Interventional Spine & Pain Management

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Patient Information:

Last Name _____ **First Name** _____ **M.I.**_____

Date of Birth _____

Address _____ **City, State, ZIP** _____

Phone (_____) _____ **Cell (_____)** _____

Email _____

Referring Physician _____ **Primary Physician** _____

Emergency Contact Information:

Name _____ **Relationship to Patient** _____

Phone (_____) _____

Address _____ **City, State, ZIP** _____

Insurance Information:

Primary Insurance Name _____ **Policy#** _____

Group# _____**Effective Date** _____

Insured Name _____ **Date of Birth** _____

Pharmacy Information:

Pharmacy Name _____

Address _____ **Phone Number** _____

Patient Health History

Name_____

1. Any RELEVANT **SURGERIES** (i.e., spine surgery). If yes, give the name and date of surgery.

2. Any RELEVANT **HOSPITALIZATIONS**. If yes, give place and date of hospitalization.

3. Any RELEVANT **MEDICALHISTORY**. (Example Diabetes, High Blood Pressure etc.)

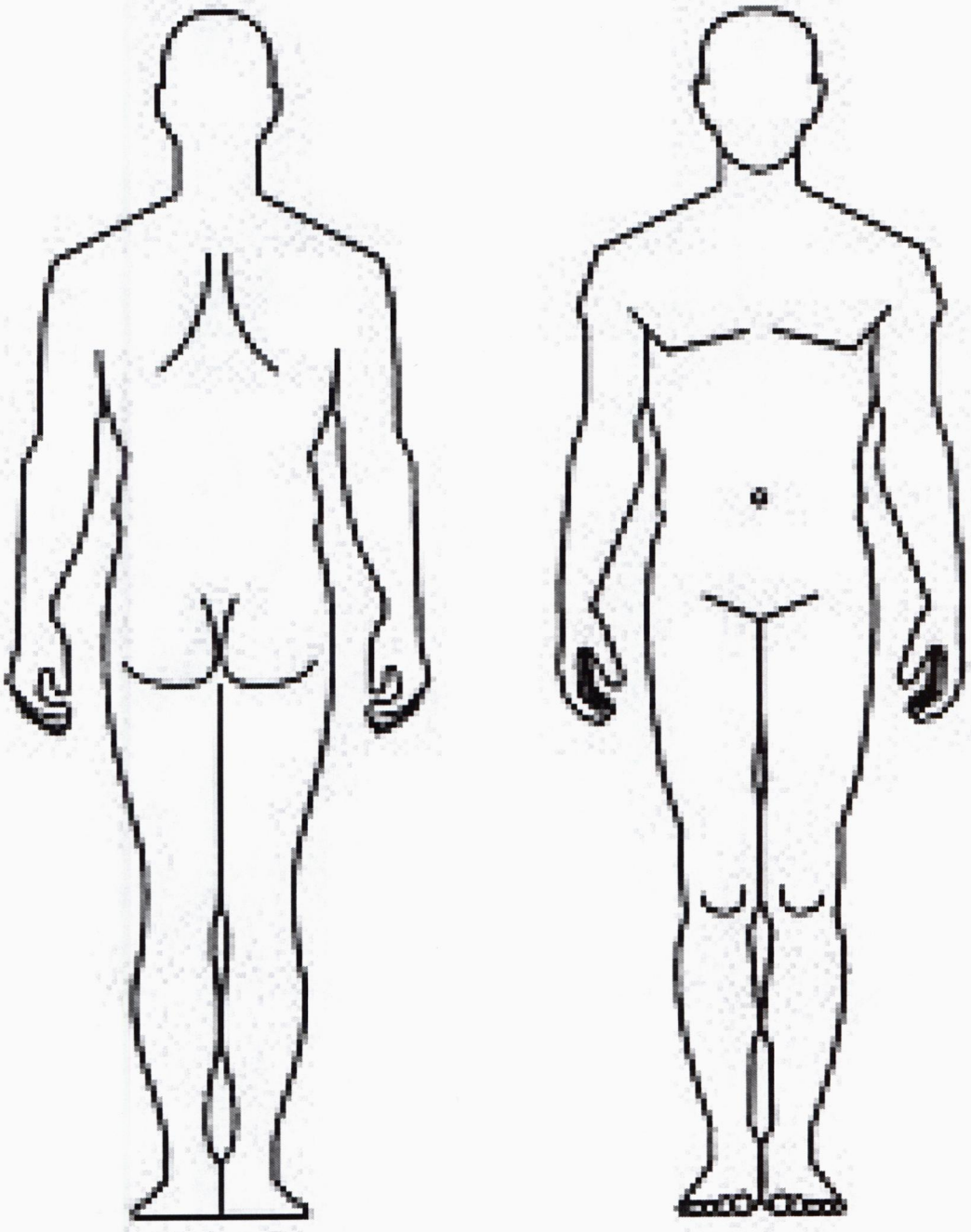
4. Any RELEVANT ***FAMILY HISTORY***

5. List of Any ***ALLERGIES***

6. List of Any ***CURRENT MEDICATIONS***

Name: _____ **Date of Birth:** _____

Please mark your pain on this diagram



Consent and Conditions of Treatment

Thank you for choosing Interventional Spine and Pain Management to provide for your healthcare needs. We are committed to providing exceptional healthcare. The first step in this process is to provide information regarding patient rights, risks and responsibilities. The second step is to obtain your consent to treat the patient. The admitting staff can answer any questions that you may have in regard to the following agreement. I agree to the following:

Consent to Treat: I consent to the treatment or admission of_____ **(Patient Name)** at Interventional Spine and Pain Management for services or supplies that have been or may be ordered by a licensed professional healthcare provider. I understand that treatment may include but is not limited to; physical examinations, laboratory procedures, anesthesia, nursing care or medical and surgical treatment. I understand that all licensed professional healthcare providers that render service to the patient are responsible and liable for their own acts, orders and omissions. I acknowledge that the clinic cannot make a guarantee of the outcome of treatment.
Personal Valuable and Belongings: I agree that the Interventional Spine and Pain Management Clinic is not responsible for the loss or damage of any article or personal property.

Advance Directive/Living Will: Please mark one of the followings:

- I have provided a copy of my Advance Directive or Living will and request that it be put in my chart as part of my Medical Record.
- I have received information with regard to my right to make Advance Healthcare directives.
- I decline information regarding an Advance Directive or Living Will.
- I have not provided, nor do I have an Advance Directive or Living Will.
- I understand if Advance Directive or Living Will **is not present** in my medical record its directives **will not** be followed.

_____ _____

Signature of Patient, Parent or Parent Representative **Date**

Records Release Form

I hereby authorize the office of Interventional Spine and Pain Management to use, disclose or release information from the medical records of:

Patient Name_____
Date of Birth_____ Social Security # _____

Release to
Name_____
Phone_____Fax_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosed, as provided in DFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the staff at Interventional Spine & Pain Management.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Clinic. I understand that the revocation will not apply to my insurance company when laws provide my insurer with the right to contest a claim under my policy.

_____ _____

Signature of Patient, Parent or Parent Representative **Date**

FINANCIAL POLICY

The patient or their guarantor is responsible for full payment for services provided by our physicians at the time of service. The only exception is if our office has contracted with your insurance carrier to accept their payment in full after all deductibles, co-insurance and/ or co-pays have been paid by the patient. Our staff is required by insurance carriers, Medicare and Medicaid to collect deductibles, co-insurance and/or co-pay amounts at the time of service. I assign and authorize payment to Interventional Spine and Pain Management directly of any healthcare benefits that the patient is entitled to receive. This assignment will not be withdrawn or voided at any time unless I pay the account in full. I understand that I am responsible for any and all charges not covered by my insurance policy(s). If the patient is entitled to Medicare or Medicaid benefits under Title XVIII of the Social Security Act, I request assignment of benefits directly to Spine and Pain Management Center.

To effectively submit your insurance claim and to determine your payment responsibility, we require a copy of your insurance, Medicare, Medicare supplement, or Medicaid card, and your current mailing address. If this information cannot be provided, then full payment for services rendered will be required at the time of service.

If we are not contracted with your insurance carrier, we will provide you with a copy of your bill which contains all the information necessary for you to bill your insurance carrier. It will be your responsibility to bill and collect from your insurance carrier. Please be aware that your insurance carrier may not cover medical services provided by our office if we are not under contract. Consequently, if we are not contracted with your insurance carrier, full payment for all services rendered will be required at the time of service.

As a matter of general policy, all patient accounts over 60 days will be charged 1.5% monthly interest of a $3.00 minimum on the outstanding balance. In the event that your balance is not paid as agreed, the undersigned jointly and severally agrees to pay all costs, allowed by the law, to be charged to a collection agency, including but not limited to collection, attorney and court fees.

For your convenience, we accept cash and credit cards in our office. If you have any questions regarding this policy or payment for services, please contact the receptionist or a representative of the accounts receivable department.

I have read all the information above and understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account and for any professional services rendered. In the event my insurance is billed, I authorize payment of medical benefits to be paid directly to our office. A photocopy of this agreement shall be considered as effective and valid as the original.

Non-covered medical services are the responsibility of the patient and payment is due at the time services are rendered.

ALL COPAYS ARE DUE AT THE TIME OF SERVICE

FOR ANY MISSED APPOINTMENT WITHOUT 24 HOUR NOTICE, THERE CAN BE A FEE ASSESED BEFORE RESCHEDULING APPOINTMENT UP TO $100.

