Dr. Heather Smith, DNP, APN, NP-C
2249 Broadway, Suite 8
Grand Junction, CO 81507
Phone: (970)424-0722 Fax: (575)205-0393
Email: admin@riversedgepain.com

NEW PATIENT CHECKLIST

Prior to your consultation appointment, please use this checklist as a reference to ensure that all your documentation is ready and already in the hands of your provider. Please **return the following documents** and the attached paperwork via email or through US Mail:

- **Ensure that the New Patient Packet is complete, with all pages signed and required initials included; incomplete packets will not be reviewed**.
  - Copy of Driver's License or Photo ID
  - List of your current medications including any over-the-counter medications or supplements
  - List of any surgeries
  - List of all care providers involved in your care

OTHER INFORMATION:

You will not be scheduled for an appointment until we have received the paperwork back, fully completed, with all of the documents listed above.

APPOINTMENT TIMING:

Most of our appointments will be completed in person, but if needed we do have the ability to provide visits via telehealth or telephone. If a video telehealth is scheduled, prior to your appointment, you will receive an emailed or texted link for the appointment. Your "Consent for Treatment" paperwork will have information specific to telehealth visits that you should make certain you review.

We want to provide our patients with treatment in a timely fashion. Please plan on checking into your in-person OR virtual waiting room at least 10 minutes before your scheduled appointment time, as there may be additional details that must be gathered or paperwork to be completed. Failure to arrive at least 10 minutes prior to your appointment time may result in rescheduling your appointment. Please complete AND RETURN all forms prior and we will contact you to set up your initial consultation appointment.

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NEW PATIENT INTAKE

Legal Name _____
(Last Name) (First Name) (Middle Name)

Nickname _____ Previous/Maiden Name _____

Sex/Gender: ☐ M ☐ F ☐ Other Social Security Number _____ Date of Birth _____

Race _____ Ethnic Group ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Address _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

_____

City _____ State _____ Zip Code _____

Home Phone _____ Ok to leave message? Yes ☐ No ☐

Alternate phone _____ Ok to leave message? Yes ☐ No ☐

Email Address _____ Ok to leave message? Yes ☐ No ☐

Marital Status _____

Preferred Language _____ If not English speaking, family interpreter? Yes ☐ No ☐

Religion _____ Do you have an Advanced Directive? Yes ☐ No ☐

EMERGENCY CONTACT

Emergency Contact _____ Relationship _____

Phone _____ Alternate Phone/Alternate Contact method _____

EMPLOYMENT INFORMATION

Employer _____

Address _____ Phone number _____

PHYSICIANS

Primary Care Physician _____

Referring Physician (if different)

_____

Preferred Pharmacy _____ Phone _____

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NEW PATIENT FORM

PLEASE COMPLETE THE FOLLOWING PATIENT INFORMATION:

RATE YOUR PAIN ON A SCALE OF 0-10 WITH 10 AS THE WORST PAIN YOU HAVE EVER EXPERIENCED:

Present pain is rated ___ /10 Worst pain is rated ___ /10 Best pain is rated as ___ /10 Acceptable level of pain is ___ /10

What is the primary reason for your initial visit? _____

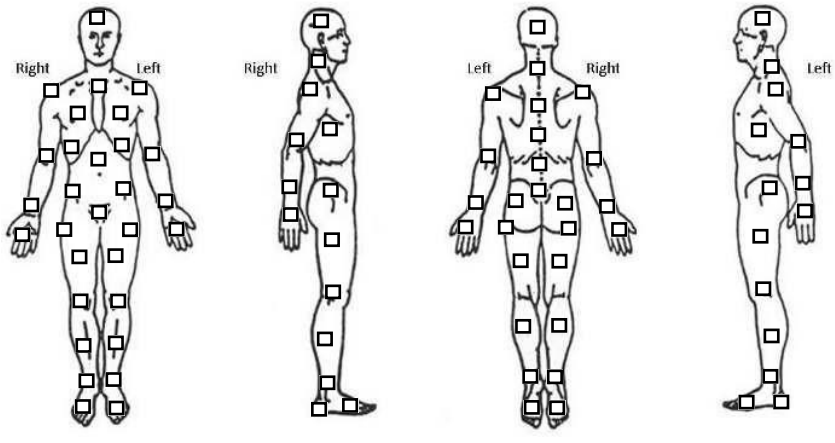
List any other providers involved in your PAIN MANAGEMENT: _____

MY PAIN:

My pain starts:

- ☐ Suddenly
- ☐ Constantly present
- ☐ at any time
- ☐ with certain motions
- ☐ frequently
- ☐ sneaks up on me
- ☐ in certain positions
- ☐ at certain times
- ☐ when resting
- ☐ when sitting
- ☐ when standing
- ☐ occasionally

LOCATION – Please mark location of pain on the drawing below



The pain is:

- ☐ short in duration
- ☐ constant
- ☐ location specific
- ☐ always strong
- ☐ long lasting
- ☐ grows in intensity
- ☐ radiation
- ☐ varying

The pain feels:

☐ sharp ☐ dull ☐ burning ☐ aching
☐ stabbing ☐ throbbing ☐ pins/needles ☐ tingling

List activities limited by your pain _____
Please list previous medical tests or treatments for your pain?

