valley medical & wellness

• Burnsville • Minneapolis • Woodbury

Address: 2428 E 117th St, Burnsville, MN 55337

Tel: (612) 444-3000 • Fax: (612) 444-9000

IMPORTANT INFORMATION

PLEASE COMPLETE AND RETURN THESE FORMS PRIOR TO YOUR FIRST APPOINTMENT

Welcome, New Patient!

At Valley Medical & Wellness it is our mission to improve quality of life for those suffering from pain or afflicted with addiction. Both pain and addiction can have detrimental effects on every aspect of our lives – from our physical health, our jobs and finances, to our relationships with friends and family, and our own mental health, self worth, and pride. We work closely with patients to identify the problem, set treatment goals, and put methods into place to achieve those goals. Through individualized treatment plans, we strive to improve your health and comfort, and help you get back to being your very best self.

This "New Patient Packet" will need to be completed and returned prior to scheduling your first appointment. Enclosed is a Release of Information form which needs to be signed so that we can collect your medical records and imaging results, such as MRI or X-rays, prior to your initial consultation. If you need an interpreter, contact our office ten business days prior to your appointment. We will have a few more forms for you to sign on the day of your appointment, so please remember to arrive at least **20 minutes early.** Your initial consultation will be roughly an hour and a half to two hours long—please plan accordingly.

BRING TO YOUR FIRST APPOINTMENT:

- ☐ Driver's License or other state/federally-issued photo identification
- ☐ Insurance card or Worker's Comp/Auto Injury claim number
- ☐ Any prescribed medications you are currently taking

HOW TO CONTACT US:

Klara is a confidential patient messaging portal which allows you to easily communicate with your provider through your mobile device. To get started, please visit our website at valleymedical.com and enter your mobile phone number into the Klara chat invitation. You will receive a verification code via text and then you are all set!

If you have any questions about these forms or your appointment, please call us at (612)444-3000 or visit us on Klara.

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ADDRESS & INSURANCE FORM

I. PATIENT DEMOGRAPHIC INFORMATION:

LAST NAME: **FIRST:** **MIDDLE:**	**DATE OF BIRTH:**
SEX *(circle)*: **MALE** **FEMALE** **INTERSEX** **MtF** **FtM**	**SSN#:**
ADDRESS:	**MOBILE PHONE:**
CITY: **STATE:** **ZIP:**	**HOME PHONE:**
RACE: **PREFERRED LANGUAGE:**	**EMAIL:**
DRIVER'S LICENSE NUMBER:	**REFERRED BY:**
ETHNICITY *(circle):* **HISPANIC OR LATINO / NON-HISPANIC OR LATINO**	**MARTIAL STATUS *(circle)*: MARRIED SINGLE DIVORCED WIDOWED**
PHARMACY NAME & LOCATION:	**EDUCATION *(circle):* HIGH SCHOOL COLLEGE TRADE/TECHNICAL**
PRIMARY CARE PROVIDER:	**CLINIC NAME:** **PHONE:**
OCCUPATION:	**EMPLOYER NAME:**

II. GUARANTOR OF ACCOUNT (if different than above):

LAST NAME: **FIRST:** **MIDDLE:**	**DATE OF BIRTH:** _____/_____/_____
ADDRESS:	**PRIMARY PHONE:** **SECONDARY PHONE:**
CITY: **STATE:** **ZIP:**	**RELATIONSHIP TO PATIENT:**

III. PATIENT PRIMARY INSURANCE: (present insurance card)

INSURANCE COMPANY: **EFFECTIVE DATE:**	**POLICY HOLDER NAME:** **DOB:**
POLICY NUMBER or ID NUMBER:	**GROUP NUMBER:**
PHONE NUMBER: **PAYER ID:**	**ADJUSTER NAME:** **PHONE NUMBER:**
CIRCLE IF APPLICABLE: WORKER'S COMP AUTO INJURY	**DATE OF INJURY:**

IV. PATIENT SECONDARY INSURANCE: (present insurance card)

INSURANCE COMPANY:	**EFFECTIVE DATE:**	**POLICY HOLDER NAME:**	**DOB:**
POLICY NUMBER or ID NUMBER:		**GROUP NUMBER:**	
PHONE NUMBER:	**PAYER ID:**	**ADJUSTER NAME:**	**PHONE NUMBER:**

V. NOTIFY IN CASE OF EMERGENCY:

NAME(LAST,FIRST):	**PHONE #:**	**RELATIONSHIP TO PATIENT:**
NAME(LAST/FIRST):	**PHONE #:**	**RELATIONSHIP TO PATIENT:**

Assignment of Benefits Clause: I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any profession services. I authorize direct payment of medical benefits to Valley Pain Relief and Wellness Center for services rendered. I also authorize release of any information concerning my past medical care to my insurance companies, referring physician, or legal guardian.

