TREATMENT AUTHORIZATION AND CONSENT FORM

I hereby consent and authorize Kara Diersing Clapp, PhD NP-c, a certified Family Nurse Practitioner, to assess, diagnose, and treat any and all medical conditions I may have as a voluntary client of Basement Lab LLC Telemedicine and House Call Nurse Practitioner Clinic.

I also understand that I may be referred to other professional health care providers and services and hereby consent to any recommended medically necessary referral as a part of my treatment plan. In the event I fail to adhere to my treatment plan or fail to schedule and maintain timely follow up with said referral, I hereby release Basement Lab LLC Nurse Practitioner Clinic from liability related to any further injury, disability or death resulting from my failure to comply with recommended medical referrals.

Timely compliance is defined as 15-30 minutes for any life threatening condition, 1-4 hours for very urgent medical conditions, and 5-12 hours for moderately urgent medical conditions. All referrals of life threatening and imminently life threatening nature will be made to an emergency room nearest the location of the client, I understand I will be advised of the urgency of my condition and the type of recommended referral being made as defined above.

For referrals that are not immediately or imminently life-threatening, all follow up is expected to be completed within 14-30 days of the date the recommended referral was made. Examples of this type of referral may include, but are not limited to: follow up of normal/abnormal test or procedure results by a specialist physician, referral for additional assessment and treatment by a medical specialist physician, medically-complex illnesses and conditions that are beyond the scope of practice of the nurse practitioner in the state of Utah.

I also understand the clinic will use the contact information I provided (which has been recorded in my medical record) to send written communication, verbal phone calls, or email. It is my responsibility as a client to provide updated information in writing to the clinic in event of any changes in my personal contact information. In the event I fail to maintain updated contact information in writing, I release Basement Lab LLC Nurse Practitioner Clinic from any and all liability that results in injury, disability or death as a result of written and verbal communications that fail to reach me at the appropriate address, phone number, or email address.

In the event of any disputes arising from a treatment plan or medical services rendered by the clinic, I agree to contact Kara Diersing Clapp, PhD, NP-c in writing within 14 days and agree to submit the dispute within 30 days to arbitration services for final and binding resolution.

_____ (initial here) I understand I am being treated by a Certified and Licensed Family Nurse Practitioner who has a PhD.

Client Name (Printed) _____ Date _____

Client Signature _____

Client Address: _____

Client Phone: Home _____ Mobile: _____ Preference: Home or Cell

Emergency Contact Name and Phone Number: _____

Original Date: 11/01/06

Dates Revised: 03/01/12

Kara Diersing Clapp, PhD, NP-c
Family Nurse Practitioner
PO Box 901020, Sandy UT 84090
Phone: 801-495-9303

CLIENT AGREEMENT: CONTROLLED SUBSTANCE CLASS II-III

This agreement is strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F **DOB**:

Social Security Number (last 4 digits only):

TERMS AND CONDITIONS OF THIS AGREEMENT:

1. I understand that initial treatment consultation will provide only 3 days of controlled substance before requiring a follow-up visit with Dr. Kara.

2. I understand that subsequent treatment consultation will provide only a 7-day supply of controlled substance before requiring a follow-up visit with Dr. Kara.

3. I understand that only a 30-day total supply of controlled substance may be provided by Dr. Kara as treatment of acute pain. Pain that remains unresolved after 90 days will require a referral to a pain specialist for further evaluation and treatment.

4. I agree to receive controlled substances from Dr. Kara only and will not seek additional controlled substances from other providers, clinics, hospitals, Emergency Room departments.

5. I understand that Dr. Kara may elect to request a DOPL report from the state of Utah without my knowledge or consent to confirm that I have not violated the terms of this agreement.

6. I agree to maintain my follow-up appointments with Dr. Kara as scheduled. In the event I cancel an appointment, I will not expect Dr. Kara to renew my controlled substance prescriptions until she has completed a face to face assessment of my condition and response to treatment.

7. To facilitate provider communications with other treatment plan team members, **I agree to have my controlled substance prescriptions filled only by the following pharmacy**:

Pharmacy Name Address and Phone Number: _____

8. I agree to maintain current and correct contact information with Dr. Kara during the time I am receiving controlled substances from her.

9. I agree to maintain personal custody of and control over my controlled substances to prevent accidental loss or theft. I understand that I cannot ask Dr. Kara to replace them in the event of accidental loss or theft, regardless of the circumstances of the loss or theft.

10. I understand that my privilege to receive controlled substances from Dr. Kara, as a part of my medical treatment plan, will remain intact as long as I maintain the conditions of this agreement. In the event that I do not follow the conditions of this agreement, Dr. Kara has the right to terminate her willingness to provide me with controlled substances as a part of my treatment plan. Violations of this agreement do not terminate my non-pharmaceutical portion of the treatment plan. I understand that Dr. Kara will use my contact information to provide me written notice within 3 business days of the termination of controlled substance portion of my treatment plan. It is my responsibility to notify Dr. Kara of any changes in my contact information.

11. (**Interim Chronic Pain Clients Only**) I am scheduled with _____ on_____
I acknowledge that I may receive controlled substances from Dr. Kara only until the date of the appointment as listed above or until Dr. Kara has confirmed that the Pain Specialist is able to assume responsibility for the treatment plan established by the specialist. Appointment cancellations and reschedules initiated by me will void the contract I have with Dr. Kara. In the event of appointment reschedules initiated by the pain clinic, Dr. Kara will confirm the re-schedule request with the pain clinic in order to validly and potentially extend the length of this interim contract.