_____

Have you had any previous medical treatments FOR YOUR PAIN SPECIFICALLY? ☐ YES ☐ NO

Do you have a pacemaker? ☐ Yes ☐ No

TEST	WHERE	WHEN	TREATMENTS	WHERE	WHEN	HELPFUL?
X-RAY			Spine Injections			❒ Yes ❒ No
MRI			Physical Therapy			❒ Yes ❒ No
CT SCAN			Chiropractor			❒ Yes ❒ No
EMG			Back brace			❒ Yes ❒ No
BONE DENSITY			Massage			❒ Yes ❒ No
OTHER						❒ Yes ❒ No

Medication allergies:

Are you taking any blood thinners such as coumadin, Plavix or aspirin? ❒ Yes ❒No
Are you allergic to contrast dye, iodine, shellfish or latex? ❒ Yes ❒ No
List and indicate type of reaction: _____

List Medications (if more room is needed, please attach separate sheet):

Name	Dosage / Frequency

Previous Surgery:

Type of Surgery	Year	Reason

General Medical:

Heart problems ❒ Yes ❒ No Explain:	High blood pressure ❒ Yes ❒ No Explain:
Lung problems ❒ Yes ❒ No Explain:	Cancer ❒ Yes ❒ No Explain:
Liver disease ❒ Yes ❒ No Explain:	Ulcers ❒ Yes ❒ No Explain:
Kidney problems ❒ Yes ❒ No Explain:	Diabetes ❒ Yes ❒ No Explain:
Any disease of the nerves or muscles ❒ Yes ❒ No Explain:	Stroke ❒ Yes ❒ No Explain:
Drug or alcohol problems ❒ Yes ❒ No Explain:	Any previous fractures? ❒ Yes ❒ No Describe:
Psychiatric treatment ❒ Yes ❒ No Explain:	Any other serious injuries? ❒ Yes ❒ No Explain:
Other:	

Social History: Please check or complete as appropriate

Tobacco products _____ Smoking ☐ Y ☐ N How many packs a day _____ years used ____

Alcoholic beverages a day _____ Caffeinated beverages a day _____ Recreational drugs _____

Marital: ☐ Single ☐ Married ☐ Previous ☐ Divorced ☐ Widow/er

Children - number and ages _____

Highest level of education achieved _____ Occupation _____

Current/last employment _____ Amount of time at current/last job _____

Family History: Please list any known conditions affecting your biologic parents and relatives

Mother: Alive ❒ Yes ❒ No Age _____ Condition _____

Father: Alive ❒ Yes ❒ No Age _____ Condition _____

Other family conditions _____

Family history is UNKNOWN ☐ YES ☐ NO

General:

How did you find out about us? ☐ Internet ☐ Friend ☐ Family ☐ Newspaper ☐ Other _____

CONSENT

I hereby consent to have River's Edge Pain Specialists, PLLC, acquire medical and imaging records from previous provider(s) and via QHN as needed.

* By typing my name below I hereby consent to digital signature and I understand and acknowledge that electronic signature is the legal equivalent of a handwritten signature and is as valid.

Patient's Signature: _____ Date: _____

INSTRUCTIONS FOR PATIENTS TAKING ASPIRIN / BLOOD THINNING MEDICATIONS

Anticoagulants, anti-platelet drugs, or blood thinners may need to be discontinued prior to some procedures to minimize your risk of bleeding.

If it is necessary for you to hold or stop your blood thinner prior to a procedure, our office must consult with your cardiologist, primary care physician, or prescribing physician regarding temporary discontinuation of these medications. We will obtain approval and clearance for you to stop these if needed. You may restart your medications the following day (24 hours) after the procedure, unless otherwise indicated.

The following medications place you at risk for bleeding and therefore, must be discussed at each visit:

- Aspirin or aspirin containing products to include but not limited to: Ecotrin, baby aspirin, Anacin, Alka-Seltzer, Pepto-Bismol, Excedrin.
- NSAIDs: Advil, Motrin, Ibuprofen, Aleve, Celebrex (celecoxib), Mobic (meloxicam), Voltaren (diclofenac), Naproxen, Anaprox
- Coumadin (warfarin)
- Plavix (clopidogrel)
- Lovenox (enoxaparin)
- Vitamin E products
- Supplements: fish oil, garlic, Vitamin A, ginger, white willow bark, saw palmetto, ginko biloba
- Eliquis (apixaban)
- Fragmin
- Xarelto / rivaroxaban
- Pradaxa / dabigatran
- Reopro
- Aggrastat
- Integrilin
- Avastin
- Aggrenox (aspirin / dipyridamole)
- Persantine (dipyridamole)
- Arixtra (fondaparinux)
- Orgaran (danaproid)
- Heparin

ACKNOWLEDGEMENT

I understand that failure to discuss these medications prior to my appointment date could result in cancellation and/or rescheduling of my appointment

* By typing my name below I hereby consent to digital signature and I understand and acknowledge that electronic signature is the legal equivalent of a handwritten signature and is as valid.

