling, then you may no longer be allowed to make appointments or be a patient.***

Please feel free to call if you have any questions.

- Mon-Thurs: (801) 261-4988

Thank You,
New Patient Coordinator

Personal Information

Name: _____ Date of Birth: _____

Email: _____ SSN#: _____

Address: _____ Phone: _____

_____ Male ☐ Female ☐

Emergency Contact:

Name_____ PH #_____ Relationship_____

Ethnicity:
( ) American Indian/Alaskan Native ( ) Native Hawaiian or Other Pacific Islander
( ) Asian ( ) White
( ) Black/African American ( ) Other

Insurance: _____

Member ID #: _____

Phone Number #: _____

Pharmacy: _____ Address: _____

Phone Number: _____ _____

How did you hear about us?_____

Current Medication

Medication	Dose	Frequency

Allergies

Allergy	Reaction	Severity

Past Surgeries

Procedure	Doctor	Date	Hospital/Facility

OMEGA INTERVENTIONAL PAIN

Welcome Valued Patients to **Omega Interventional Pain Clinic**! The following are our current patient guidelines for existing patients as well as new patients:

MISSED APPOINTMENTS:

If you are unable to make your appointment, please call to cancel or reschedule. Otherwise, you will be charged for the visit**. If you miss 2 appointments without calling or canceling, you may no longer be allowed to make appointments or be a patient with Omega Interventional Pain.** If you are more than **5 minutes** late for your appointment, you may be rescheduled. It is the Patient's responsibility to know the start and end date of the prescriptions. Please ensure you schedule your follow-up before your prescription needs to be refilled. If you are traveling within the days that you need your medication to be refilled. You will need to provide proof of your travel days.

TELEPHONE CALLS:

The physicians and clinical staff at Omega Interventional Pain Clinic attempt to be thorough and complete during your visit, which includes answering all your questions. We encourage patients to write down all questions and have them ready for their appointed provider. Typically, Omega Interventional Pain Clinic physicians and providers do not accept phone calls unless there are unusual circumstances. If you have a clinical question that you feel cannot wait until your next regularly scheduled visit, you may call or text Omega at (**801) 261-4988** and your question will be assessed and triaged. It may take up to two days to receive a return call.

PRESCRIPTIONS

All prescriptions must be picked up in person at a scheduled office visit. Patients who come in for pain management frequently also take medicines for a variety of ailments such as high blood pressure, diabetes, heart disease, etc. Please make sure to keep your medications in a safe place and locked up if possible. Our policy is that we **DO NOT** replace lost or stolen medications. Any patient who overuses or loses a prescription or medication will not be given early refills. Please be aware that you may not be prescribed any Opioid medications on your initial visit.

INSURANCE

As a courtesy, Omega Interventional Pain will file all claims to your insurance carriers for services provided. To extend this courtesy, we will need a picture ID and a copy of the insurance cards. Many procedures that are performed by Omega Interventional Pain require preauthorization from your insurance carrier. It is not uncommon for authorization to require up to 10-14 days. Insurance coverage varies widely; we strongly recommend that you become familiar with your policy and the benefits or restrictions that are specific to your plan. If any changes in your insurance coverage or benefits occur while being treated at Omega Interventional Pain, you are responsible for notifying us immediately. We do our best to obtain benefits as accurately as possible. However, there is no guarantee of payment from insurance companies. Ultimately, you as the patient are responsible for amounts left after insurance claims are processed, denied, or left unprocessed by your insurance.

FINANCIAL POLICY

I understand that if I am not **eligible** under the terms of my medical and hospital subscriber health insurance agreement, I am **liable for all charges for services rendered**. I understand that I am responsible for any and all charges should any legal representative, court costs, and collection charges as a result of any collection activity. I further understand that a lack of financial responsibility on my part may result in dismissal from the clinic.

