valley medical & wellness
Burnsville | Minneapolis | Woodbury | Rochester
2428 East 117th Street Burnsville, MN 55337
Phone: 612-444-3000 | Fax: 612-444-9000

New Patient Intake Form

Patient Demographic Information

Last Name: _____ **First name:** _____ **MI:** _____

DOB: _____ **SS #:** _____ **Sex:** _____

Street Address: _____

City: _____ **State:**_____ **Zip Code:** _____

Home Phone:_____ **Cell Phone:** _____ **Work Phone:** _____

E-mail: _____

Race/Ethnicity: _____ **Occupation:**_____

Referral Source *(how did you hear about us)*: _____

Primary Care Provider: _____ **Clinic Name:** _____

Medical Insurance Information

Primary Insurance Co: _____

Policy ID #: _____ Group #:_____

Policy Holder name: _____ ID #: _____ D.O.B: _____

Secondary Insurance Co: _____

Policy ID #: _____ Group #:_____

Policy Holder name: _____ ID #: _____ D.O.B: _____

Will you be using either: □ Worker's Comp Insurance - OR - □ Auto Accident Injury Insurance

Date of Injury: _____ Adjuster Name: _____

Name of Insurance Company: _____ Phone: _____

Adjuster Phone: _____ Claim #: _____

Notify in Case of Emergency

Name (Last, First): _____ **Phone:** _____

Relationship to Patient: _____

Medical History Questionnaire

Chief Complaint – What Brings You Into Valley Medical? *(Check all that apply):*

□ **Pain Management –** *Pain Location(s):* _____

_____

□ **Addiction Management:**

□ Alcohol □ Benzo's □ Cocaine □ Meth □ Opioids (*Painkillers, Heroin*) □ Marijuana

□ **Worker's Compensation**

□ **Motor Vehicle Accident**

Past Medical History

Check the following conditions/diseases that you have been diagnosed with/treated for in the past:

Head/Eyes/Ears/Nose/Throat
□ Cataracts
□ Glaucoma
□ Sinusitis

Respiratory
□ Asthma
□ Emphysema
□ COPD
□ Sleep Apnea

Cardiovascular
□ Atrial Fibrillation
□ High Blood Pressure
□ High Cholesterol
□ Heart Attack
□ Heart Failure
□ Heart Murmur

Gastrointestinal
□ Celiac Disease
□ Constipation
□ Chron's Disease/ Ulcerative Colitis
□ GERD (Acid reflux)
□ Pancreatitis
□ GI Bleeding
□ Irritable Bowel Syndrome (IBS)

Genitourinary/ Nephrology
□ Chronic Kidney Disease (CKD)
□ Kidney Infections
□ Kidney Stones

Obstetric/ Gynecological
□ Endometriosis
□ Dysfunctional Uterine Bleeding
□ Ovarian Cyst

Musculoskeletal
□ Back Pain
□ Carpal Tunnel Syndrome
□ Neck Pain
□ Osteoarthritis
□ Osteoporosis
□ Trochanteric Bursitis

Rheumatologic
□ Ehlers-Danlos Syndrome (EDS)
□ Fibromyalgia
□ Psoriatic Arthritis
□ Rheumatoid Arthritis

Neurological
□ Epilepsy
□ Head Injury/TBI
□ Headaches
□ Neuropathy
□ Stroke/TIA

Dermatological
□ Eczema
□ Psoriasis

Endocrine
□ Diabetes
□ Hyperthyroidism
□ Hypothyroidism
□ Low testosterone

Infectious Disease
□ Hepatitis
□ HIV/AIDS

Cancer/Blood Disorders
□ Anemia
□ Cancer

Psychiatric
□ Anxiety
□ ADHD
□ Bipolar Disorder
□ Depression
□ Drug or Alcohol abuse
□ PTSD
□ Schizophrenia
□ Suicide Attempt

☐ I have NEVER been diagnosed with any of the above conditions.