Patient's Signature

Date

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REVIEW OF SYSTEMS

Constitutional please check all that apply

☐ Reviewed All Elements ☐ No Symptom

☐ Anorexia ☐ Chills ☐ Fatigue

☐ Fevers ☐ Malaise ☐ Sweats

☐ Weight Loss ☐ Weight Gain ☐ Other

Constitutional Note

ENMT please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Ear Pain or Discharge ☐ Decreased Hearing ☐ Nosebleeds

☐ Hoarseness ☐ Dysphagia ☐ Tinnitus

☐ Nasal Obstruction or Discharge

☐ Sore Throat ☐ Sinus Pains ☐ Other

ENMT Note

EYES please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Blurring ☐ Diplopia ☐ Discharge ☐ Eye Pain

☐ Irritation ☐ Photophobia ☐ Vision Loss

☐ Floaters ☐ Other

Eyes Note

RESPIRATORY please check all that apply

☐ Reviewed All Elements ☐ No Symptoms at this time

☐ Cough ☐ Dyspnea ☐ Excessive Sputum

☐ Hemoptysis ☐ Wheezing ☐ Painful Breathing

☐ Sleep Disorder ☐ Snoring ☐ Other

Respiratory Note

Cardiovascular please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Chest Pains ☐ Palpitations ☐ Syncope

☐ Dyspnea on Exertion ☐ Orthopnea ☐ PND

☐ Peripheral Edema ☐ Tightness Chest ☐ Other

Cardiovascular Note

GI please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Abdominal pain ☐ Constipation ☐ Hematochezia

☐ Jaundice ☐ Melena ☐ Nausea ☐ Vomiting

☐ Change in Bowel Habits ☐ Diarrhea

☐ Fatty Food Intolerance ☐ Heartburn ☐ Hemorrhoids

☐ Indigestion ☐ Loss of Appetite ☐ Blood in Stool

☐ Acid Reflux ☐ Other

GI Note

GENT/Genitourinary please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Decreased libido ☐ Dysuria ☐ Hematuria

☐ Hesitancy ☐ Impotence ☐ Incontinence

☐ Nocturia ☐ Discharge ☐ Genital Sores

☐ Other

GENT/Genitourinary Note

BJE/Musculoskeletal please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Arthritis ☐ Back Pain ☐ Joint Pain

☐ Joint Swelling ☐ Muscle Cramps

☐ Muscle Weakness ☐ Stiffness

☐ Leg Cramps ☐ Other

BJE/Musculoskeletal Note

Skin/Integumentary please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Dryness ☐ Itching ☐ Rash

☐ Suspicious Lesions ☐ Ulcers ☐ Breast Lumps

☐ Breast Pain ☐ Nipple Discharge ☐ Other

Skin/Integumentary Note

Neurological please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Paresthesia's ☐ Seizures ☐ Syncope

☐ Transient paralysis ☐ Tremors ☐ Vertigo

☐ Weakness ☐ Headache ☐ Other

Neurological Note

Psychiatric please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Anxiety ☐ Depression ☐ Hallucinations

☐ Memory loss ☐ Mental disturbance

☐ Paranoia ☐ Suicidal ideation

☐ Panic Attacks ☐ Other

Psychiatric Note

Endocrine please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Cold Intolerance ☐ Heat Intolerance ☐ Polydipsia

☐ Polyphagia ☐ Polyuria ☐ Weight Change

☐ Abnormal Sweat ☐ Excessive Hair ☐ Other

Endocrine Note

Hematologic/Lymphatic please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Abnormal Bruising ☐ Bleeding

☐ Enlarged Lymph Nodes ☐ Anemia

☐ Bleeding Gums ☐ Lethargy ☐ Nausea

☐ Vomiting ☐ Other

Hematologic/Lymphatic Note

Allergic/Immunologic please check all that apply

☐ Reviewed All Elements ☐ No Symptoms

☐ Hay Fever ☐ HIV Exposure

☐ Persistent Infections ☐ Urticaria

☐ Postnasal Drip ☐ Stuffy Nose ☐ Unusual Fatigue

☐ Frequent Colds ☐ Other

Allergic/Immunologic Note

☐ Constitutional, Gastrointestinal, Neurological, Musculoskeletal, Cardiovascular, Respiratory review of systems performed and all Negative

☐ All Negative: General, Respiratory, Neurological, Gastrointestinal, Genitourinary, Endocrinological and Immunological symptoms reviewed, and all found to be negative at this time.

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management.

Use only one column – choose the gender column that most closely matches your gender

Mark each box that applies	Female	Male
Family history of substance abuse	Yes- No	Answers
Alcohol 1-3		
Illegal drugs 2-3		
Rx drugs 4-4		
Personal history of substance abuse	Yes- No	Answers
Alcohol 3-3		
Illegal drugs 4-4		
Rx drugs 5-5		
Age between 16—45 years 1-1		
History of preadolescent sexual abuse 3-0		
Psychological disease	Yes- No	Answers
ADD, OCD, bipolar, schizophrenia 2-2		
Depression 1-1		
Scoring		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction,

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6): 432

Summary

This document presents scoring information for psychological disorders such as ADD, OCD, bipolar disorder, schizophrenia, and depression, as part of a questionnaire designed to assess the risk of opioid addiction. The assessment tool referenced was developed by Dr. Lynn R. Webster and is preliminarily validated as described in a 2005 Pain Medicine publication.