CO-PAY'S / DEDUCTIBLES

If your insurance coverage requires a co-pay, it will be collected when you check-in before you see the pain care provider. Deductibles are determined by your insurance company, and Omega Interventional Pain will notify you of your responsibilities after an Explanation of Benefits (EOB) are received.

MEDICAL RECORDS

If you request medical records from Omega Interventional Pain, there is a charge of $.28 per page for each page exceeding 10 pages; the first ten will be free of charge.

PRIMARY CARE PHYSICIAN

If you were referred to Omega Interventional Pain Clinic by another specialist, it is imperative to your overall health that you have/or establish a relationship with a primary care physician. Our physicians serve as consultants and cannot assume the role provided by a primary care doctor.

EMERGENCIES

Fortunately, there are very few medical emergencies related to chronic pain. However, if you believe you are experiencing such an emergency, you should go immediately to the nearest urgent care facility or emergency room. The physician attending to your problem in the urgent care facility or emergency room should be the one to call and communicate with your pain care provider. Please request that the attending physician initiates communication. Therefore, it is only in very unusual circumstances that an unscheduled or urgent visit is necessary.

_____ _____

Patient Signature Date

OMEGA INTERVENTIONAL PAIN

HIPAA ACKNOWLEDGMENT AND CONSENT FORM

NOTICE OF PRIVACY PRACTICES

Upon request, we will provide you with a copy of the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

RELEASE OF INFORMATION

I hereby permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other Omega Interventional Pain affiliated facilities may be made available to subsequent Omega Interventional Pain affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood-borne diseases, such as HIV and AIDS.

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

AUTHORIZATION TO RELEASE INFORMATION TO:

Name(s):	**Relationship:**	**Contact Number:**
Name(s):	**Relationship:**	**Contact Number:**

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

OMEGA INTERVENTIONAL PAIN

PRESCRIPTION ORDER PICK-UP	
There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. For us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to the release of the script, your designee will need to present valid picture identification and sign for the prescription.	
I wish to designate the individual(s) to pick up a prescription order on my behalf: ☐Yes ☐ No	
Name(s):	Name(s):

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTH CARE OPERATIONS
I consent to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted by law.