Other Medical Conditions: _____

_____

Past Surgical History

Please indicate any surgical procedures you have had in the past including the approximate date, levels/laterality, and location (if applicable):

Abdominal Surgery
□ Gallbladder Removal: _____
□ Appendectomy: _____
□ Bariatric Surgery: _____

Female Surgeries
□ Caesarean section: _____
□ Hysterectomy: _____
□ Ovarian: _____

Heart Surgery
□ Valve Replacement: _____
□ Stent Placement: _____
□ Cardiac Bypass: _____

Joint Surgery
□ Shoulder: _____
□ Hip: _____
□ Knee: _____

Back / Spinal Surgery
□ Discectomy: _____
□ Laminectomy: _____
□ Spinal Fusion: _____

Other Common Surgeries
□ Hernia repair: _____
□ Thyroidectomy: _____
□ Tonsillectomy: _____
□ Vascular Surgery: _____
□ Carpal Tunnel Release: _____

□ I have NEVER had any surgical procedures

Please List Any Other Surgeries with Approx. Dates: _____
_____

Family History

Please check all appropriate diagnoses as they pertain to your biological mother and father only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Failure	High Blood Pressure	Kidney Problems	Liver Problems	Osteoporosis	Seizures	Stroke	Drug/Alcohol Abuse
Mother												
Father												
Grandparents												
Siblings												
Children												

Other medical problems in your family: _____

□ I have a family history of drug/alcohol abuse *(relationship to you):* _____

□ I have NO significant family medical history

□ I was adopted *(No Medical History Available)*

Social History

Marital Status: □ Single □ Married □ Separated □ Divorced □ Other: _____

Members of Household: □ Spouse □ Children (#: ___) □ Other: _____

Sexual Activity:

Sexually Active with: □ Men □ Women □ Both

Method of Protection: □ Abstinence □ Condoms □ IUD □ Pill □ Other: _____

# of Partners in Past Year: _____

Education: □ High School □ College □ Post-Graduate □ Trade School

Occupation: □ Employed □ Unemployed □ Retired □ Disabled

Substance Abuse History

Tobacco Use: □ Never Used Tobacco □ Ex Tobacco User *(Stop Age: _____)*

□ Currently Tobacco User *(Start Age: _____ # Packs per Day: _____)*

Substance Abuse History: _____

_____

_____

_____

Select the type of drug(s) you have tried/used in the past below:

□ Alcohol □ Ecstasy □ Heroin □ Marijuana □ Prescription Pain Killers

□ Benzo's □ GHB □ IV Drugs □ Methamphetamines □ Steroids (Anabolic)

□ Cocaine □ Hashish □ LSD □ Opioids □ Other Drug(s): _____

□ I Have Never Abused Any Of The Drugs Listed Above

If you checked any of the above, which options apply to you? □ Currently using □ Used in Past

□ Overdosed □ Withdrawals □ Attempts to Quit □ Cravings □ Change in effect over time

Addiction Treatment History:

□ 12 Step Programs □ Medication □ Inpatient Treatment *(# Times: _____)*

□ Hypnosis □ Group Counseling □ Outpatient Treatment *(# Times: _____)*

□ Individual Counseling □ Other: _____

Pain Description *(If Applicable)*

Brief History of your Pain: _____

_____

_____

_____

Please mark all of the following treatments you have used for pain relief and their effect:

Complementary Therapies:	Helped with pain	Worsened pain	No change in pain
Acupuncture	☐	☐	☐
Biofeedback	☐	☐	☐
Chiropractic Treatment	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Injection Therapy	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
Physical Therapy	☐	☐	☐
TENS Unit	☐	☐	☐

Other:_____

Description of Pain *(Check all that apply):*

☐ Aching	☐ Dull	☐ Shooting	☐ Spasming
☐ Burning	☐ Tingling/Pins & Needles	☐ Gripping	☐ Throbbing
☐ Cramping	☐ Numbness	☐ Stabbing	☐ Sharp

What makes your pain better or worse *(e.g. standing, sitting, exercise, stretching, bending, etc)***?**

_____

_____

What are your major concerns about your condition?