_____	_____
PATIENT SIGNATURE **DATE:_____**	**GUARANTOR SIGNATURE** **DATE:_____**

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RELEASE OF INFORMATION & CONSENT FORM

It is important that health care providers work together. As such, Valley Pain Relief and Wellness Center, would like your permission to communicate and obtain medical records, when necessary, with your medical providers.

This release form is enforceable from _____ (today) to expire one year from today's date.

Patient Name		DOB	
SSN		Phone	
Address		City, State, Zip	

Releasing To:			
Address:			
Phone:		Fax:	

By signing below, I hereby authorize the release and exchange of information specified below between the above listed organization and **Valley Medical and Wellness.**

This release of information shall be limited to the following specific types of information**: ____ ALL MEDICAL RECORDS**

___Assessment
___Diagnosis
___Treatment Plan or Summary
___Current Treatment Update
___Medication Management Information
___Presence/Participation in Treatment
___Nursing/Medical Information
___Toxicological Reports/Drug Screens
___Educational Information
___Psychiatric/Psychological Evaluations
___Drug Use/Addiction History
___Toxicological Reports/Drug Screens
___Education Information
___Discharge/Transfer Summary
___Continuing Care Plan
___Demographic Information
___Progress in Treatment/Notes
___Lab Results
___Imaging: _____
___Other: _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to Valley Medical and Wellness in writing. However, the revocation will not apply to records already released. I understand that the information can be re-disclosed by the third party listed above and once received it may no longer be protected by federal or state privacy laws. I am aware that some requests may be charged a fee as allowed by law.

Patient Signature: _____ Date: _____

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New Patient Intake Form

Patient's Name (Printed): _____ Date: _____

CHIEF COMPLAINT:

What brought you in today?_____

How long have you had these complaints?_____

Are you currently suffering from any of the following conditions (*circle*)?

Depression When were you diagnosed? _____ Medications: _____

Anxiety When were you diagnosed? _____ Medications: _____

Joint Pain Location:_____ Duration:_____ Medications: _____

Myalgia Location:_____ Duration:_____ Medications: _____

Headaches How many headache-days per month?_____ Medications: _____

What is your current pain level? (1 = Least 10 = Greatest) 1 2 3 4 5 6 7 8 9 10

Have you tried any alternative therapies besides medication *(circle)*?

Physical Therapy Acupuncture Chiropractic Biofeedback Acupressure Massage (Other:_____)

How has your activity level changed since the onset of your chief complaint (*circle*)? Improved Worsened Unchanged

How has your quality of life changed since the onset of your chief complaint (*circle*)? Improved Worsened Unchanged

How has your sleep quality changed since the onset of your chief complaint (*circle)*? Improved Worsened Unchanged

CURRENT MEDICATIONS

Name:_____ Strength: _____ Dosage:_____ Date started:_____

Name:_____ Strength: _____ Dosage:_____ Date started:_____

Name:_____ Strength: _____ Dosage:_____ Date started:_____

Name:_____ Strength: _____ Dosage:_____ Date started:_____

Name:_____ Strength: _____ Dosage:_____ Date started:_____

Please attach a separate page with a list of your current medications if you need more space.

MEDICATIONS YOU HAVE TRIED IN THE PAST WHICH HAVE <u>NOT</u> BEEN EFFECTIVE

Name:_____ Strength: _____ Dosage:_____ Date ended:_____

Name:_____ Strength: _____ Dosage:_____ Date ended:_____

Name:_____ Strength: _____ Dosage:_____ Date ended:_____

New Patient Intake Form (Continued)

PAST MEDICAL HISTORY

Surgery:_____ Date:_____ Surgery:_____ Date:_____

Surgery:_____ Date:_____ Surgery:_____ Date:_____

Surgery:_____ Date:_____ Surgery:_____ Date:_____

Do you have any other Medical Issues/Diagnoses?

_____

_____

_____

FAMILY HISTORY

Paternal History *(circle):* Living or Deceased | Illnesses:_____ Habits *(circle):* Drugs | Alcohol | Smoking

Maternal History *(circle)*: Living or Deceased | Illnesses:_____ Habits *(circle):* Drugs | Alcohol | Smoking

Do you have any children? Yes or No

Name: _____ Age:____ | Illnesses:_____ Habits *(circle):* Drugs | Alcohol | Smoking

Name: _____ Age:____ | Illnesses:_____ Habits *(circle):* Drugs | Alcohol | Smoking

Name: _____ Age:____ | Illnesses:_____ Habits *(circle):* Drugs | Alcohol | Smoking

Do any of your siblings or relatives have any illnesses or habits (including drugs and alcohol)? If so, please list them below:

_____

SOCIAL HISTORY

Yes **No** Do you smoke cigarettes or use e-cigarettes? If so, how much per day? _____ For how long? _____

Yes **No** Do you drink caffeine (coffee, tea, or soda)? If so, how much per day?_____

Yes **No** Do you exercise? If so, what type and how often?_____

Employment Status *(circle)*: Employed Unemployed Retired Disabled (Year:_____)

Martial Status *(circle)*: Married Single Divorced Separated Other:_____

How many members of your household? _____ Relation to you:_____

SUBSTANCE ABUSE HISTORY (If Applicable)

Please provide a brief history of your substance use history (if applicable):

_____

_____

_____

_____

_____

New Patient Intake Form (Continued)

Pain Location Chart

Patient's Name (Printed): _____ Date: _____

Instructions: Please **CIRCLE** where you feel pain and **RATE** how much pain you are feeling.

0 No Pain **1** **2** **3** **4** **5** Moderate Pain **6** **7** **8** **9** **10** Worst Pain

Please provide a brief history of your pain (if applicable):