Dr. Heather Smith, DNP, APN, NP-C
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Summary

This document outlines the responsibilities and consent required of patients receiving care from River's Edge Pain Specialists (REPS), including safe medication storage, timely updates of contact and payment information, adherence to treatment plans determined by the medical provider, and refraining from unsafe behaviors during interactions. Patients must fully understand and agree to these terms, and acknowledge that payment for medical services is due at the time of service. The agreement also emphasizes that treatment decisions and referrals are at the provider's discretion

CONSENT FOR TREATMENT

River's Edge Pain Specialists, PLLC, (hereafter referred to as REPS or REPS, PLLC) is committed to providing the highest quality healthcare services. These terms govern your use of the REPS services and are required to receive services from REPS. Please read the Terms of Services carefully before using REPS, PLLC services.

Please refer to our Notice of Privacy Practices to learn how REPS collects, uses, shares and protects your Protected Health Information (as defined under the Health Insurance Portability and Accountability Act of 1996 or "HIPAA").

Revisions We may modify these terms from time to time. We will notify you of material changes by posting the amended terms on the website (if applicable). If we have your email on file, we will also notify you of material changes by email. Please make sure we have your current email address so that you will receive notice of any material changes. If you do not agree with the revised changes, you should discontinue your use of the services before the effective date of the change. If you continue using the services after the effective date, you will be bound by the updated terms.

General Consent for Treatment You have the right, as a patient, to be informed about your condition and the recommended medical or

diagnostic procedure(s) to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

These terms affirm your permission to perform reasonable and necessary medical examinations, testing and treatment. You agree that that these terms are continuing in nature even after a specific diagnosis has been made and treatment recommended, and that you consent to treatment at this office or any other satellite office under common ownership, you consent to the use of information obtained over the course of your care for quality improvement and research purposes. These terms will remain fully effective until it is revoked by you in writing.

You have the right at any time to discontinue services and/or decline any and all treatments, even if against medical advice. You have the right to discuss the treatment plan with your medical provider regarding the purpose, potential risks, and benefits of any test, procedure, or treatment ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, you have the right and we encourage you to ask questions.

You hereby voluntarily request a physician, or advanced practice clinician (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or their designees, as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which brought you to seek care at this practice. You understand that if additional testing, or invasive or interventional procedures are recommended which are outside the scope of this general consent to treatment, you will be asked to read and agree to additional consent forms prior to the test(s) or procedure(s).

Our providers are an addition to, and not a replacement for, your local primary care provider. Responsibility for your overall medical care should remain with your local primary care provider, if you have one, and we strongly encourage you to locate and establish care with one if you do not.

Informed Consent for Telehealth Services

Telehealth involves the use of secure electronic communication, information technology, or other means to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering clinical care.

Telehealth may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate. Some clinical needs may not be appropriate for a telehealth visit, and your provider will make that determination.

Your provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law and will establish a provider-patient relationship in accordance with the laws and rules in the applicable state. Your provider may only provide services to you while you are physically located in a state where your provider is licensed and authorized to practice. It is your responsibility to inform your provider anytime you require services in a different state.

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

Completion, exchange, and review of medical intake forms and other clinically relevant information (for example: health records; images; output data from medical devices; sound and video files; diagnostic and/or lab test results) between you and your provider via: asynchronous communications, two-way interactive audio in combination with store-and-forward communications; and/or two-way interactive audio and video interaction.

Treatment recommendations by your provider based upon such review and exchange of clinical information; Delivery of a consultation report with a diagnosis, treatment and/or prescription recommendations, as deemed clinically relevant; Prescription refill reminders (if applicable); and/or
Other electronic transmissions for the purpose of rendering clinical care to you.

Emergencies:
Our providers do not address medical emergencies. Please do NOT use the services, including telehealth, for emergency or urgent medical matters. For all urgent or emergency matters that you believe may immediately affect your health, you should immediately call 911 or go to the nearest emergency room or urgent care facility.

Security Measures:
The electronic communication systems we use incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Possible Risks:
Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability. In the event of an inability to communicate as a result of a technological or equipment failure, please contact the REPS, PLLC at (970)424-0722 or at **admin@riversedgepainspecialists.com**

In uncommon circumstances, your provider may determine that the transmitted information is of inadequate quality, thus necessitating a re-scheduled telehealth consult or an in-person meeting with your provider or with your primary care provider, depending on circumstances.

In very rare circumstances, security protocols could fail, causing a breach of personal medical information.

Informed Consent for Quality Improvement and Research

REPS, PLLC seeks to provide the best possible quality of clinical services, and use of health information for quality improvement and research activities is a crucial part of continuous practice improvement. You hereby consent for your health and general information, including lab results, to be used by River's Edge Pain Specialists, PLLC, for quality improvement and research purposes.

Consent to Use of Genetic Information

REPS provides point of care drug screening tests as a convenience to improve your ability to benefit from treatment. A potential risk of point of care testing is that some patients may provide a test sample that is not their own, and to improve the integrity of testing your provider may periodically order a test to analyze genetic information in the sample to confirm its source.
You hereby consent to use of genetic information in lab samples that you provide for the purpose of confirming that the sample provided is yours.

Patient Acknowledgments:

You further acknowledge and understand the following (please read and initial each item):

_____ 1. You have the right to withhold or withdraw your consent to the use of telehealth in the course of your care at any time, and this will not affect your right to continue to be seen in person or re-enroll in future care or treatment.

