UTAH PAIN RELIEF INSTITUTE
PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT'S LAST NAME_____ **FIRST** NAME _____M.I._____

MAIDEN NAME_____**NAME YOU GO BY**_____**MARITAL STATUS (CIRCLE)**

S M D W

Address:_____

STREET CITY STATE ZIP

E-mail: _____ HOME #:(___)_____Cell #: (___)_____

Social Security #____-____-_____ Age:____ Date of birth:___/___/____ Gender: ___M ___F

Employer:_____Occupation: _____ Work #: (___)_____Ext:_____

Emergency Contact_____Emergency Phone #:(____)_____

RESPONSIBLE PARTY INFORMATION

RELATIONSHIP TO PATIENT ☐ **Parent** ☐ **Legal Guardian** ☐ **Other**

LAST NAME_____ **FIRST** NAME _____M.I._____

Address:_____

STREET CITY STATE ZIP

E-mail: _____ HOME #:(___)_____Cell #: (___)_____

Social Security #____-____-_____ Date of birth:___/___/____ Gender: ___M ___F

Employer:_____Occupation: _____ Work #: (___)_____Ext:_____

Primary INSURANCE INFORMATION

Insurance Company:_____ Phone: (____)_____Co-Pay_____

The # is listed on the back of your insurance card.
Effective Date:_____Policy ID# _____ Group # _____

Insured's Name: _____ Phone: (___)_____
LAST FIRST M.I.

Insurance Address:_____ Social Security #_____-____-_____
STREET CITY STATE ZIP

Date of Birth: ____/_____/_____ Relationship to Insured _____

Secondary INSURANCE INFORMATION

Insurance Company:_____ Phone: (____)_____Co-Pay_____

The # is listed on the back of your insurance card.
Effective Date:_____Policy ID# _____ Group # _____

Insured's Name: _____ Phone: (___)_____
LAST FIRST M.I.

Insurance Address:_____ Social Security #_____-____-_____
STREET CITY STATE ZIP

Date of Birth: ____/_____/_____ Relationship to Insured _____

HOW DID YOU HEAR ABOUT US? (circle all that apply)

Friend or Relative: _____ Emergency Room_____

Website/Phone Book/Newspaper/Community event/lecture

Referred by another physician Insurance provider list Direct mail to your home Urgent care_____

Dr. _____ Other_____

Authorized Signature_____ Date_____

Consent to Treatment

Please Initial:

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment. I agree to the capture of a digital picture image of me for medical record identification. _____

Financial Responsibility and Assignment of Benefits

1. To pay the amount charged by the doctor for all professional treatment and services to the undersigned and/or his/her family. Payment to be made to UPRI East, LLC. ..... _____
2. All charges/co-pays are due and payable at the time of service. ..... _____
3. Any balance due 30 days after treatment will be subject to a 2% per month service charge (APR of 24%). ..... _____
4. To pay all collection fees, settlement costs and reasonable attorney fees in the event of referral to any collection agency, arbitration or mediation procedure, or suit. I further agree to pay all costs of collection, including a 50% agency commission. ..... _____
5. Any change of insurance coverage or method of payment for services rendered must be communicated to the UPRI staff 24 hours before your next appointment or you will be processed through as a self-pay patient. If your appointment is on a Monday we need to know by the Thursday before your appointment. _____
6. That in the event of death, this obligation shall be binding on the estate, heirs and successors of the undersigned. ..... _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, 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 among the many health professionals who contribute to my care. ..... _____
A source of information for applying my diagnosis and information to my bill. ..... _____
A means by which a third-party payer can verify that services billed were actually provided. ..... _____
And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. ..... _____
Your records may be released in response to a subpoena, to the practice attorney, and/or the practice insurance carrier in the event of legal proceedings. ..... _____

If you want to restrict the use of your healthcare information, please describe below. Utah Pain Relief Institute reserves the right to refuse to abide by certain restrictions as described above: _____

_____

_____

Medical Records

I understand that if I request my medical records to be copied and picked up or sent to another provider, there will be a $50.00 administrative fee that is my responsibility. _____
My records will be ready within 30 days. .....

Please note: if you were referred to our office by HealthQuest, please understand that Dr. Duy Tran owns HealthQuest and has a financial interest in the Utah Pain Relief Institute.

