PEAK
HEALTH & WELLNESS

Welcome to Peak Health and Wellness. We are happy that you have chosen our clinic to help you with your Pain Management needs and look forward to meeting you.

A visit to a reputable pain management clinic should be just like seeing any other doctor in any other medical specialty. We hear a lot from patients who worry about going to a pain clinic. There is a lot of stigma about having to step foot in the door of a pain clinic and patients worry about what others will think of them. Here at Peak Health and Wellness we try hard to make sure every patient is treated well and has a comprehensive medical plan to treat their pain. We want to make sure every patient is as comfortable as possible and to include up to date best practices in our treatment regimens. We are not a pill mill and we do not treat our patients like numbers. We also treat addiction and work very hard to minimize any long-term negative effects from chronic pain management.

If you are one of the 76 million American's who suffers chronic pain, you are not alone! We are here to help in any way we can.

Address 2850 N. 2000 W. #203, Farr West, UT 84404 Phone 801.689.3389 Fax 801.689.2320

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NEW PATIENT REGISTRATION FORM

Today's Date:				
PATIENT INFORMATION				
Patient's last name: First:		Middle:		Marital status:
Former name:	Birth date:	Age:	Sex:	Social Security no.:
Address: City, State, Zip Code:				
Home phone no.:	Cell phone no.:			Email:
Occupation:	Employer:			Employer phone no.:
Chose clinic because/referred to clinic by:		Primary Care Physician:		
Other family members seen here:				
INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Person responsible for bill:	Birth date:	Address (if different):		Home phone no. (if different):
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?		○ Yes ○ No
Please indicate primary insurance:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Policy no.:	Group no.:	Co-payment:
Patient's relationship to subscriber:				
Name of secondary insurance (if applicable):		Subscriber's name:	Policy no.:	Group no.:
Patient's relationship to subscriber:				
IN CASE OF EMERGENCY				
Name of local friend or relative:		Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Peak Health and Wellness, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

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Financial Policy and Consent to Proceed

THANK YOU FOR YOUR COOPERATION. BY PROVIDING US WITH ACCURATE INFORMATION, WE CAN SERVE YOU BETTER AND MORE EFFICIENTLY.

1. We need copies of your insurance card or cards for our files. Proper group numbers and Social Security numbers of any and all insurances are required with the name of the person who carries the insurance. If retired, please list under employer "Retired From" (List name of company). Without the information completed you will be considered a personal pay account. RESPONSIBLE PARTY IS THE PERSON SIGNING THIS FORM.
2. We expect you to know and understand your insurance policy. Insurance is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay that portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with your insurer). FOR UN-INSURED PATIENTS, WE REQUEST PAYMENT BE MADE *BEFORE YOUR* VISIT. Special arrangements can be made for large accounts.
3. As a courtesy we will file your insurance. (If you do file your own insurance, you need to pay for your services today.) We do not accept what auto insurance pays as payment in full.
4. If your insurance requires a special claim form, we must have it within two working days or the insurance billing will be processed and sent without it.
5. If your visit is related to an injury at work, you must report it to the receptionist. A special form needs to be completed. The patient does not file on his work related injury; it must be done by this office. Patients will continue to receive statements for their record until we are satisfied by the insurance.
6. In accordance with the FEDERAL TRUTH-IN-LENDING ACT, all doctors are required to give to their patient's complete information in connection with the extension of credit. BASIC POLICY: The patient is responsible for all medical bills in our office. Our staff will help with completion of insurance forms as an accommodation and convenience to you, without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us and to negotiate with your insurance company over any disputed claims.
7. WORKMAN'S COMPENSATION: In the event it is determined by the Workman's Compensation board that the illness or injury is not a result of a compensated Workman's Compensation case, I hereby agree to pay usual and customary fees for services rendered.
8. REJECTED CLAIMS: If your insurance company rejects your claim, policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full, contact our Billing Office.
9. DELINQUENT ACCOUNTS: Delinquent accounts over 90 days are turned over to our Collection Manager. If the bill remains unpaid and satisfactory arrangements for payment are not made, the Collection Manager will review the account with the provider to decide appropriate legal action. We reserve the right to add late charges for delinquent accounts requiring collection action and to add attorneys' fees and court costs. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorneys' fees and costs of collection.
10. MONTHLY STATEMENTS: You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance. This is a courtesy to you to be aware of the status of payments on your account and have a record of services. Once your insurance has paid, you are responsible for the unpaid balance.
11. Co-Payments or payments on unpaid account with payment arrangements must be made before your appointment. Otherwise your appointment may be rescheduled.
12. RETURNED CHECKS: A $15.00 handling charge is applied to all returned checks.
13. YOU MAY BE CHARGED A FEE OF $50.00 IF AN APPOINTMENT IS MISSED OR NOT CANCELLED 24 HOURS PRIOR TO SCHEDULED APPOINTMENT OR BEING 15 MINUTES LATE AND THE APPOINTMENT MAY BE RESCHDULED. A PATIENT MAY BE DISMISSED FROM OUR PRACTICE FOR EXCESSIVE MISSED APPOINTMENTS IN A YEAR.