_____ 2. There is a risk of technical failures during the telehealth visit beyond the control of REPS. You AGREE TO HOLD HARMLESS REPS AND ITS EMPLOYEES, CONTRACTORS, AGENTS, DIRECTORS, MEMBERS, MANAGERS, SHAREHOLDERS, OFFICERS, REPRESENTATIVES, ASSIGNS, PARENTS, PREDECESSORS, AND SUCCESSORS for delays in evaluation or for information lost due to such technical failures.

_____ 3. In choosing to participate in a telehealth visit, you understand that some parts of the services involving tests (e.g. labs or bloodwork) may be conducted at another location such as a testing facility, at the direction of your provider, and will require you to travel to complete the test(s).

_____ 4. Persons may be present during the telehealth visit other than your provider in order to operate the telehealth technologies, assist the provider in performing their responsibilities, or improve the quality of REPS services. If another person is present during the telehealth visit, you will be informed of the individual's presence and role.

_____ 5. Your provider will explain your diagnosis and its evidentiary basis, and the risks and benefits of various treatment options.

_____ 6. You have the right to request a copy of your medical record. You can request to obtain or send a copy of your medical records to your primary care or other designated health care provider by contacting REPS.

_____ 7. It is necessary to provide a complete, accurate, and current medical history to your provider.

_____ 8. There is no guarantee that you will be issued a prescription, and that the decision of whether a prescription is appropriate will be made in the professional judgement of your provider. If your provider issues a prescription, you have the right to select the pharmacy of your choice.

_____ 9. There is no guarantee that you will be treated by a REPS provider. Your provider reserves the right to deny care for potential misuse of the services or for any other reason if, in the professional judgment of your provider, the provision of the services is not medically or ethically appropriate.

Notice of Privacy Practices Acknowledgement

Our Notice of Privacy Practices will be sent with all other patient paperwork. Please refer directly to that document for questions or concerns regarding how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. By signing this form, you acknowledge that you have reviewed our Notice of Privacy Practices attached. You may obtain a current copy of our Notice by sending us an email at **admin@riversedgepainspecialists.com**

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

You consent to our use and release of protected health information about you for treatment, payment, and health care operations as described in our Notice. You have the right to revoke this consent in writing, and we will honor your revocation except where we have already made releases in reliance on your prior consent.

Notice of Potential Information Loss Due to Technological Failure

Information transmitted through telehealth technology may be lost due to technological failure beyond the control of the REPS which can result in delays in treatment or other adverse consequences. You agree to hold harmless REPS and its employees, contractors, agents, directors, members, managers, shareholders, officers, representatives, assigns, parents, predecessors, and successors for consequences of information loss due to technological failure.

Consent to Receive Protected Health Information via Email and SMS

You consent and state your preference for your provider and other staff and designees of REPS to communicate with you by email or standard SMS messaging regarding various aspects of your medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

You understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. You further understand that, because of this, there is a risk that email and standard SMS messaging regarding your medical care might be intercepted and read by a third party.

Payment for Services

You hereby agree to one of the self-payment plans with River's Edge Pain Specialists, PLLC. You agree and understand that you will be billed on a monthly basis even if you are not seen during that month as it is a concierge-type membership fee. You agree and understand that you are responsible for payment in full of any amount due at the time of service or you may not be seen by the provider.
You authorize REPS to charge your chosen payment method (your "Payment Method") for the medical services provided to you. If your Payment Method is invalid at the time payment is due, you agree to pay all amounts due upon demand. The third-party services provider who manages your Payment Method may impose terms and conditions on you, which are independent of these terms, and you agree to comply with all of those terms.

REPS may accumulate charges that you've incurred for the services and submit them to you at the end of each billing cycle. REPS reserves the right to correct any billing errors, charge errors, or mistakes even if payment has already been requested or received.

In the event of failure to pay for the services rendered, you understand that you may be discharged from the services by REPS until such time as your account is paid in full. Additionally, you understand that you may be referred to a collections agency for non-payment of costs and fees due for the services rendered by REPS.

Rates are subject to change. Your subscription to the services is continuous and will be automatically renewed at the end of the applicable subscription period, unless you cancel your subscription before the end of the then-current subscription period. You may cancel your subscription any time.

Treatment Agreement (please carefully read and initial each item):

_____ 1. You agree to be civil and never to intimidate, threaten, or verbally abuse REPS staff.

_____ 2. You agree never to sell, share or give any of your medication to another person.

_____ 3. You agree to take any prescribed medication exactly as directed and to notify your provider if directions are unclear or you are unable to follow them for any reason.

_____ 4. You agree to notify your provider anytime a new medication is prescribed by another medical provider.

_____ 5. You agree to provide complete and accurate answers to your REPS provider.

_____ 6. You agree to provide your own sample of urine or saliva for drug testing promptly when directed.

_____ 7. You agree not to fill any prescription for an opioid medication unless it is prescribed or specifically authorized by your REPS provider, except in a medical emergency.

_____ 8. You agree to provide at least 24 hours' notice to reschedule an appointment, and you understand that medication refills will only be provided during scheduled appointments. You understand that your

REPS provider is only licensed in certain states and can provide no service to you while you are located outside of their states of licensure.