_____

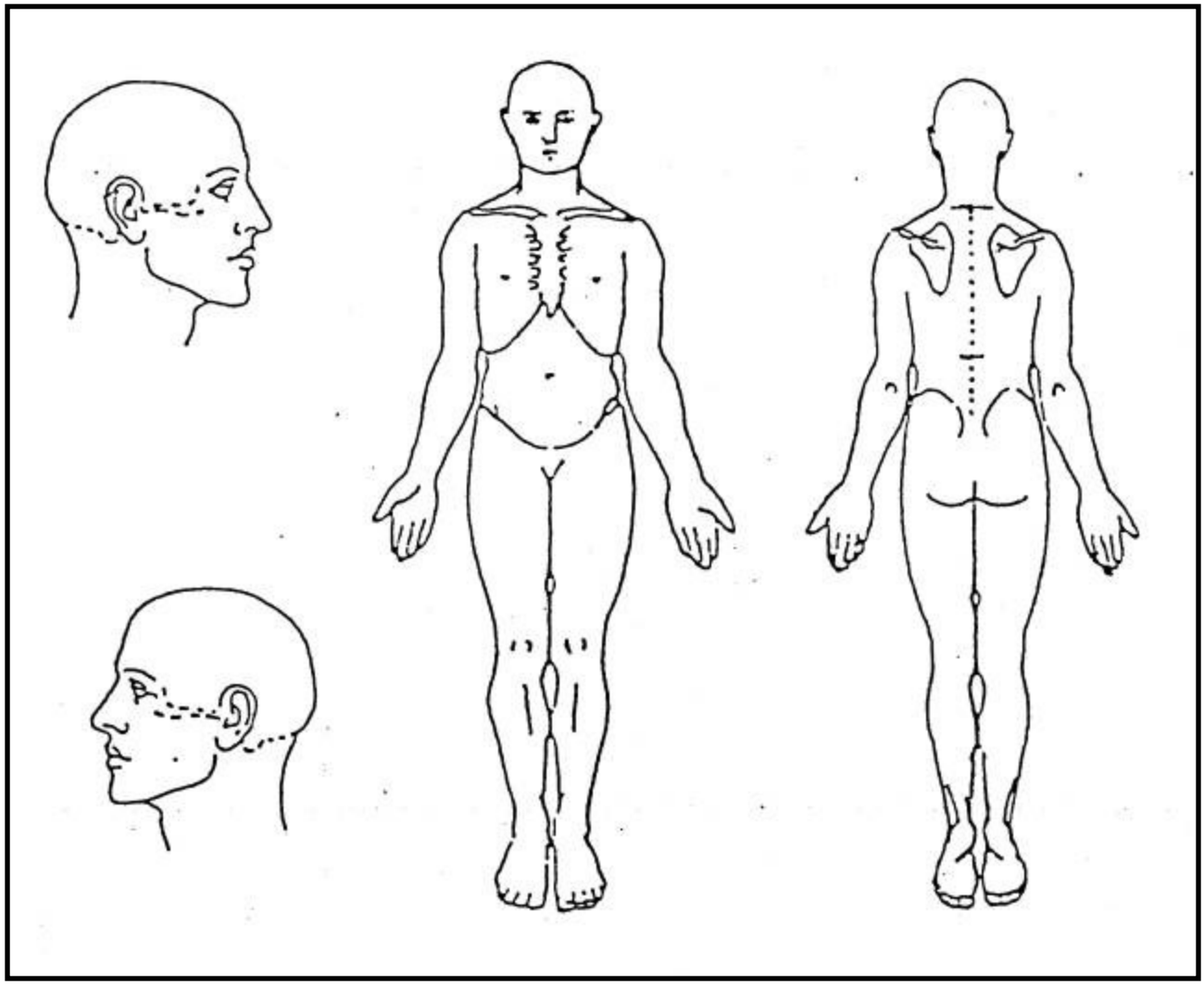
_____

_____

_____

_____

_____



New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as a part of my health care, Valley Medical and Wellness, PLLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication to other health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I have the following rights and privileges:

- The right to object the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Valley Medical and Wellness, PLLC reserves the right to change their notice and practices and prior to implementation, In accordance with Section 164.520 of the Code of Federal Regulations. Should Valley Pain Relief and Wellness Center, PLLC change their notices, they will send a copy of my revised notice to the address I have provided.

I understand that as a part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

By signing below, I attest that I fully understand and agree to the terms of this consent:

Patient Printed Name: _____

Patient Signature:_____ Date:_____

FOR OFFICE USE ONLY:

Consent Received By:_____ Date:_____

Restricted Pharmacy Agreement

I am seeking healthcare services from the physicians and providers at Valley Medical and Wellness (VMW) for the treatment of my condition. I acknowledge that I intend to provide all necessary releases for healthcare and to be accurate, complete, and truthful in disclosing my history and symptoms so that VMW may safely treat me for my condition. By signing below I understand and agree to the following:

1. I give consent for VMW to share medical history with the pharmacy or pharmacies listed in this agreement so that my prescriptions may be monitored for my safety and continuity of care.
2. I understand that obtaining prescription medication(s) through false representation is a crime, and that I will be reported to local law enforcement officials for attempting to fraudulently obtain prescription medications for non-therapeutic purposes.
3. If I need to change pharmacies I will contact Valley Medical and Wellness' clinic manager, choose a different pharmacy, and fill out a new Restricted Pharmacy Agreement with the clinic manager's approval.
4. I agree to only use one pharmacy, except when otherwise noted below, to get my medication(s). The name of my pharmacy is:

Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone Number:_____

☐ *(Check only if applicable)* I have more than one place of residence and as a result would like to have an additional pharmacy on file to include in this agreement. The name of the pharmacy is:

Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone Number:_____

I have read and understand what is required of me.

Patient's Signature_____ Date_____

VMW Staff Signature_____ Date_____

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Patient Treatment Agreement

The purpose of this agreement is to give you information about the medications you will be to assure that you and your health care provider (HCP) at Valley Medical and Wellness (VMW) comply with all state and federal regulations concerning the prescribing of controlled substances. While the goal is to improve your qualify of life, controlled substances have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Successful treatment depends on mutual trust and honesty between the HCP and patient along with a full agreement and understanding of the risks and benefits of using controlled substances. I (the patient) agree to the following conditions:

1. I am responsible for my medications. I agree to take the medication only as prescribed and to comply with the following:

    a. I am responsible for keeping my medications in a safe and secure place out of reach of children and pets. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed, for keeping track of the amount remaining, and how long it should last before needing a refill. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my HCP. If my medications are lost, misplaced, or stolen my HCP may choose not to replace the medications.
    b. I agree not to hoard or acquire any opioid medication including those from outside medical professionals (including emergency rooms), and to follow the dosing instructions on my prescription. I understand that unauthorized changes may result in my running out of medications early, and early refills will not be allowed.
    c. I will not use illicit substances such as cocaine, marijuana, etc. while taking these medications. The use of alcohol together with opioid medications is dangerous and may result in overdose or death.
    d. I will treat all VMW staff respectfully at all times and I will not disrupt the care of other patients.

2. I will not request or accept controlled substance medication from any other medical professional or individual unless I have consent from my HCP at VMW.

3. I understand that by signing this agreement that my signature indicates that I understand the risks and benefits associated with controlled substances and have agreed to their use as it has been explained to me that taking controlled medications has certain risks associated with it.

4. I understand that if I have a history of alcohol or drug misuse/addiction that I must notify my HCP of that history because treatment with opioids for pain may increase the possibility of relapse.

5. It is my responsibility to notify my HCP of any side effects. I am also responsible for notifying my HCP immediately if I need to visit another medical professional or emergency room due to pain, or if I become pregnant or may become pregnant.

6. I understand that my controlled substance medication is strictly for my own use. Controlled substances should **never** be given or sold to others because it may endanger that person's health and is **against the law.**

7. It is my responsibility to tell any medical professional that is treating me or prescribing me medications that I am taking controlled substance medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my medicines.

8. I will inform my HCP of all medications I am taking, including herbal remedies and other supplements and over the counter medications. Medications like benzodiazepines (e.g. Xanax or Ativan); sedatives (e.g. Soma, Fiorinal); antihistamines (e.g. Benadryl); herbal remedies, Kratom, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects.

Patient Treatment Agreement (Continued)

9. I understand that controlled substance prescriptions **will not** be mailed or electronically sent to the pharmacy without an office visit.

10. I will communicate fully with my HCP to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medications. This information allows my HCP to adjust my treatment plan accordingly.

11. I will participate in all other types of testing and treatment that are recommended by my HCP at VMW.

12. I understand that I must bring back all controlled medications prescribed by my VMW HCP in the original containers/bottles at every visit for pill counts. I also understand that I may be called in at random between visits for pill counts.

13. If an appointment for a prescription refill is *missed*, another appointment will be made as soon as possible. *Immediate* or *emergency* appointments may not be granted.

14. I will keep, and be on time, for all my scheduled appointments with VMW. I will make sure that I have an appointment scheduled for refills, and I will notify VMW immediately if I am having trouble making an appointment.

15. I understand that I will be prescribed enough medication to last from appointment to appointment. Prescriptions will not be written in advance due to vacations, meetings, or other commitments. If you can't make it to an appointment due to significant illness, severe weather, or other possible emergencies as deemed by the covering HCP, a 3-day prescription or withdrawal medications may be prescribed without a visit.

16. If it appears to my HCP that there is no improvement in my daily function or quality of life from the controlled substance, my treatment plan may be changed at my provider's discretion.

17. I will submit to urine and/or oral tests as requested by my HCP to monitor my treatment. I also understand that I may be called in at random between visits for drug testing. I understand that the presence of any unauthorized substances, or absence of prescribed substances, in my urine or saliva, may prompt assessment of addiction or chemical dependency and a change in my treatment plan.

18. I agree to allow VMW to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my condition as outlined in the Notice of Privacy Policy.

19. I have read the above information or it has been read to me and all my questions regarding my treatment plan with the use of controlled substances, which includes the use of opioids or buprenorphine, have been answered to my satisfaction. I understand that any failure to comply with the above conditions may result in a change to my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the HCP/patient relationship.

20. I hereby acknowledge receipt and understanding of this document.

Patient's Signature---_____ Date_____

VMW Staff Signature_____ Date_____