I have read and agree with the Financial Policy of this office.

Patient_____ Date_____

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PEAK
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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act; HIPPA

1. I _____ authorize Peak Health and Wellness to use and disclose the protected health information described below to any covered entities under HIPAA and any vendors with Business Associate Agreements as described by HIPAA.

2. This authorization for release of information covers all past, present, and future periods.

3. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

8. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out treatment, direct or indirect treatment by other healthcare providers involved in my treatment. Obtaining payment from third party payers; insurance companies. And the day to day healthcare operations of your practice.

Signature of patient or representative _____

Printed name of patient or representative _____

Relationship to patient_____

Date _____

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Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [] my home [] my work [] my cell number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Signed: _____ Date: ____/____/____

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CONTROLLED SUBSTANCE REFILL PROGRAM: PATIENT AGREEMENT FORM

Treatment Agreement for Chronic Opioids

We want to ensure that patients and caregivers have clear communication and safe, effective procedures when patients use opioids.

EFFECTIVENESS: For most patients and pain conditions, opioids are effective pain-relieving medications. However, it is possible opioids will not work well for you and your pain.

SAFETY: Most people can take these drugs safely, but some people do experience side effects. (See below.)

SIDE EFFECTS: Most patients do not have serious side effects or drug interactions. Unfortunately, some do experience side effects and must stop the medication(s). Common side effects include constipation, itching, nausea, vomiting, sedation or lightheadedness. Uncommon reactions include swelling in the legs, water on the lungs, trouble breathing (especially if you have emphysema/COPD or are on other narcotics), mental slowing and loss of coordination, lowering of sex drive, decreased testosterone (male sex hormone) and addiction. Note: Pregnant women using opioids could make their newborn child dependent upon opioids. If you are pregnant, you need to alert your health care provider.

DEPENDENCE: Dependence is not the same as addiction. Many people who take opioids daily will become dependent on them. Dependence is when your body adapts to the medication and then experiences withdrawal if the medication is stopped or lowered too quickly. Withdrawal symptoms include moodiness, aches and pains, sweating, diarrhea, abdominal pain and even seizures.

ADDICTION: Addiction is not the same as dependence. While many people become dependent on daily opioids, only a small percentage of these people will become addicted. Addiction is characterized by behaviors such as loss of control of drug use, compulsive use and craving, and continued use despite harm or risk to the person. When people are addicted, they are not taking opioids simply to treat the pain.

GOALS: The goals of chronic pain management are to:
1 Improve your ability to function in your daily life,
2 Lower your pain.

TREATMENT OPTIONS:
1 Medications,
2 Counseling, relaxation training, hypnosis and meditation,
3 Chiropractic care, massage, acupuncture and physical therapy,
4 Surgery and injections.

WHAT YOU NEED TO DO:
1 Realize that opioid therapy is only one part of treatment.
2 Remain active every day and try to increase activity a little bit at a time.
3 Use your medications ONLY as directed by your provider.
4 Work with your provider and follow treatment recommendations in addition to taking prescribed medications.

Statistics have shown that chronic pain patients on a stable long term opioids are safer driving with their medications than without. This is due to the pain distracting the driver. I will exercise caution and do not drive for 72 hours after any changes (including changes in dose) to my chronic pain medications. I will not drive or exercise heavy machinery at any time if I am inhibited in any way by my use of chronic pain medications.

I understand that my medications may be changed. I will arrange monitoring by a companion, family member or friend for 72 hours after any change in medications. If there is any change in breathing, severe sedation or allergic reaction I or my friend will call 911.

I understand that the risk from opioids is increased by use of Benzodiazepines (e.g. Valium, Xanax, Klonopin, etc.) and other medications. I will not use opioids with benzodiazepines under any conditions unless I have discussed the safety and risks with my prescribers and pharmacists. If I choose to combine these medications, I accept any and all risks associated including respiratory depression and death.

I will not increase the dose or stop the medication unless asked to do so by my provider or my provider's partner.

I will report any worrisome side effect soon after it begins.

I will follow through on appointments that may help me with chronic pain and functioning. These may include physical and occupational therapy, counseling and other mental health practices, neurosurgery, neurology and orthopedics. Consistent failure to keep these appointments and therapies may result in the stopping of the opioid medications.

If prescribed, I will use medications other than opioids to control pain.

I will accept opioids for chronic pain from my provider only.

I will not share, exchange or sell my opioids, as the law prohibits those actions. I understand that my provider will report serious concerns of drug misuse to any and all authorities for investigation.

I will not use illegal/street drugs (this includes marijuana unless active medical marijuana card). I will not use narcotic medications unless provided to me from my provider.

I agree to provide samples for random drug testing when asked. If I fail to provide the sample when asked or if the results are unsatisfactory, I may forfeit the right to continue receiving the medication.

If my provider is concerned that I might have a substance abuse problem, I must agree to an evaluation by a specialist in abuse/addiction. If the evaluation suggests I have a drug abuse problem, my provider may stop my medication in a way that does not cause withdrawal symptoms.

I will not get early refills unless something has dramatically changed and then only if my provider agrees.

I recognize that opioids by themselves, in combination with alcohol or in combination with other medications can result in unclear thinking and loss of coordination. I agree to contact my provider if these symptoms arise. I should not drive or operate equipment if I have these side effects.

It is my responsibility to keep my medications safe. If opioids are lost, damaged or stolen, the medication may or may not be refilled early. Each case will be looked at individually. If the medication is stolen, I must file a police report and submit the number for verification to my provider's office. Again, stolen medications may or may not be refilled. If a refill is given, it will be given only once.

If a new condition develops that causes acute pain, I have the right to expect appropriate treatment for that new condition from the provider treating me for the new condition. I should not be required to increase the use of my chronic pain medication for a serious and new pain.

I understand that if my provider does not feel I am following through adequately with the treatment plan, my provider may lower or stop the opioid altogether.

I understand that my provider may decide to stop the opioid if after increasing it adequately, my pain and function have not responded positively.

I agree that when I have contact with the providers, nurses, or other staff members IE: medical assistants, receptionists, phone answers, etc. I will not be rude, aggressive, swear and or be disruptive, with any member of the office.

By signing this form, I authorize my provider's office to contact any and all groups and organizations involved with my care and involved with the investigation of medication and drug abuse. I give permission to my provider to discuss my care with past caregivers, all pharmacies and policing agencies. This also gives these caregivers and pharmacies permission to share with my provider information about my past treatments and care.

PATIENT SIGNATURE_____DATE_____

Pharmacy name _____ Phone _____

PROVIDER SIGNATURE_____

New Pain Patient

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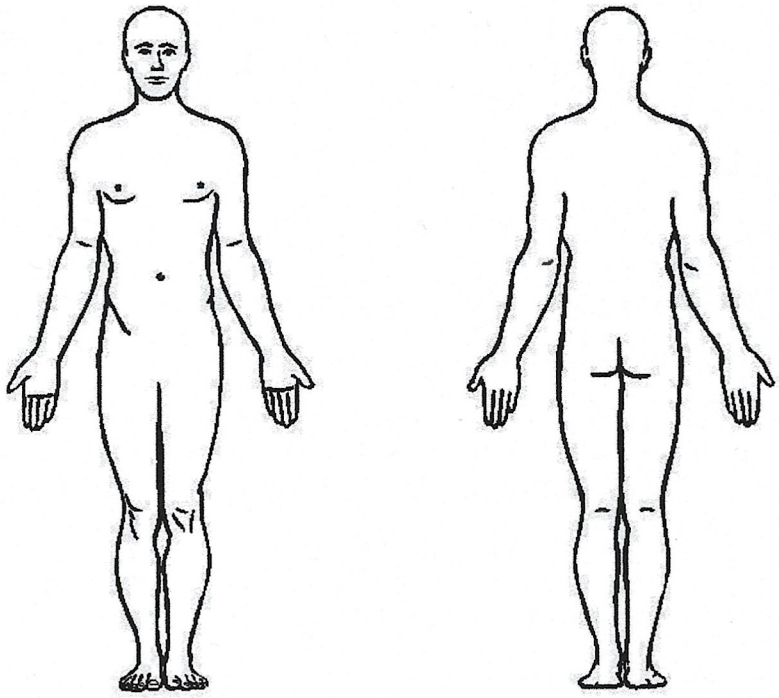
Name_____

Date_____

Date of Birth_____



1. Using the diagram to the right please circle the most painful areas.
2. Mark a (1) by the most painful area, a (2) by the next most painful, (3) by the next, etc
3. When did your pain begin?

   _____

4. Was their an associated injury? If yes, please describe the injury.

   _____

   _____

   _____

   _____

5. Please circle your most common pains:
   - Burning
   - Aching/Throbbing
   - Stabbing
   - Pins/Needles
   - Numbness
6. Does your pain radiate into:
   - Left Leg?
   - Right Leg?
   - Left Arm?
   - Right Arm?
   - Neck/Head?
   - Other?
   - No radiation?
7. Is the pain:
   - Coming and Going?
   - Constant?
   - Constant with break through pain?
8. Is the pain:
   - Getting better?
   - Getting worse?
   - Staying the same?

What is your pain today?
(no pain) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst pain possible)

What was your pain on average lately?
(no pain) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst pain possible)

Are you experiencing any of the following? Please circle any that apply.

- Change in vision/hallucinations
- Change in hearing
- Constipation/diarrhea
- Difficulty urinating
- Loss of bowel or bladder control
- Unexpected Weight gain or Loss
- Heart Palpitations or Racing
- Chest Pain
- Shortness of Breath
- Night sweats

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Previous or referring doctor:		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

MRI, CT Scans, Xrays

Year	Reason	Hospital

What non-medication treatments have you tried? Example: Surgery, Physical Therapy Epidural, Trigger Point Injections. Did these help?

Procedure	When	Help or Not Helped

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

What prescriptions have you tried previously? Please mark if the medication helped or did not help, gave you side effects, etc		
Name the Drug	Helped or Not Helped	Side Effects

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	