_____ 9. You agree to notify REPS in advance when you are going to be unavailable to complete a random drug screen or medication count.

_____ 10. You agree to complete a medication count promptly within 24 hours when directed.

_____ 11. You agree to store your medication in a safe, secure place where it's not accessible to others and especially not accessible to children.

_____ 12. You agree to provide prompt notice to REPS of any change in your contact or payment information.

_____ 13. You agree to read all materials and ask any questions needed to help you understand them before signing anything.

_____ 14. You agree never to operate a motor vehicle while speaking or texting with any REPS staff member, and not to openly display or use an illegal substance during your interactions with staff or providers.

_____ 15. You understand that your treatment plan is determined by your medical provider and will be modified based on your changing situation and needs. Your provider will develop the treatment plan collaboratively with you and will respect your preferences and decisions to every extent possible. Situations may occur when your preferred treatment is no longer medically safe. Failure to abide by this treatment agreement may lead your provider to determine that your current treatment regimen is no longer safe and to refer to a different treatment setting.

_____ 16. You understand that REPS provides medical assessment, treatment, and needed support for that treatment which may include referral when needed. The appropriate treatment is always at the discretion of your provider.

You certify that you have carefully read, understand, and agree to the terms above, and you consent fully and voluntarily to this agreement. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

* By typing my name below I hereby consent to digital signature and I understand and acknowledge that electronic signature is the legal equivalent of a handwritten signature and is as valid.

_____ _____

Client Signature Date

. Dr. Heather Smith, DNP, APN, NP-C

2249 Broadway, Suite 8
Grand Junction, CO 81507

Phone: (970)424-0722 Fax: (575)205-0393

Email: admin@riversedgepain.com

Summary

This document outlines a Financial Responsibility Agreement stating that the client is responsible for monthly fees and additional charges, including a $30 late cancellation or no-show fee, with all payments processed automatically. It clarifies that the agreement does not constitute health insurance, nor does it cover specialty care or external medical services. The Advance Beneficiary Notice warns that the patient may be liable for costs of pain management services not covered by their insurance, even if deemed medically necessary.

FINANCIAL RESPONSIBILITY AGREEMENT

*** Payment is required at the time medical service is rendered ***

For the purposes of this Financial Responsibility Agreement (this "Agreement"), River's Edge Pain Specialists, PLLC, is hereby referred to as REPS or REPS, PLLC.

REPS, PLLC, is committed to providing the best quality medical services. REPS provides comprehensive pain management diagnosis, medical assessment for prescribing medication management, and additional services (collectively, the "Services"). This Agreement outlines your financial responsibility in relation to receipt of the Services from REPS, PLLC.

Payment Options and Fee Schedule

At this time, REPS is not accepting insurance plans and does not offer insurance billing for services rendered. We operate under a concierge-type subscription service for medical care. At this time, REPS offers two subscription plan options:

Basic package *- Unlimited monthly in-person/telephone visits with medication management (if applicable) and referrals for outside care.*

Enhanced package *– Unlimited monthly in-person/telephone visits with medication management (if applicable), referrals for outside care, and in-office procedures: (medications/supplies used for procedures will be charged to the patient separately – costs will be disclosed to the patient prior to the procedure taking place).*

You understand that a hold in the amount $30.00 will be placed on your credit card for scheduling your first appointment with REPS. This hold will be released after you arrive at your first appointment.

Lastly, by signing the acknowledgment below, you consent to the use and disclosure of protected health information as regulated by HIPAA and authorize the release of any information needed for the purposes of treatment, payment and health care operations, including, but not limited to the processing of payment for the Services you receive. with their costs.

Fee Schedule – Please Select One of the following sign only one)

* By typing my name on either line below I hereby consent to digital signature and I understand and acknowledge that electronic signature is the legal equivalent of a handwritten signature and is as valid.

Option A: Basic package - $120 monthly starting on the day of the initial appointment. Includes unlimited monthly in-person/telephone visits with medication management (if applicable), referrals for outside care, an initial assessment of your full medical history, mental health history and substance use history, performance of a physical exam, diagnosis and creation of a care plan. Your card will be automatically charged every 28-31 days, starting the day of your initial appointment.

$120.00sign only one _____ _____

Client Signature Date

Option B: Enhanced package – $220 monthly starting on the day of the initial appointment. Includes unlimited monthly in-person/telephone visits with medication management (if applicable), referrals for outside care, in-office procedures, (medications/supplies used for procedures will be charged to the patient separately – costs will be disclosed to the patient prior to the procedure taking place), an initial assessment of your full medical history, mental health history and substance use history, performance of a physical exam, diagnosis and creation of a care plan. Your card will be automatically charged every 28-31 days, starting the day of your initial appointment.

$220.00sign only one _____ _____

Client Signature Date

By initialing below, you understand and acknowledge that (read and initial each item):

_____ 1. You are electing to purchase the Services which may or may not be covered by your medical insurance if you obtained similar services from a different provider.

_____ 2. You understand that we do not accept insurance or bill insurance on your behalf and are electing not to use a medical insurance policy benefit.

_____ 3. You have been given a choice of the Services provided by REPS, along with their costs.

_____ 4. You have selected the Services and you are willing to accept full financial responsibility for payment of the Services.