Patient's Signature_____ Date_____

Responsible Party's Signature _____ Date_____
(If Patient is Minor)

ABRITRATION AGREEMENT

Article 1 Dispute Resolution

By signing this Agreement ("agreement") we are agreeing to resolve any Claim for medical malpractice by the 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

C. (Utah Code 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.

D. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.

E. The term "Patient" or "you" means:

(1) you and any person who makes a Claim for care given to YOU, such as yours 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 Resolutions. 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.

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 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 can not 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 selects 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.

A. 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 Selected Arbitrator and any other expenses of the arbitration panel.

B. 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.

C. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding
("Joined 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 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 rescinded, it will automatically renew 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, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined 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 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 cancelled before the renewal date. I understand that I can decline to enter into 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 I have received a copy of this document.

VIKAS GARG/ ALEX NELSON
Name of Physician, Group or Clinic

_____
Name or Patient (Print)

_____
Signature of Physician or Authorized Agent

_____
Signature of Patient or Patient's Rep

NARCOTIC MEDICATION AGREEMENT

You have agreed to receive narcotics for the treatment of your pain. It is important that you understand the risks and responsibilities that go along with this treatment. ***Please read each statement and sign this agreement/contract below.*** If you have any questions regarding this information or the office policy regarding the prescribing of narcotics, please request clarification.

I, _____,
(PRINT NAME)

understand that:

Any medical treatment is: Any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand that the goal of using narcotics is to decrease my pain and increase my functional level. If my pain does not significantly decrease and/or my function increase, the medication will be stopped.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief

The overuse of narcotic medication can result in serious health risks including respiratory depression or even death.

This medication will be strictly monitored and all of my medications should be filled at the same pharmacy. (Should the need arise to change pharmacies our office must be informed). The pharmacy that I have selected is:

I cannot receive this medication by phone. I will not call the office to have a prescription called in.

I am responsible for making and keeping scheduled appointments. Early refill requests will not be honored.

I will take the narcotic medication only as prescribed. Any changes must be first discussed and agreed upon with the physician.

Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. if my medication has been stolen and I complete a police report regarding the theft, an exception might be made. It is expected that you will take the highest possible degree of care with your medication and prescription.

It is recommended that I keep medications stored in a locked box where I or one controlling my meds has access.

They should not be left where others might see or otherwise have access to them.

I agree that only my ISPM physician will prescribe my narcotic medication. I will not obtain or use narcotics or other controlled substances from a source other than ISPM. I will instruct my other physicians to confer with the ISPM physician for any changes or need for additional narcotic medications. If it is brought to the attention of the clinic that other providers are prescribing medications for me, the ISPM reserves the right to discontinue prescribing medications and/or discharge me from the clinic.

I will inform my ISPM physician of any changes in my medical condition, any changes in any prescription and/or over the counter medication that I take and of any adverse affects that I may experience from any of the medications that I take.

I agree tell my ISPM physician my complete and honest personal drug / medication usage and history.

I will not use any illegal "street drugs" while receiving medications from ISPM. Including, non-prescribed cannabis products.

I will communicate fully and honestly with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will inform the provider of the name and contact information for which I receive a prescription for cannabis products.

Routine blood work and random drug screens may be a part of my treatment plan. I agree to have them done on the day the physician requests it.

The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my records.

I agree that use of **cannabis (marijuana)** is restricted to situations in which a formal medical cannabis card has been provided by a licensed provider in the state of UT and that the product is only acquired through a state sponsored and approved pharmacy (dispensary). I agree that I must be able to demonstrate proof of my medical cannabis card and purchase of an approved product upon request from my provider at ISPM. I agree that the use of medical cannabis will be disclosed to my provider at ISPM and must be approved in writing before other controlled substances, including narcotics, will be prescribed.

I agree to minimize the use of **alcohol**. If urine drug screens reveal a pattern of consumption that raises the concern for alcohol abuse, I agree that my providers can limit or stop prescription of controlled substances.

It is a felony to obtain narcotic medications under false pretenses. This could include getting medication from more than doctor, misrepresenting me to obtain medications, using them in a manner other then prescribed or diverting the medications in any other way (selling).

I know that narcotic medications will be stopped if any of the following occurs:

- **I trade, sell, or misuse the medication**
- **The clinic finds that I have broken any part of the agreement**
- **I do not go for a blood/urine test or pill count within 24 hours of being asked to.**
- **My blood or urine test shows the presence of medications that the staff are not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for**
- **I get narcotics from sources other than ISPM**
- **Any member of the professional staff of ISPM feels that it is in my best interests that Narcotic treatment is stopped**
- **Any aggressive behavior toward physicians or staff**
- **I consistently miss scheduled appointments**

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no narcotic prescriptions will be written) by ISPM physicians.

I have read the Narcotic Medication Agreement and without question understand all of this agreement. By signing this agreement, I affirm that I have read, understand and accept all the terms of this agreement.

Patient Signature _____ Date _____

Clinical Witness Signature _____ Date_____