_____

_____

_____

What goals do you hope to accomplish with Valley Medical and Wellness?

_____

_____

_____

Notice of Privacy Practices

The purpose of this notice is to describe how your Personal Health Information (PHI) may be used and disclosed and how you can get access to this information at Valley Medical and Wellness (VMW).

1. **You have rights when it comes to your PHI. This section explains your rights and some of our responsibilities to help you.**

    - You may ask to see or receive an electronic or paper copy of your medical records. We will provide a summary or copy of your request within 30 days.
        i. At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardians of a child under the age of 18 will be allowed to access medical record information with proof of child's social security number and date of birth.
        ii. All requests for medical records should be hand written and should contain the following: Full Name, Date of Birth, Mailing Address, Phone Number, and Written Signature.
        iii. Records requested for the purpose of reviewing your current medical care may not be charged a fee. [Minn. Stat. § 144.292 subd. 6]If you request copies of your patient records of past medical care, or for certain appeals, we may charge you specified fees. [Minn. Stat. § 144.292 subd. 6]
    - You may ask us to correct PHI about you that you think is inaccurate. Your request may be declined, and VMW will provide a written explanation if needed within 60 days.
    - We will accommodate any reasonable request to contact you in a specific way (e.g. home or work phone number) or to send mail to a different address.
    - You may ask us not to share certain PHI for treatment, payment, or operations.
        i. We are not required to agree to this and may decline if it would affect your care.
    - We will never share your information for marketing purposes or sell your information without your permission.
    - If you pay for a service "out of pocket", you may ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to these requests unless the law requires that we share the information.
    - You may ask for a list (accounting) of the times we've shared your PHI for six years prior to the date you ask, whom we shared it with, and why.
        i. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). One free accounting may be provided a year, but a fee may be applied if you ask for another within 12 months.
    - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI on your behalf.
        i. We will verify that the person has this authority and can act for you before we take any action.
    - If you feel we have violated your rights you may contact us at patientservices@valleymedical.com.
    - If you wish to file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights, you can reach them by mail at 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting www.hhs.gov/ocr/privacy/hipaa/ complaints/.
        i. We will not retaliate against you for filing a complaint.

2. **This section explains the responsibility VMW has in the handling of your PHI.**

    - We are required by law to maintain the privacy and security of your PHI.
    - We will notify you if a breach occurs that may have compromised the privacy or security of your PHI.
    - We must follow the duties and privacy practices described in this notice and give you a copy of it.
    - We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.

3. **This section explains how VMW may utilize or share your PHI.**

- We can use and share your PHI with other medical professionals who are treating you.
- We can use and share your PHI to run our practice, improve your care, and contact you when necessary.
- We can use and share your PHI to bill and get payment from health plans or other entities.
- We may share your PHI to contribute to the public good or safety in certain situations such as:
    i. Preventing disease
    ii. Helping with product recalls
    iii. Reporting adverse reactions to medications
    iv. Reporting suspected abuse, neglect, or domestic violence
    v. Preventing or reducing a serious threat to anyone's health or safety
        1. You may provide specific instructions for how you prefer VMW to handle your PHI in the event of an emergency. If you are unable to provide a preference we may share your PHI if we believe it is in your best interest to lessen a serious threat to your health or safety.
- With your permission we may use or share your PHI for health research. These studies will not affect your treatment or welfare, and your PHI will continue to be protected. [Minn. Stat. § 144.295 subd.1].
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, to see that we're complying with federal privacy law.
- We can use and share PHI about you with organ procurement organizations.
- We can use and share PHI with a coroner, medical examiner, or funeral director when an individual dies.
- We can use and share PHI about you to address special requests in certain instances such as:
    i. For workers' compensation claims
    ii. For law enforcement purposes or with a law enforcement official
    iii. With health oversight agencies for activities authorized by law
    iv. For special government functions such as military, national security, and presidential protective services
- We can use and share PHI about you in response to a court or administrative order, or in response to a subpoena.
    i. [Minn. Stat. § 144.293 subd. 2] In Minnesota, we need your consent before disclosing PHI for treatment, payment, and operations, unless the disclosure is to a related entity, or for a medical emergency and we are unable to obtain your consent. [Minn. Stat. §§ 13.386, 254A.09]

Changes to the Terms of this Notice

The terms of this notice are subject to change and the changes will apply to all PHI we have on file for you. The new notice will be available upon request in our office or on our web site at www.valleymedical.com.