I certify that I have read this form and understand its contents. I certify that I have received a copy of the document titled "Notice of Health Information Practices" or that I was offered a copy and declined to take it.

_____ _____
(Patient or Other Legally Authorized Person) (Date)

_____ _____
(Witness) (Date)

UPRI ARBITRATION AGREEMENT

Article 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 Definitions

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.

B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.

C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.

D. The term "Patient" or "you" means:
(1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND
(2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
(1) working directly with each other to try and find a solution that resolves the Claim, OR
(2) using non-binding mediation (each of us will bear one-half of the costs); OR
(3) using binding arbitration as described in this Agreement.
You may choose to use any or all of these methods to resolve your Claim.

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.

C. Arbitration – Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.

B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
(1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
(2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.

C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

UPRI ABITRATION AGREEMENT CONTINUED

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue / Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Term / Rescission / Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it

B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this agreement (see Article 4(E)).

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement and I have been verbally encouraged to read it and this Agreement. I have had the right to ask questions, I have been verbally encouraged to ask any questions, and I have had all my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 Receipt of Copy I have received a copy of this document.

Provider

_____	_____
Name of Physician, Group or Clinic	Name of Patient (Print)
By: _____	_____
Signature of Physician or Authorized Agent	Signature of Patient or Patient's Representative (Date)

(06/2011)

U P R I
Utah Pain Relief Institute

32 W. Winchester St. (6400 S) Ste. 200
Phone: (801) 466-7246
Fax: (801) 327-9339

Name:_____

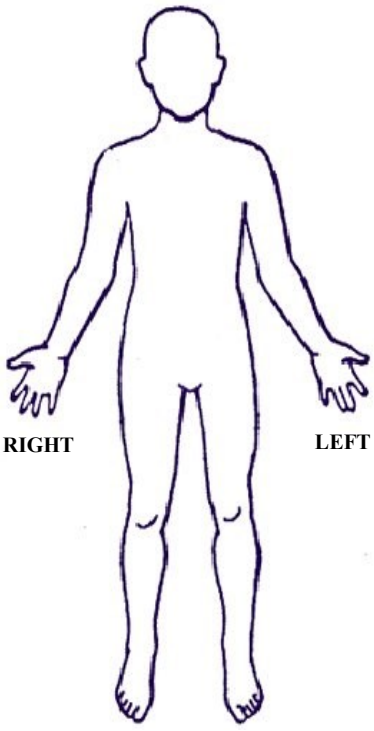
For your appointment, help us understand your problem, please complete ALL QUESTIONS on this form and any of the attached forms.

1. Reason for Visit? _____
2. Which part of your body hurts the most? _____
3. How long have you had this pain? _____
4. What aggravates your pain? _____
5. What relieves your pain? _____
6. Are you or could you be pregnant? ☐ Yes ☐ No

On a scale of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that describes your level of pain right now:

No pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst pain imaginable.

Shade in areas below where you have pain and check *ALL* the words that best describe your pain:



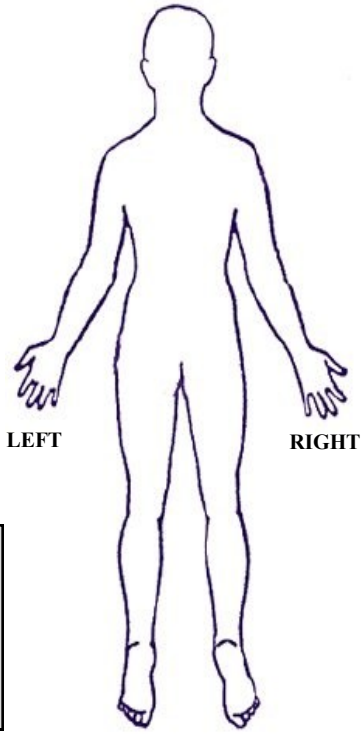
Front

☐ Aching	☐ Stinging
☐ Soreness	☐ Unbearable
☐ Shooting	☐ Burning
☐ Cramping	☐ Stabbing
☐ Tingling	☐ Numbness
☐ Radiating	☐ Excruciating
☐ Hotness	☐ Coldness
☐ Tightness	☐ Heaviness
☐ Dullness	☐ Sharpness
☐ Constant	☐ Brief

This box for in office use only!