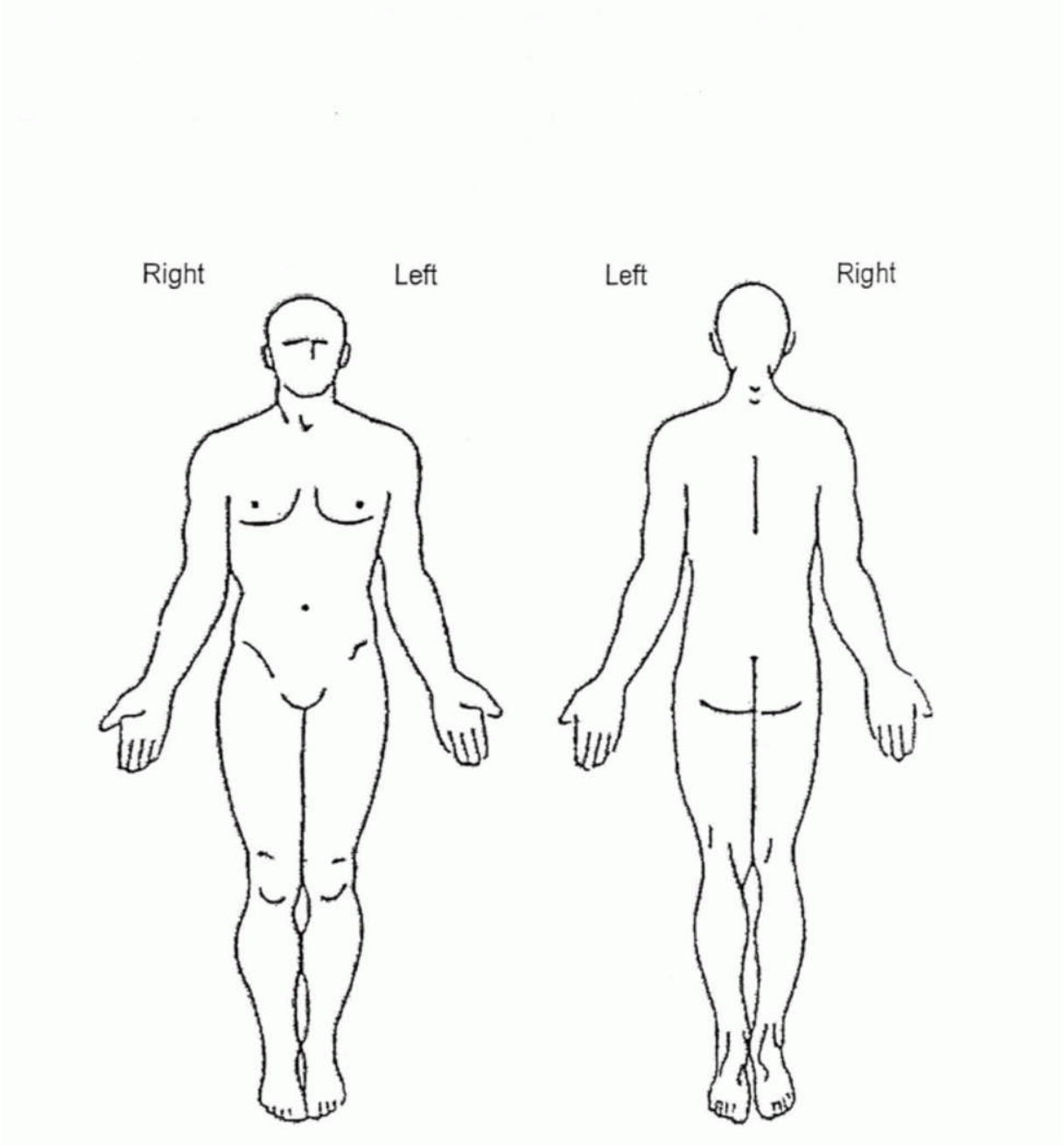
CONSENT TO EMAIL OR TEXT MESSAGE USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS:
We want to stay connected with our patients! **Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided with general health reminders/information.** If at any time, you provide an email address or text number below, you understand that you may get these communications from the practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard messaging rates may apply as provided in your wireless plan (contact your wireless carrier for pricing plans and details).
Please notify staff if you DO NOT want to use this service

PATIENT ATTESTATION:	
I acknowledge that I have reviewed this information and at my request, a copy of this office's Notice of Privacy Practices can be made available to me. We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so.	
Patient or Guardian Name (Printed):	**Date:**
Patient or Guardian Signature:	**Date:**

OMEGA INTERVENTIONAL PAIN

(Please indicate the areas where you are having pain)

How long have you had this pain? _____



Was there an initiating event? _____

What makes your pain worse? _____

What makes your pain better? _____

OMEGA INTERVENTIONAL PAIN

How would you describe your pain? *(Check all that apply)*

___ Aching	___ Sharp	___ Hot	___ Taut
___ Throbbing	___ Cutting	___ Searing	___ Numb
___ Shooting	___ Cramping	___ Tingling	___ Tearing
___ Burning	___ Tugging	___ Itching	___ Pins & Needles
___ Stabbing	___ Pulling	___ Stinging	

Circle the number that best describes your baseline or constant level of pain

1	2	3	4	5	6	7	8	9	10

Circle the number that best describes your lowest level of pain

1	2	3	4	5	6	7	8	9	10

Circle the number that best describes your worst level of pain

1	2	3	4	5	6	7	8	9	10

Function:

What areas of your life have been affected by your pain? *(Circle all that apply)*

Sleep	Finances	Household Duties
Appetite	Recreational Activity	Recreational Drug
Weight	Alcohol Use	Use
Sexual Activity	Social Activity	Other: _____
Physical Activity	Emotions	
Work	Concentration	

Mood:

	Yes	No
• Do you feel blue, depressed, down or hopelessness due to pain?	( )	( )
• Do you feel anxious or nervous due to your pain?	( )	( )
• Do you have thoughts of harming yourself?	( )	( )
• Do you have thoughts of harming others?	( )	( )
• Have you attempted suicide?	( )	( )
• Are you currently or previously seen a mental health specialist?	( )	( )

Sleep:

- How many hours do you sleep a night? _____
- Do you wake up feeling refreshed? ( ) Yes ( ) No
- How many times do you wake up at night due to pain? _____
- Are you using sleep aids? ( ) Yes ( ) No If yes, what do you take? _____

Pain Medication

- Have you been given opioid *(narcotic)* medication for your pain? ( ) Yes ( ) No
- If yes, have they improved your activity or general level of function? *(circle)*

  No A little bit Somewhat Quite a bit Very Much

- Do you feel your doctor is reluctant to prescribe opioids? ( ) Yes ( ) No
- Are you concerned about addiction if you are prescribed opioids? ( ) Yes ( ) No
- Are any family members concerned about you becoming addicted? ( ) Yes ( ) No

What pain medications have you taken in the past?					
Medication	**Helpful**	**Not Helpful**	**Medication**	**Helpful**	**Not Helpful**
Vicodin			Neurontin		
Percocet			Cymbalta		
Davocet			Savella		
Morphine			Baclofen		
Fentanyl			Flexeril		
Demerol			Tizanidine		
Methadone			Lidoderm		
Lortab			Ibuprofen		
Hydrocodone			Tylenol		
Oxycodone			Tegratol		
Oxycontin			Topamax		
Lyrica			Seroquel		
Gabapentin			Other:		

Treatment	Date of treatment	NO	Improved	No Change	Worse
Occupational therapy					
Physical Therapy					
Massage Therapy					
Heat					
Exercises					
TENS					
Chiropractic Manipulations					
Psychological counseling for Pain					
Biofeedback					
Trigger Point Injections					
Joint Injections					
Epidural Steroid Injections					
Facet Joint Injections					
Nerve Blocks					
Local anesthetic or Steroid Injections					
Ultrasound Massage					

ave you had any of the following tests for your pain?				
Blood Tests	NO	Yes		Results:
X-Rays	NO	Yes		Results:
MRI	NO	Yes		Results:
CT-Scan	NO	Yes		Results:
EMG	NO	Yes		Results:
Bone Scan	NO	Yes		Results:
Myelogram	NO	Yes		Results:
Discogram	NO	Yes		Results:

PATIENT ACCOUNT TERMS & WAIVER OF LIABILITY

Billing:

Upon admission to Omega Interventional Pain Clinic, you have contractually agreed to pay for services rendered to you. If you have health insurance coverage, Omega will agree to file your initial claim(s), provided we have complete insurance information and your Insurance forms at the time of admission (if forms are required). However, your health insurance contract(s) are between you and the insurance carrier. Because of this relationship, it is your primary responsibility to pay for services and provide follow-up communication with your health insurance carrier(s), if necessary. Regarding your insurance, they could deny payments for Office Visits and Clinical Procedures for one of the following reasons:

1. **Not a covered benefit**
2. **Not medically necessary**

Should your health insurance reject our claim for any reason, you are financially responsible. This includes the acquisition of prior authorizations. If your health insurance coverage requires the insured to pay a deductible and percentage or a copay, these amounts will be due on the day of service. We will try to give you an estimate of the amount you may owe before your visit. Payment can be made by cash, Visa, MasterCard, Discover Card, or American Express. We do not accept checks.

If you do not have health insurance, you will be required to pay for all services at the time they are received. Liens will **NOT** be accepted under any circumstances.

Missed Appointments:

Any appointment not canceled with a 24-hour notice will be assessed a fee, as follows:

- New Patient Evaluation $100.00
- Follow-up Patient Evaluation $50.00
- Scheduled Procedure $100.00

These fees will need to be paid before another appointment can be scheduled.

Medicare:

Omega participates with Medicare and will accept what Medicare allows. Omega will bill Medicare for you. However, Medicare is a co-pay carrier, which means they will pay 80% of the allowed charges. You will be responsible for 20% of the allowed charges plus any deductible. These amounts will be due on the day of service unless you have supplementary insurance.

Agreement:

I have acknowledged that I understand and have received a copy of this notice. I agree to make payment for services rendered by Omega Interventional Pain according to the above terms. I authorize my insurance to send payment directly to Omega Interventional Pain. I agree to pay and finance a charge of one and a half percent (1 ½ %) per month on all amounts due to and owing to Omega Interventional Pain.

Attorney's Fees & Collections:

If any legal action by Omega Interventional Pain is necessary to enforce the terms of this agreement or if it is necessary to employ the services of an attorney or collection agency upon the patient's failure to pay any amounts due, the patient agrees to pay reasonable attorney's fees, court costs, collection fees, and any other relief to which Omega Interventional Pain may be entitled to. I agree to pay up to 33% of collection expense incurred by Omega Interventional Pain in attempting to collect such amounts from me, in addition to the aforementioned attorney's fees, collection fees and costs.

_____ _____

Patient Name - *(Print clearly)* Date

_____

Patient Signature

OMEGA INTERVENTIONAL PAIN

Consent for Chronic Opioid Therapy

The Providers at Omega Interventional Pain Clinic may be prescribing Opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of: _____.

This decision was made after a thorough discussion of potential risks and benefits because my condition is serious and other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: tolerance, respiratory depression, hypoxic brain injury, death, immunosuppression, atrophy of the brain, stop breathing at night, accidental overdose, decreased sex drive, osteoporosis, fracture, dependence and addiction, sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, the medicine will not provide complete pain relief, as well as risks of other potential side effects.

I am aware of the possible risks and benefits of other types of treatments that do not involve the use Opioids. The other treatments discussed included:

- Injection therapy
- Non-opioid/narcotic medication treatment
- Cognitive-Behavior Therapy
- Alternative Medicine Therapy
- Surgical Intervention
- Other:_____

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself. You are advised not to drive while using any medication we prescribe without an appropriate driver's test indicating it is safe for you to drive.

I am aware that addiction is defined as the use of a medication even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that there is a chance of becoming addicted to my pain medicine. I am aware that the development of addiction is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medications for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that Opioid withdrawal is uncomfortable but not life-threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and will most likely occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to Opioids may cause my doctor to choose to wean me off all opiate/narcotic medication.

(Males ONLY) I am aware that chronic Opioid use has been associated with low testosterone levels in males. This may affect mood, stamina, sexual desire, physical & sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females ONLY) If I plan to become pregnant or believe that I have become pregnant while taking this medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon Opioids. I am aware that the use of Opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have birth defects while I am taking an Opioid.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with Opioid pain medicines.

Patient Name - *(Print clearly)*

Patient Signature

Date

Agreement for Long-Term Opioid Use

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as Opioids, Benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have the potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. Unless specific authorization is obtained for an exception, all Pain Medication must come ONLY from the physicians, nurse practitioners, or physician assistants at Omega Interventional Pain Clinic. You will not attempt to get pain medication from any other healthcare provider without telling them that you are taking pain medication prescribed by this clinic. You understand it is against the law to do so. If your primary care physician is willing to prescribe your medications, this clinic will have to approve the arrangements to make sure there is no duplication. **You will discontinue all previously used pain medications unless told to continue them.**
2. Some other clinical policies concerning medications are as follows:
    a. You will receive only 1 short-acting Opioid and only 1 long-acting Opioid, not to exceed 150mg Morphine equivalent per day. Patients who need higher doses of medications need to be considered for possible alternatives ie: Intrathecal Pain Pump.
    b. **EVERYONE** who is not compliant with their treatment for sleep apnea will require stopping their Opioids. Anyone who has an Upper Respiratory Infection or pneumonia must reduce their Opioids by 1/2 and stop using them at night.
    c. Patients requiring muscle relaxants will be given Flexeril, Zanaflex, Robaxin, etc…NOT barbiturates, such as Soma.
    d. We do not prescribe Benzodiazepines. These must be prescribed by your Mental Health Provider.
    e. No initiation or prescription assumption for respiratory depressing sleep aids will be provided from Omega Interventional Pain.
    f. For your continued safety and comfort, we advise using interventions to reduce medication use.
    g. Exercise can and should be used as an additional form of conditioning.
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for the purpose of maintaining accountability. You agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of your pain medication and you authorize the clinic and your pharmacy to cooperate fully with any city, state, or federal law enforcement agency including the Utah Department of Professional and Occupational Licensing, in the investigation of any possible misuse, sale, or other diversion of your pain medication. You authorize the clinic to provide a copy of this Agreement to your pharmacy.
5. Patients on long-term Opioid therapy should be evaluated by a Mental Health Provider for the psychiatric effects of chronic pain.
6. You may not share, sell, or otherwise permit others to have access to these medications.
7. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
8. **Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. The presence of unauthorized substances may prompt an adjustment in your treatment and monitoring.**
9. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with our medication and prescription. They should not be left where others might see or otherwise have access to them.

10. **You may be called in for a random pill count at any time. You will be required to bring in all prescribed opiates in their original containers. You will be given 24 hours to come in, failure to do so may result in discharge from the clinic**.
11. Since the drugs may be hazardous or lethal to a person who is not tolerant of their effects, especially a child, you must keep them out of reach of such people.
12. **Medication will not be replaced if they are stolen, even with a police report, lost, get wet, are destroyed, left on an airplane, regardless of any extenuating circumstances. A reassessment of your treatment will occur and may result in an alternative therapy.**
13. All refills require a 5-business day advance notice to be processed in an efficient and timely manner (per prescription refill policy). Early refills will not be given.
14. If the responsible legal authorities have questions concerning your treatment, as might occur, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration (as stated in #4).
15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
16. Renewals are contingent on keeping scheduled appointments. You may pick up prescriptions **Monday through Thursday from 7:30 am to 4:30 pm.** There will be no other time to pick up prescriptions.
17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
18. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such an explanation].
19. You affirm that you have full right and power to sign and be bound by this agreement and that you have read, understand, and accept all of its terms.
20. You are advised not to drive while using any medication we prescribe without an appropriate driver's test indicating it is safe for you to drive.
21. I hereby consent and give the employees at Omega Interventional Pain Clinic the right to access my personal information on the national Sure Scripts Pharmacy Data Base. I waive any right to privacy regarding my national prescription filling information for the employees at Omega Interventional Pain Clinic. I authorize the use of this information to be added to my medical record and made a part of my permanent medical record. I will notify Omega Interventional Pain Clinic in writing that I revoke their right to use this information and understand from that time forward they will no longer have the right to access that information. I also understand that if I revoke the use of this information for my care, the providers at Omega Interventional Pain Clinic may alter my current treatment plan.

If any of the above conditions are violated, the provider may choose to wean me off Opioid medication and the painful condition will be managed without the use of Opioids. Further Opioids may not be prescribed for any chronic painful condition that may develop. Violations of the above-stated terms might also result in my being discharged from the clinic (with appropriate written notice and warning) and not receiving weaning medications or treatment from Omega Interventional Pain Clinic.

_____ _____

Patient Name - *(Print clearly)* Date

_____

Patient Signature

OMEGA INTERVENTIONAL PAIN

ARBITRATION AGREEMENT

Article 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by Dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a Judge or jury.

Article 2 Definitions

A. The term "we", "parties" or "us" means you, (The Patient), and the Provider.
B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.
C. The term "Provider" means the physician, group, or clinic and their employees, partners, associates, agents, successors and estates.
D. The term "Patient" or "you" means:
    (1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents, or legal representatives, AND
    (2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any claim by:
    (1) working directly with each other to try and find a solution that resolves the Claim, OR
    (2) using non-binding mediation (each of us will bear one-half of the costs); OR
    (3) using binding arbitration as described in this Agreement.
    You may choose to use any or all of these methods to resolve your Claim.
B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.
C. Arbitration—Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators unless we agree that a single arbitrator may resolve the Claim.
    (1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
    (2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.
C Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joint Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5: Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6: Venue/Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7: Term/Rescission/Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not canceled, it will automatically be renewed every year unless either party notifies the other in writing of a decision to terminate it.

B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, the Agreement will govern all medical services received by the Patient from the Provider after the date of signing, except in the case of a Joint Party that provided care prior to the signing of this agreement (see Article 4(E)).

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8: Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9: Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration-related costs. I understand that this Agreement renews each year unless canceled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10: Receipt of Copy. Upon request, we will provide you with a copy of this document.

Provider: Omega Interventional Pain

_____

Name of Patient - *(Print clearly)*

_____ _____

Signature of Patient or Patient's Representative Date

OMEGA INTERVENTIONAL PAIN

Past Medical History Questionnaire

Have you ever had serious accidents or injuries?

_____
_____
_____
_____

Have you been diagnosed with any of the following:

Yes	No	
☐	☐	Cancer
☐	☐	Did you ever have radiation or chemotherapy?
☐	☐	Heart Disease
☐	☐	Stroke
☐	☐	High Blood Pressure
☐	☐	Diabetes Type I
☐	☐	Diabetes Type 2
☐	☐	Emphysema
☐	☐	COPD
☐	☐	Pneumonia (recurring)
☐	☐	Asthma
☐	☐	Sleep Apnea
☐	☐	Do you use CPAP or BiPAP?
☐	☐	Other breathing or sleeping problems
☐	☐	Kidney failure
☐	☐	Kidney disease
☐	☐	Kidney infections (recurring)
☐	☐	Stomach or duodenal ulcer
☐	☐	Have you ever been told you cannot take NSAIDs?
☐	☐	Liver Disease
☐	☐	Have you ever been told you cannot take Tylenol?
☐	☐	Thyroid Disease
☐	☐	Blood Clots
☐	☐	Bleeding Disorder
☐	☐	Prolonged bleeding due to a slight cut
☐	☐	Seizures
☐	☐	Orthopedic implant, joint replacement
☐	☐	Head or neck injuries
☐	☐	History of headaches or migraines
☐	☐	Treatment for anxiety/depression
☐	☐	Other psychiatric diagnosis

Yes	No	
☐	☐	Have you ever had problems with anesthesia?
☐	☐	Have you ever had problems with oral steroids?
☐	☐	Have you ever had problems with injections?
☐	☐	Current everyday smoker? If yes, number of years_____ packs per day_____
☐	☐	Occasional smoker? If yes, number of years_____ packs per day_____
☐	☐	Previous smoker, but quit? If yes, number of years quit_____
☐	☐	Never smoked
☐	☐	Do you drink alcohol? If yes, list amount_____ and type_____ _____
☐	☐	Have you ever used illicit drugs (Cocaine, Heroine, Methamphetamine)?
☐	☐	Have you ever taken a prescribed medication/pills obtained from someone or given to you by a friend?

Have any of your family members been diagnosed with:

Yes	No	
☐	☐	Lupus
☐	☐	Crohn's
☐	☐	Psoriasis
☐	☐	Psoriatic Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Ankylosing Spondylosis
☐	☐	Juvenile Arthritis
☐	☐	Sjogren's Syndrome
☐	☐	Ulcerative Colitis