_____ 5. Should you choose to submit a claim to your insurance company on your own behalf for the charges incurred for the Services provided by REPS, you understand and agree that whether or not your insurance company provides any reimbursement does not affect your continued subscription with REPS or alter any amount due to REPS directly from you.

Additional Fees and Charges

Urine Drug Screening: You will be required to provide a specimen for a point of care urine drug screening every 3 months and if selected for a random screening or screening upon suspicion. You agree to present to the clinic within 24 hours of being notified of a random or suspicion screening. You will be responsible to pay $35 for each point of care urine drug screening and the charges are due prior to providing the sample. If results are not as expected or your specific prescriptions are not testable on a point of care basis, your sample may be sent to a laboratory for confirmation of the results. You may provide your insurance information to the laboratory and they may bill your insurance as a courtesy if they are able.

Saliva Testing: You may receive a saliva drug test based on your provider's discretion for a variety of reasons. You will be responsible to pay $30 per saliva test and charges are due prior to providing the saliva sample.

For patients purchasing the Enhanced Package, you may incur additional charges for medications or supplies required for procedures. You will be informed the total cost of those items prior to the procedure taking place.

✓ By signing the acknowledgement, you have read and agree to the payment options outlined in Additional Fees and Charges.

* By typing my name below I hereby consent to digital signature and I understand and acknowledge that electronic signature is the legal equivalent of a handwritten signature and is as valid.

_____ _____

Client Signature Date

MISCELLANEOUS PAYMENT TERMS AND CONDITIONS

CONSENT FOR RECURRING CREDIT OR DEBIT CARD PAYMENTS

By signing below, you have read and agree to the payment and subscription terms set forth in REPS terms of treatment. You acknowledge that you will be charged the rate above monthly as part of your subscription to REPS services. Such rates are subject to change. Your subscription to the Services is continuous and will be automatically renewed at the end of the applicable subscription period, unless you cancel your subscription before the end of the then-current subscription period. You may cancel your subscription any time.

PATIENT DISCHARGE/ COLLECTIONS FEES

In the event of failure to pay for the Services rendered, you understand that you may be discharged from the Services by REPS until such time as your account is paid in full. Additionally, you understand that you may be referred to a collections agency for non-payment of costs and fees due for the Services rendered by REPS. You understand that you will be responsible for a 30% collection fee, all agency and attorney fees and costs associated with the collection process (such as court costs), and that these fees and costs will be added to your account balance. Should REPS at any time be utilizing a contracted billing and/or collection service, you will be responsible for whatever collection fees and costs associated with your collectible account in accordance with their policies and the laws of the State of Colorado. You understand and agree that that you will be responsible for paying the entire amount of your account balance due in addition to the collection fee.

RETURNED CHECK FEE

You understand that in the event that your check is returned for insufficient funds, you agree to provide cash, money order or certified check for the full amount of the payment owed, in addition to a $50.00 returned check charge. Should REPS at any time be utilizing a contracted billing and/or collection service, you will be responsible for whatever collection fees and costs associated with your collectible account in accordance with their policies and the laws of the State of Colorado.

RE-APPLICATION FEE

You understand that should you allow your membership subscription to lapse for any reason, you may re-apply with the clinic, but a $99 re-registration fee will be charged.

CANCELLATION POLICY

REPS requires 24 hours notice to cancel an existing appointment, whether in-person or via telehealth or telephone. If 24 hours notice is not provided to REPS, it will be considered a "no show".

NO SHOW AND LATE CANCELLATION POLICY

You understand that you will be assessed a $30.00 fee if you miss an appointment without having provided a 24-hour advance notice of cancellation. You further understand that if you show up more than 5 minutes late to a 15 minute appointment or 10 minutes late to a 30 minute appointment, you will be considered absent and will be assessed a $30.00 fee for missing your appointment.

CREDIT CARD AUTHORIZATION AND DECLINED CARD FEES

You authorize REPS to charge your saved "Card on File" until the card expires. If your card is declined, a $25 reprocessing fee applies. Checks are not accepted for monthly membership payments.

AUTHORIZATION

On behalf of myself, I understand and agree to the following (read and initial all items indicating your acceptance):

_____ 1. I will be charged a monthly fee in the amount agreed upon in the Fee Schedule section above for Pain Management Services as described at REPS.

_____ 2. If I elect to prepay annually, I will receive a one-month discount per year.

_____ 3. I may cancel at any time, but no refunds will be issued for paid fees.

_____ 4. If my membership lapses I may re-apply at any time subject to a $120.00 re-registration fee; acceptance will be dependent upon availability of clinic space.

_____ 5. I will pay a $25 fee for declined credit or debit card transactions.

_____ 6. A $50 fee will be applied for any unpaid or returned check. Acceptance of checks for payment of past due amounts is determined on a case-by-case basis.

_____ 7. I will pay a $30 fee for late cancellation or no show of any appointment.

_____ 8. Any fees in addition to the specific fees described in the Financial Responsibility Agreement will be discussed with me in advanced and automatically charged to my account's credit/debit card at the time such items or services are provided to me.

_____ 9. My participation is continuous and by signing below I authorize recurring credit/debit card charges.

_____ 10. My participation is voluntary and subject to the terms and conditions of membership detailed in the Consent for Treatment, Financial Responsibility Agreement, and Controlled Substance Agreement (if applicable).

_____ 11. I understand this agreement does not include comprehensive health insurance coverage nor is it a contract of insurance.

_____ 12. I understand other specialty care, hospitalizations, surgery, third-party medical treatment and other medical products and services not specifically provided by REPS are my sole responsibility and are not included or paid for by REPS.

****

I, THE UNDERSIGNED HAVE READ AND UNDERSTAND THIS FINANCIAL RESPONSIBILITY AGREEMENT. I HEREBY ACKNOWLEDGE THAT I AM FULLY RESPONSIBLE FOR MONTHLY FEES WITH SELF-PAYMENT OF SERVICES.

* By typing my name below I hereby consent to digital signature and I understand and acknowledge that electronic signature is the legal equivalent of a handwritten signature and is as valid.

_____ _____

Client Signature Date

Dr. Heather Smith, DNP, APN, NP-C
2249 Broadway, Suite 8
Grand Junction, CO 81507
Phone: (970)424-0722 Fax: (575)205-0393
Email: admin@riversedgepain.com

A. Notifier: Dr. Heather Smith, DNP, APN, NP-C

B. Patient Name: _____ **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If your insurance doesn't pay for **D. Pain Management Services** below, you may have to pay. Your insurance company may not offer coverage for the following services even though your health care provider advises these services are medically necessary and justified for your diagnoses.

We expect your insurance may not pay for the **D. Pain Management Services** below.

D. Pain Management Services	E. Reason Insurance May Not Pay:	F: Estimated Cost
Pain management services including medication management, joint injection, trigger point injections, Botox for chronic migraine, or other pain management services	River's Edge Pain Specialists operates as a Direct Patient Care clinic, a membership model of medical care on a monthly fee-based plan. They do not bill or accept insurance.	Monthly membership ranges from $120 per month to $220 per month depending on the chosen plan. Procedures may have additional costs for supplies and medications associated that the patient may also be responsible for. The patient will be notified of these charges prior to the procedure.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Pain Management Services** as above.
  Note: If you choose Option 1,we will not assist with billing or appealing for reimbursement from your insurance company, as we operate as a Direct Patient Care clinic utilizing membership based monthly billing and do not code visits utilizing CPT coding as required for insurance billing.

F. OPTIONS: Check only one box. We cannot choose for you.

☐ **OPTION 1.** I want the **D. Pain Management Services** listed above. You may ask to be paid now, but I understand I can try to obtain reimbursement from my insurance company on my own without assistance from River's Edge Pain Specialists. I understand that visits are not coded (CPT coding) as required by most or all insurance companies, and I likely will not be reimbursed.

☐ **OPTION 2.** I want the **D. Pain Management Services** listed above, but do not bill my insurance company. You may ask to be paid now as I am responsible for payment.

☐ **OPTION 3.** I don't want the **D. Pain Management Services** listed above. I understand with this choice I am **NOT** responsible for payment.

H. Additional Information – This ABN is in effect until further notice.

This notice gives our opinion, not a denial from your insurance company. If you have other questions on this notice please ask the front desk person, the billing person, or the physician before you sign below.

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature	J. Date

Dr. Heather Smith, DNP, APN, NP-C
2249 Broadway, Suite 8
Grand Junction, CO 81507
Phone: (970)424-0722 Fax: (575)205-0393
Email: admin@riversedgepain.com

Summary
This document outlines client guidelines for visiting the REPS office, including only arriving for scheduled appointments, not arriving excessively early, not leaving items or messages outside the office, and respecting the building's other tenants and policies. It emphasizes confidentiality and personal responsibility for information, as well as compliance with property and privacy rules.

Dear valued patients,

We are asking you please review the details of your responsibilities pertaining to a new policy regarding presence at the office when you do not have an appointment. We request that you please review the details and initial and sign where indicated. We appreciate you're understanding and cooperation in this matter.

While most of our patients would never behave inappropriately, some people who are in pain can be unpredictable in their behavior and this is a safety concern for all patients and staff. We also have fire department regulations and privacy issues to be considered. Due to these factors, we ask that none of our patients are present at our office if they do not have an appointment.

Thank you,
River's Edge Pain Specialists Staff

Date: _____

(read and initial each item):

_____ I will not show up at the REPS office for any reason unless I have an appointment scheduled or staff has asked me to come in for a specific reason.

_____ I will not arrive more than 15 minutes early for my scheduled appointment.

_____ If I am unable to reach the clinic by phone, I will leave a message on the appropriate line or wait until my next appointment. I will not leave multiple messages.

_____ I will not loiter in the parking area if the clinic is not open.

_____ I will not leave anything outside of the office for staff.

_____ I will not attach or tape anything outside of the office or to the door/window and anything left in this manner will be thrown away, as REPS has no way to verify it was truly from me.

_____ I understand that if I leave my personal information outside of the office, I have put myself at risk for identity theft and that REPS staff is NOT responsible to ensure that information is not seen by others.

_____ I understand that the building REPS operates in is owned by another party and there are a number of other businesses operating in the building as well. I will be respectful of the owner/landlord, their loitering policies, as well as the other businesses and business owners in the building.

_____
Client Signature