Weight:_____ Height:_____ BP____/___

Pulse_____ Temperature_____ 02_____



Back

Pain caused from: Accident– Yes No Illness- Yes No Unknown Cause- Yes No

If accident or illness explain and give dates: _____

_____

_____

_____

Medication Allergies:_____

_____

Other Allergies:_____

_____

Utah Pain Relief Institute

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

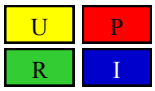
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Name _____

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.



Utah Pain Relief Institute

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **February 16, 2010.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (801) 285-7052.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____
Print patient's name

_____
Patient Signature

2nd party authorization clearance:

I _____ give permission to Utah Pain Relief Institute, LLC to discuss my Medical records and case with

_____ who is _____.

_____
Patient Signature

UTAH PAIN RELIEF INSTITUTE
Your Pain Solution Center

LATE ARRIVAL & MISSED APPOINTMENT POLICY

To insure patient flow and thereby minimize the waiting, UPRI has implementing these two policies:

LATE ARRIVAL: Patients are requested to arrive **30** minutes early for their first appointment with all of their intake paperwork completed. If this is not done, you will be rescheduled. **10** minutes early for all appointments after that. If you are less than **5** minutes early for your appointment you will not be seen but be rescheduled for a different time or date, whichever is available first. There will be no exceptions. This is to maintain a low wait time for all patients.

MISSED APPOINTMENT POLICY: UPRI requests patients to notify the office within **24** hours if they are unable to keep their scheduled appointment. If we are not notified in advance, **we will charge a missed appointment fee of $50.00 for standard appointments and $99.00 for injection appointments.** This fee is not billed to the patient's insurance, work comp carrier, or attorney, but is due and payable from the patient directly before their next scheduled appointment. All fees must be paid before continued service will be granted.

Most doctors' offices overbook their schedules to compensate for those patients who do not call to cancel their appointments. As a consequence, overbooked schedules often create wait times of 30 minutes to 90 minutes to see the doctor. We are sure you have been to such offices. Because we will not overbook, we strive to keep wait times to a minimum at this clinic. It is, therefore, important for the office to be aware of openings in the schedule as far in advance as possible. There have been times when we have had to turn someone away only to have the person that was scheduled in that time slot not show up. Please help this office to be able to help as many patients as possible by remembering to notify us, with-in 24 hours of your scheduled appointment, that you will not be able to make it. If you do not remember, you will be charged the appropriate fee.

Please provide a VISA, Master Card, American Express, Discover Card, or Debit Card that will only be used if you fail to notify us that you will not make your appointment. If you do not have any of the above mentioned, you will be required to pay a cash payment before your next appointment to clear your assessed account. Failure to do this will result in the need to reschedule your appointment:

Card Number: _____ Expiration date: _____ Type: _____ (VISA, MC, DISC, AMER EXP)
CVVS # _____ (four or three numbers depending on the card and it is located on the back of the card or on the front of the American Express cards.)
Patient Printed Name:_____ Patient Signature:_____

This signature authorizes UPRI to charge my Card in the case I do not notify them that I will miss my appointment within 24 hours of my scheduled appointment.

I understand and agree to the above,

_____ _____

Patient Signature Date

_____ _____

Phone: 801-466-7246
Fax: 801-327-9339

Utah Pain Relief Institute
32 W. 6400 S. Suite 200
Murray, UT 84107

Gary L. Child, D.O.
Clark Pratt - Facility Director
Jennie Nguyen – Billing Specialist

Authorization to Release
Protected Health Information
(Valid for 1 year following dated signature)

Name of Patient: _____
Address: _____City: _____ State: _____ Zip: _____
Telephone: _____Birth Date: ___/_____/_____ Social Security # _____-_____-_____

Approximate date(s) of hospitalization or treatment: _____

Reason for request (check all that apply):

_____Continuing Medical Care _____Personal _____Vocational Rehab

_____Disability Determination _____Other _____

Information to be released (check all that apply):

_____Consultation Report _____Lab Reports _____Operative Report _____History & Physical

_____Emergency Room Report _____X-Ray Films _____X-Ray Report _____Discharge Summary

_____ Other (specify): _____

I request that the above information be released FROM:

Name: _____ Phone: _____

Address:_____ Fax: _____

Release To:

Utah Pain Relief Institute Murray

32 W. 6400 S. Suite 200
(801) 466-7246
Fax (801) 327-9339

Patient/Guardian Signature: _____ Date: _____

Relationship if patient is a minor: _____

Utah Pain Relief Institute
Your Pain Solution Center

Things We Must Receive Before Your First Appointment

- ☐ Copy of Medical Records from last prescribing physician (last 3 office visit notes, MRI report if there is one, CT report if there is one, X-ray report if there is one.
- ☐ Copy of a medical referral to be seen in our office for evaluation and treatment.
- ☐ List of procedures done and dates when they were done.

Things You Must Bring to Your First Appointment

- ☐ This packet completely filled out and signed. If you have any questions please call the office before your appointment.
- ☐ Current list of all medications prescribed to you.
- ☐ Photo ID (State ID, Drivers License, or Passport)
- ☐ Current Insurance Card
- ☐ If referred to us by another Physician, a copy of the referral with the physician's name and office phone number.

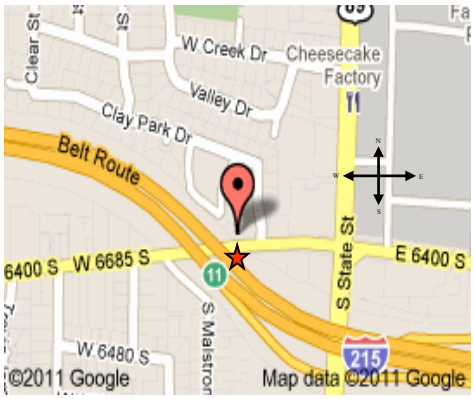
Utah Pain Relief Institute Hours of Operation

Monday: 8:30am - 12:00pm and 2:00pm - 6:00pm
Tuesday, Wednesday and Thursday 8:30am - 12:00pm and 1:00pm - 6:00pm

Friday, Saturday, and Sunday **CLOSED**

Directions to the Utah Pain Relief Institute

32 W. 6400 S. (Winchester St.) Suite 201
Murray, UT 84107
P: 801-466-7246
F: 801-327-9339



The clinic is one block West from State Street on the North corner of Clay Park drive and 6400 S. (Winchester St.). Come inside the building and up to the second floor. Enter into Suite 201.

Please call us if you are lost as it is important that you arrive at your appointed arrival time or else we will have to reschedule your appointment for a different time or day, which ever is sooner. There will be no exceptions.

UTAH PAIN RELIEF INSTITUTE STANDARD OF CARE DISCLOSURE AND AGREEMENT

All Utah Pain Relief Institute patients are given the best care that the medical industry has to offer for chronic pain relief. As a result there are certain diagnostic tests and procedures that you may be required to under go so the medical providers, over your care, can best determine the proper treatment plan for your situation. Below are listed various types of diagnostic tests or procedures that may become part of your individual treatment plan and must be followed to maintain a positive association with the Utah Pain Relief Institute. Please also understand that some of these tests and/or procedures may not be covered by your insurance carrier and you will be responsible to pay for those services at the time of service.

Standard of Care Diagnostic Tests and Procedures

Diagnostic Test or Procedure	**Some services may or may not be covered by your insurance.**
Urine Analysis	Bill Insurance, Some Insurances do not cover this service.
Saliva Drug Screen	Not Covered
Pharmacogenetic Screen	Not Covered
Bone Density Screen	Bill Insurance, Some Insurances do not cover this service.
Electrocardiography (ECG)	Bill Insurance, Some Insurances do not cover this service.
Trigger point injections	Bill Insurance, Some Insurances do not cover this service.
Large Joint injections Without Fluoroscopy	Bill Insurance, Some Insurances do not cover this service.
Large Joint Injection With Fluoroscopy	Bill Insurance, Some Insurances do not cover this service.
Lumbar spinal injection, Caudal Injection, SI Joint Injection, Facet Injection, Medial Branch Block Injection, and Transforaminal Injection.	Bill Insurance, Some Insurances do not cover this service.

When any of these services are requested, at any given time, the patient will be responsible for the payment of the service. If the service is covered by the patient's health insurance, the health insurance will be billed and the patient is only required to pay the appropriate co-pay.
Please sign below acknowledging that you have read this form and agree with the Standard of Care for Diagnostic Testing and/or Procedures of the Utah Pain Relief Institute.

Patient Name:_____ Patient Signature:_____ Date:_____