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 schedule 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 - Saturday: 7:30 AM – 5:00 PM
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, if your new patient packet is not fully completed by your appointment then you will be rescheduled.**

You will have 40 minutes to 1 hour with the provider so please make sure to write down all your questions so that you can get them answered.

If you need to change your appointment or cancel for any reason, please make 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 allowed to make appointments or be a patient.***

If you have any questions, please feel free to call,

- 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 Clinic

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 _____

OMEGA
Interventional Pain Clinic

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.

_____ _____

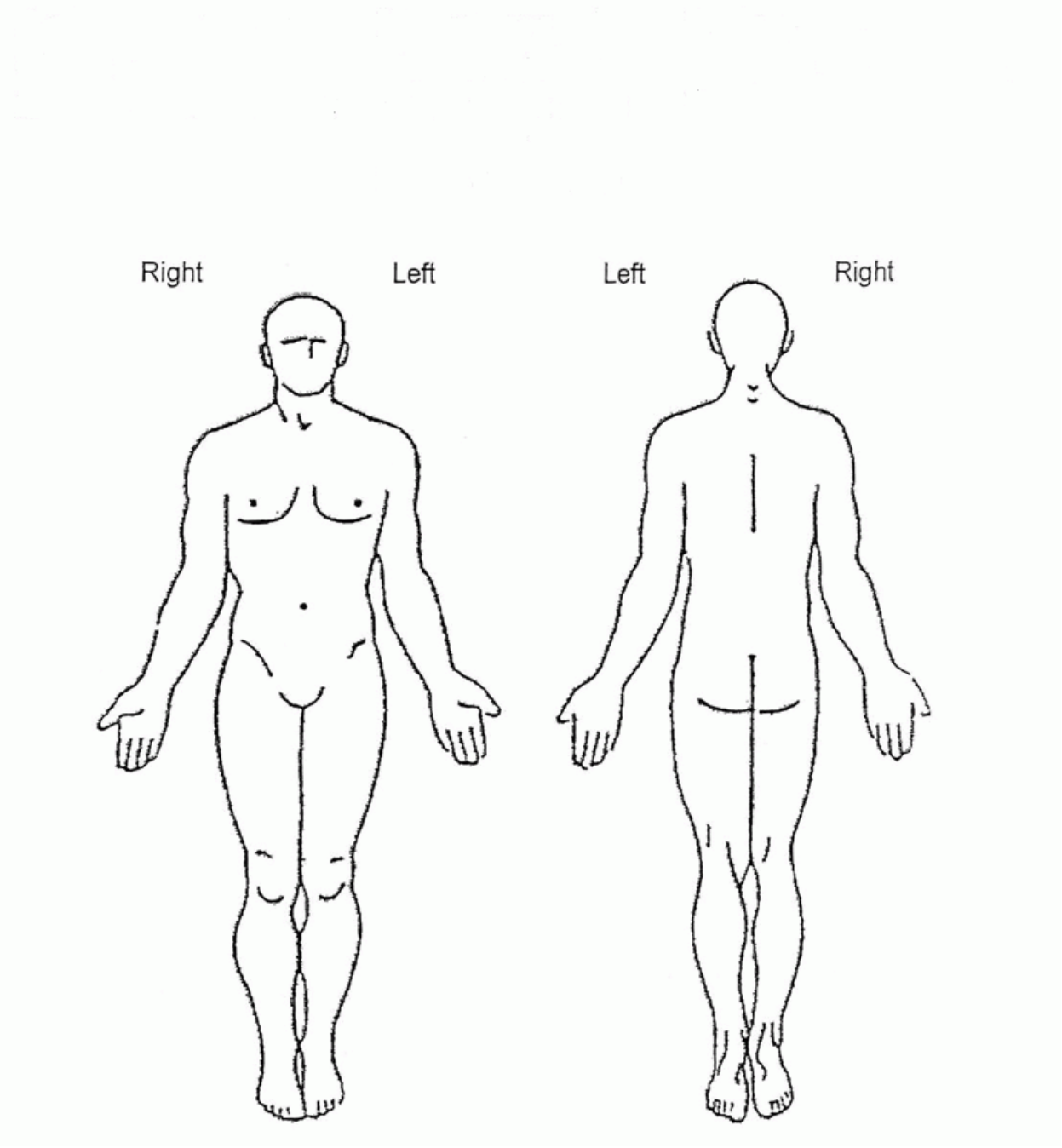
Patient Signature Date

_____

Witness

(Indicate the areas 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? _____

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:

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

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 about 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, they baby will by 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 Signature Date

_____

Patient Name *(printed)*

_____

Provider Signature

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 potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to you 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 controlled substances 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 health care 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 clinic 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** with doses above 100mg Morphine equivalent must have a documented sleep study for your safety. Anyone that is not compliant with their treatment for sleep apnea will require stopping their Opioids. Anyone having an Upper Respiratory Infection or pneumonia must reduce their Opioids by 1/3 and stop use 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 prescribe by your Mental Health Provider.
    e. No initiation or prescription assumption for respiratory depressing sleep aids.
    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 purposes 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. Presence of unauthorized substance may prompt 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 other 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 will result in discharge from the clinic**.
11. Since the drugs may be hazardous or lethal to a person who is not tolerant to 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. Refills will be given only on the decision of the provider. 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, only if the provider feels there is justification.
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 7:30am to 4:30pm.** There will be no other times 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 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 it terms.
20. You are advised not to drive while using any medication we prescribe without an appropriate drivers 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 of 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 Signature Date

_____

Patient Name - *(Print clearly)*

_____

Provider Signature

Opioid Risk Assessment Tool

Today's Date:

FOR OFFICE USE ONLY

	Mark each box that applies	Female Pt.	Male Pt.
1) Family history of substance abuse	[ ] Alcohol [ ] Illegal drugs [ ] Prescription drugs	1 2 4	3 3 4
2) Personal history of substance abuse	[ ] Alcohol [ ] Illegal drugs [ ] Prescription drugs	3 4 5	3 4 5
3) Age (Mark box if age 16-45)	[ ]	1	1
4) History of preadolescent sexual abuse	[ ]	3	0
5) Significant psychological disease -ADD -OCD -Bipolar (any variant) -Schizophrenia -Personality disorder -Significant affective disorder -Somatiform disorder	[ ]	2	2
6) Depression / Anxiety	[ ]	1	1
7) Mark if nothing applies	[ ]	0	0
Total score		_____	_____

Scoring:

Low risk	0-3
Moderate risk	4-7
High risk	8 or greater

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