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Valley Medical and Wellness, I and understand that if I have questions regarding this notice that I may request a copy at any time or may contact the office by mail at 2428 E 117th St., MN 553371269, by calling 612-444-3000, or by email at patientservices@valleymedical.com.

Patient's Signature_____ Date_____

VMW Staff Signature_____ Date_____

Patient Treatment Agreement

The purpose of this agreement is to give you information about the medications you will be prescribed to ensure 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 quality 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, Kratom, methamphetamine 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, prescription opioid, 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 be considering becoming pregnant. I understand that use of these medications poses special risks to women who are pregnant or may become pregnant. I have been advised that, should I carry a baby to term while taking these medications, the baby may be physically dependent on opioids and has the potential for opioid withdrawal after delivery. I also understand that birth defects can occur whether or not the mother is on medication and that there is always the possibility that my child will have a birth defect while I am taking controlled substance medications and that long-term effects on a child's development is not fully understood.

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.

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.

9. I understand that controlled substance prescriptions **will not** be 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 consult and all follow-up visits with regards to my pain level and functional activity along with any side effects of the medications.

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 even if the original container is empty. 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 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 understand that it is illegal to drive under the influence of prescribed medications and that I could be charged for driving under the influence if I am suspected of driving while impaired.

18. I will submit to urine and/or oral drug 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 for addiction or chemical dependency and a change in my treatment plan.

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

20. 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.

Patient Name (Printed): _____

Patient's Signature_____ Date_____

VMW Staff Signature_____ 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 medications(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_____

Mediation and Dispute Resolution Agreement

Your care is important to us, and we feel it is vital to your treatment that we communicate openly and honestly. As such, we request that you: Ask questions and participate in your care, be honest about your history, symptoms, and other important health information, prepare for and keep scheduled visits, and be respectful to our office staff and healthcare providers. In exchange, we agree that we will: Explain diagnosis, treatment recommendations, and outcomes in an easy-to-understand way, listen to your questions and help you make decisions about your care, keep discussions and records private, and determine when a referral or termination of care is appropriate.

MEDIATION

As a part of our emphasis on open communication, we ask our patients to sign this mediation agreement. While we do not anticipate any issues or concerns during the course of your treatment, if any arise, you (and/or your legal counsel) and your healthcare provider (and/or their legal counsel) agree to meet with a neutral mediator and work toward a solution. Whether or not a solution is found, mediation may postpone but does not remove or block your legal rights. Importantly, you agree that any usage or inference to a "claim" will be understood and read as "potential claim" until the mediation is complete. This designation allows us to begin in a less formal manner that has been shown to expedite the resolution process. Your signature on this page confirms that should a concern arise in any aspect of the care provided by this office, staff, and affiliated healthcare professionals, you agree to mediate first before pursuing legal action.

EXPERT WITNESSES

Further, if after mediation, you still wish to pursue a court action relating to your care, your signature on this page confirms that you will use, as your expert witness(es) in your legal action, American Board of Medical Specialties board-certified medical witness(es) in the same specialty as Physician. Furthermore, you agree that the physicians who you select will be in good standing and adhere to all of the rules and guidelines of professional conduct of the American Board of Medical Specialties. As consideration for this agreement, we agree that we will adhere to these same guidelines in selecting our expert witness(es) for any court action relating to your care.

ACKNOWLEDGEMENT

I certify that I have read or had read to me the contents of this form. I understand the possible advantages that compliance with professional healthcare recommendations can provide as well as potential consequences of non-compliance. I attest that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient/Guardian Signature_____ Date_____