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 are scheduled with Dr. David Min on ______________________________, at ______________am/pm.

Please arrive no later than ______________am/pm.

WELCOME

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

Neurosurgery Office Hours:

Monday: 9:00 AM – 1:00 PM

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, this patient packet needs to be completed by your scheduled appointment time. Otherwise, you will be rescheduled.**

You will have up to 40 minutes with the provider. Please write down all your questions before your visit so that you can get them answered.

If you need to change your appointment or cancel for any reason, please be sure to give a 24-hour notice (if possible) or you may be charged. ***If you miss 2 appointments without calling or cancelling, then you may no longer be seen as a patient or allowed to make future appointments.***

If you have any questions, please call.

- Mon-Thurs: (801) 261-4988

Thank You,
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

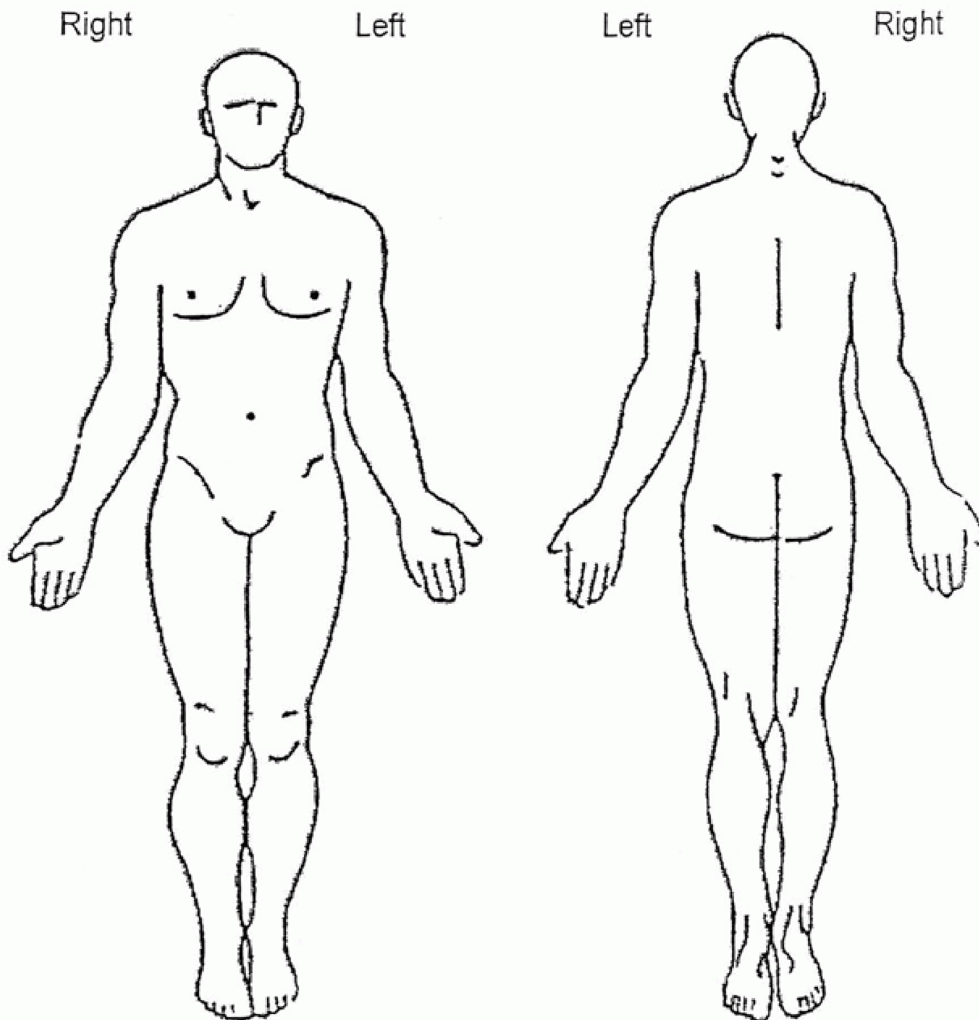
Allergy	Reaction	Severity

Past Surgeries

Procedure	Doctor	Date	Hospital/Facility

<u>(Indicate the areas you are having pain)</u>

How long have you had this pain? ____



Was there an initiating event? ____

What makes your pain worse? ____

What makes your pain better? ____

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 Use
Weight	Alcohol Use	Other: _____________
Sexual Activity	Social Activity	
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 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	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				

Have 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:

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 can and either cancel or reschedule otherwise you may be charged for the visit**. If you miss 2 appointments without calling or cancelling then you may no longer be allowed to make appointments or be a patient with pain management.**

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. You might notice that the provider you see is rarely interrupted by a telephone call during your visit. This is because we ask our patients to respect one another's time by saving questions for their appointment. We encourage patients to write down all questions and have them ready for their appointed provider.

In other words, 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 Omega at **801-261-4988.** Your question will be assessed and triaged according to the clinical significance and responded to accordingly.

PRESCRIPTIONS

All prescriptions must be picked up in person at a scheduled office visit. Patients who come in for pain management frequently must 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. In order to extend this courtesy, we will need a picture ID and copy of 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 to notify us immediately.**

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 cost, and collection charges as a result of any collection activity. I further understand that lack of financial responsibility on my part may result in dismissal from the clinic.

CO-PAY'S/ DEDUCTIBLES

If your insurance coverage requires 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 explanation of benefits 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 are referred to Omega Interventional Pain Clinic by another specialist, it is imperative that you have 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. You should request that physician to do so. Therefore, it is only in very unusual circumstances that an unscheduled or urgent visit is necessary.

____ ____________________

Patient Signature Date

____ ____________________

Witness Signature Date

HIPAA & PRIVACY PRACTICES ACKNOWLEGEMENT

Patient Name:____ Date of Birth:_______________

1. May we discuss treatment, payment, or private health information with a spouse, parent, or adult child?

   ☐ Yes ☐ NO

If *YES*, Please list the **name of each individual** that you are giving permission for us to discuss your information with and circle what you are giving permission for us to discuss with them:

Name	**Account Information**	**Health Information**
1. ____________________________________	☐	☐
2. ____________________________________	☐	☐
3. ____________________________________	☐	☐

	YES	**NO**
2. Can we leave appointment information with a family member?	☐	☐
3. Can we call you at work and leave a message that we called?	☐	☐
4. Can we leave test results on a home answering machine or with a spouse, parent or adult child?	☐	☐
5. Can a family member or designated person pick up medication samples or a prescriptions at our office for you?	☐	☐
6. Do you have any objections to the above? If yes, please explain.	☐	☐

____

I have been presented with a copy of the Notice of Privacy Practices written in plain language. The notice provides in detail how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

We at Omega Interventional Pain Clinic are working at protecting your private Health Information. You have the choice to create a password that we can put on your account so that whoever calls in, including yourself to schedule an appointment, cancel an appointment, make a payment, or discuss anything with our staff, they will have to give us the password that you choose. If you choose to give someone your password, they must be listed on the Privacy Practices Acknowledgement form, in order for us to give them any information.

<u>This is for your protection and is not mandatory</u>

☐ I would like to use ______________________________________ as a password for my account. I understand that this should be asked each time I or someone calls in for anything on my account. I also understand that I will need to fill out this form at any time I would like to change my password.

☐ I would not like to add a password on my account at this time. I understand that I may change this option at any time by requesting a new form at the front desk.

____ ____________________________

Patient Signature Date

____

Witness

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 & 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. If your health insurance coverage requires the insured to pay a deductible and percentage or a copay, these amounts will be due 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 cancelled with a 24 hour notice will be assessed a fee, as follows:

- Follow Up 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 the day of service unless you have a 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 charge of one and 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 patients 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% 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 *(printed)* Date

______________________________ ______________________________

Patient Signature Witness

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 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 and 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 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, the Agreement will govern all medical services received by the Patient from 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 cancelled 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. I have received a copy of this document.

Accept___________ Decline____________
(Initials) (Initials)

Provider: Omega Interventional Pain ____________________________________
Name of Patient (Print)

By: ______________________________ ______________________________________

Signature of Physician or Authorized Agent Signature of Patient or Patient’s Representative and Date