SIGNATURES:

Client Signature:

Date:

Provider Signature:

Date:

REVIEW OF SYSTEMS: (patient checklist)

Instructions: Circle all symptoms that have bothered you over the last 3 months.

General: fever, chills, feeling flu-like, fatigue, drastic changes in energy levels, night sweats, unintended weight loss or weight gain in the last 12 months.

Diet: changes in appetite (more hungry/less hungry), diet restrictions, vitamin/herbal supplements

Skin, Hair, Nails: rashes, itching, changes in skin color, changes in nails

Head & Neck: headaches, dizziness, head injuries, loss of consciousness

Eyes: blurring, double vision, visual changes, change in prescription glasses, eye trauma, eye disease

Ears: hearing loss, pain, discharge, ringing in the ears, sensation of the room spinning/ of spinning inside your body

Nose: congestion, nose bleeds, post-nasal drip

Throat & Mouth: hoarseness, sore throat, bleeding gums, ulcers, tooth problems, bad breath, difficulty swallowing, sensation of lump in throat.

Gastrointestinal: indigestion, heartburn, vomiting, bowel changes, changes in regularity

Lymph Nodes: tenderness or enlargement in nodes of neck or groin area

Endocrine: heat or cold intolerance, excessive urination, excessive thirst, hair changes, changes in neck size or appearance, increased shoe size

Chest & Lungs: cough, sputum, shortness of breath, shortness of breath with exertion, chest tightness or pressure, night sweats, exposure to TB or other respiratory illnesses.

Cardiovascular: chest pain, palpitations, number of pillows used to sleep, edema, pain in calf muscle with exercise, inability to exercise due to intolerance or shortness of breath, jaw or arm pain.

Hematology: anemia, easy bruising, blood in stool (bright red or black tarry), coffee ground vomit

Genitourinary: painful urination, flank (mid-back) pain, urine urgency or frequency, excessive night time urination, blood in urine, urine dribbling, unexpected and unintended loss of bladder control or bowel control.

Musculoskeletal: joint pain, heat in joint, redness or swelling, excessive muscle aches

Neurological: fainting, weakness, loss of coordination, seizures, migraine headaches, loss of consciousness

Mental Status: lack of concentration, insomnia, changes in socializing, mood changes, suicidal thoughts or attempts.

Female: Breast: pain, tenderness, discharge, lumps, previous sexually transmitted infections, abnormal Pap Smear results. Menopause. Infertility. Changes in sex drive

Male: changes in erections, testicular pain, discharge from penis, changes in sex drive, infertility. Changes in stream of urine, changes in urination patterns.

Pediatrics (under age 12 yrs): bed wetting or fecal incontinence after toileting trained, inability to sleeping alone, bullying, pica (eating unusual non-food items), unusual fussiness, exercise/play intolerance, excessive hitting/bullying of other children, hyperactivity, other: _____

Name: _____ Date: _____

NEW PATIENT HISTORY: Adult Version (age 18 years and older)

SOCIAL HISTORY

Allergies: □ NONE

□ Foods: _____ □ Environmental Allergies: _____

□ Medication Allergies: _____

Family History: (please put an "x" in the appropriate box)

Arthritis	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Cancer	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Diabetes	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Heart problems	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
High Blood Pressure	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
High Cholesterol	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Stroke	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Thyroid Problems	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Obesity	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Liver problems	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Kidney Problems	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Depression/Anxiety	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle
Blood Disorders	□ Mother □ Father	□ Sibling □ Children	□ Grandparent □ Aunt/Uncle

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Cohabitating

Occupation: □Retired □ Disabled

Who lives with you? □ Home □ Assisted Living □ Nursing Home

Education: □ less than HS level □ HS □ College

Do you use tobacco? □ Never □Quit Date: _____ □ Smoke (_____packs per day) □ Chew

Do you drink alcohol? □ Never □Quit Date: _____ □ rarely □daily □weekly □ special occasions

Are you sexually active? □ yes □ no

Females: Date of Last Menstrual Flow: _____

SURGICAL HISTORY:

Type of Surgery	**Year of Surgery**	**Name of Surgeon**

MEDICAL HISTORY: Have you ever had any of the following? (check ALL THAT APPLY) □ NONE

□ allergies	□ cancer	□ GERD or frequent heartburn	□ osteoporosis
□ anemia	□ cardiac arrest	□ high cholesterol	□ nerve pain
□ arthritis	□ celiac disease	□ hypertension	□ pulmonary embolism or blood clot in legs
□ atrial fibrillation	□ depression	□ hypothyroidism	□ seizures
□ asthma	□ diabetes	□ heart disease	□ shortness of breath
□ bleeding problems	□ drug/alcohol abuse	□ insomnia	□ sinus conditions
□ congestive heart failure	□ enlarged prostate	□ irritable bowel syndrome	□ stroke
□ chest pain	□ erectile dysfunction	□ kidney problems	□ Other:
□ chronic fatigue syndrome	□ frequent or prolonged infections	□ liver problems	
□ coronary artery disease	□ fibromyalgia	□ menopause	
		□ migraines/headaches	

Immunizations: □Out of Date □ Tetanus □ Influenza □ Pneumonia □ Shingles □ Hepatitis

Current Medications You Take (please include herbals supplements and any over-the-counter medications):

Signature and Date: