Northwest Orthopaedic Sports Medicine

875 Swift Blvd
Richland, WA 99352-3592
(509) 946-1654

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#	
ADDRESS OF INSURANCE COMPANY			COPAY AMT $	
CITY, STATE ZIP	PHONE		DEDUCTIBLE $	
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE

I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release information required for this claim.

I consent to the release of medical information from or to other doctors and health care institutions as is necessary to my care and treatment.

SIGNATURE OF PATIENT/GUARDIAN ______________________ DATE ____________

Authorization to Leave Personal Health Information by Alternate Means

Patient Name: ____ Date of Birth: ___________________

(Please check all that apply)

- May leave detailed message on voicemail at home number: (______)___________________
- May leave detailed message on voicemail at work number: (______)___________________
- May leave / release information with Spouse (Name): ____________________________________
- May leave / release information with other (Name): ____________________ (Relation): ______________
- May leave detailed message on cellular phone number: (______)_____________________
- May leave detailed message at a different location phone number: (______)_________________

Please provide an email address: ____

I do have / want to provide an email address ☐

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

____ ____________________

Signature of Patient or Guardian Date

____

Printed Name

Effective: April 14, 2003 (Revised: October 24, 2014)

Race (please mark one)

- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Other
- ☐ Multi-racial
- ☐ Decline

Language (please mark one)

☐ English ☐ Spanish ☐ Other (please list) __________________________

Ethnicity (please mark one)

☐ Hispanic or Latin American ☐ Not Hispanic or Latin American ☐ Declined

Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information.
By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

______________________________ ____________________
Signature of Patient or Guardian Date Time

____
Printed Name

Effective: April 14, 2003 (Revised: September 23, 2013)

Labor & Industry and/or Motor Vehicle Accident Information

DATE OF INJURY:______________________

Did this result from an Auto Accident? ☐**YES** ☐**NO**

Insurance Company ____

Claim# ______________________________________

Did this result from an accident at work? ☐**YES** ☐**NO**

State Industrial #:_________________________

Which medical office did you file your claim at? ____

NORTHWEST ORTHOPAEDIC & SPORTS MEDICINE | PROLIANCE SURGEONS®

Patient Label

Patient Financial Responsibilities

Northwest Orthopaedic & Sports Medicine, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate you choosing Northwest Orthopaedic & Sports Medicine.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Paying your co-payment at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion of the charges on the date of service.

Surgery – If surgery is indicated, a pre-payment of both physician and facility fees is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

Non-Participating Insurance – If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Uninsured Patients

Office Visits – A $250.00 deposit is required prior to the appointment. If visits and services are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office visits may include x-rays, casting and materials at an additional charge. Charges are not finalized until chart notes are complete.

Surgery – For uninsured patients having surgery, we offer a 20% discount when charges are paid before or on the day of service (see exclusions below).

Exclusions – The discounts referenced above do not apply in cases of motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

NORTHWEST ORTHOPAEDIC & SPORTS MEDICINE | PROLIANCE SURGEONS®

Patient Label

Motor Vehicle Accidents (MVA) Insured and Third Party Patients

We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance. If you do not have private insurance, we require a $250.00 deposit at the date of service.

Workers' Compensation

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $250.00 deposit that will be refunded after the claim has been opened.

Other Charges

No Show – Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We may charge a $25.00 fee for missed appointments.

Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled.

Forms – There is a $15.00 charge associated with our completion of some forms; these forms will need 5-7 business days to complete. We require payment before returning the completed form to you. A signed Release of Information may also be necessary.

Payment

Payment Options – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts – We charge a $10.25 monthly account management fee on balances over 45 days old. We may assign an account to collections if balances are unpaid after 60 days. Patients assigned to collections may be denied additional service.

Alternative Payment Arrangements – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Northwest Orthopaedic & Sports Medicine or other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service.

Assignment and Agreement

I have read and understand Proliance Surgeons Financial Policy, and agree to its terms. I hereby assign all medical/surgical benefits to Proliance Surgeons who may bill certain insurance companies as a courtesy to me, and authorize a release of all information necessary to secure the payment of benefits. I understand that I am responsible for the bill for all services rendered to me or my dependents by Proliance Surgeons regardless of whether I have insurance and regardless of how much my insurance might pay. Any copayments, deductibles and non-covered charges that might apply will be paid at the time services are rendered unless other arrangements are specifically made in advance and late fees will be imposed on any balances older than sixty (60) days.

Print Name:______________________________ Signature:_________________________________ Date:___________

NORTHWEST ORTHOPAEDIC & SPORTS MEDICINE

PATIENT H&P FORM

Name:______________________________ __________ **Today's Date:**__________
Last First M.I.

Date of Birth:__________ Social Security #: ____________ Height:______ Weight:______

E-Mail Address: ________________________ Date of last physical exam:__________

Race: ______________ Ethnicity:____________ Language: ____________

Primary Care Provider:________________ Referring Provider:______________

CURRENT or CHIEF PROBLEM

Date of injury or onset: ______________ Location/Body Part:________________

How it affects you?______________________________________

When it affects you, how long does it last?____________________________

Swelling, bruising, etc.,?____________________________________

PAST MEDICAL HISTORY

Do you now or have you ever had: (check ☑ if "yes")

☐Anemia	☐Hernia	☐Skin Disease
☐AIDS/HIV	☐Hepatitis	☐Stroke
☐Asthma	☐High Cholesterol	☐Thyroid Disease
☐Arthritis	☐Multiple Sclerosis	☐Tumor (benign)
☐Bleeding problems	☐Osteoporosis	☐Tumor (malignant)
☐Diabetes	☐Parkinson's Disease	☐Ulcers
☐High Blood Pressure	☐Sexually Transmitted Disease	☐None of the Above
☐Heart Disease	☐Seizure Disorder	☐Other-

PREVIOUS OPERATIONS

☐ Yes ☐ No, please list:

Type	Year	Reason
1.		
2.		
3.		

Have you ever had a blood transfusion? ☐ Yes ☐ No What year? __________

PRESENT MEDICATIONS

☐ Yes ☐ No, please list including aspirin, laxatives, vitamins, herbs, and other supplements:

Drug Name	Dose (mg)	Frequency (times per day)
1.		
2.		
3.		
4.		

Other significant illnesses (please list): ____________________________

Are you pregnant? ☐ Yes ☐ No Any previous fractures? ☐ Yes ☐ No Describe:______________

Have you had a Bone Density Study? ☐ Yes ☐ No If so, date of last scan____/____/____ Where:__________

(Doctor Answer) Recommends a DEXA Scan? ☐ Yes ☐ No

DRUG ALLERGIES

☐ Yes ☐ No, please list:

Drug Name	Reaction (rash, difficulty breathing, etc.)
1.	
2.	
3.	

What is your primary pharmacy? ______________________ City/State __________

This form will be retained in your medical record.

Patient's Name: ____ **Date of Birth:** ______________________

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No ☐ Past—If yes, number/day and years smoked____________ Quit when?____________

Do you drink alcohol? ☐ Yes ☐ No Type and number of drinks/week_______________________________________

Do you use caffeine? ☐ Yes ☐ No Type and number of times consumed/week_______________________________

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No If yes, please list: ___________________________

Do you exercise regularly? ☐ Yes ☐ No Type and amount per week:____

☐ Married ☐ Single ☐ Retired ☐ Living Independently Number of children:______

FAMILY HISTORY

Do you know of any blood relative who has, have had, or died from any of the following (include age) ☑ check ALL that apply:

☐ Cancer_________________________ ☐ Diabetes_________________________ ☐ Epilepsy_________________________

☐ Heart Disease_________________________ ☐ High Blood Pressure_________________________ ☐ Psoriasis_________________________

☐ Congenital Problems_________________________ ☐ Obesity_________________________ ☐ Asthma_________________________

☐ Alcoholism_________________________ ☐ Tuberculosis_________________________ ☐ Thyroid Problems_________________________

☐ Rheumatic Fever_________________________ ☐ Rheumatoid Arthritis_________________________ ☐ Stroke_________________________

☐ None of the above have affected a blood relative

SYSTEMS REVIEW

As you review the following list, please ☑ check ALL which have significantly affected you:

Changes?:
☐ Chills
☐ Fatigue
☐ Fever
☐ Malaise
☐ Night Sweats
☐ Weakness
☐ Weight Gain
☐ Weight Loss

Head:
☐ Blurred Vision
☐ Double Vision
☐ Dysphagia
☐ Ear Drainage
☐ Facial Pain
☐ Headache
☐ Hearing Loss
☐ Hoarseness
☐ Nasal Congestion
☐ Ringing in ears
☐ Vertigo
☐ Vision Loss

Respiratory:
☐ Chest Pain (respiratory)
☐ Cough
☐ Dyspnea
☐ Recent Infections
☐ Known TB Exposure
☐ Wheezing

Cardiovascular:
☐ Chest Pain
☐ Cyanosis
☐ Heart Murmur
☐ Irregular Heartbeat/palpitations
☐ Leg Swelling
☐ Syncope

Gastrointestinal:
☐ Abdominal Pain
☐ Constipation
☐ Black Tarry Stools
☐ Diarrhea
☐ Heartburn
☐ Jaundice
☐ Loss of Appetite
☐ Nausea
☐ Vomiting

Hematologic:
☐ Bleeding
☐ Bruising

Genitourinary:
☐ Dysuria
☐ Frequent Urination
☐ Hematuria
☐ Urge Incontinence
☐ Urinary Incontinence

Musculoskeletal:
☐ Negative, except as noted in HPI and Chief Complaint

Allergies/Skin:
☐ Contact Allergy
☐ Itchy Skin
☐ Rash
☐ Skin Infections
☐ Skin Lesion

Metabolic/Endocrine:
☐ Cold Intolerent
☐ Hair Loss
☐ Heat Intolerent

Neurological:
☐ Difficulty Walking
☐ Dizziness
☐ Poor Coordination
☐ Memory Loss
☐ Muscle Weakness
☐ Paresthesia
☐ Seizures
☐ Tremors

Psychiatric:
☐ Anxiety
☐ Depression
☐ Insomnia

Immunological:
☐ Asthma
☐ Bee Sting Allergies
☐ Contact Dermatitis
☐ Environmental Allergies
☐ Food Allergies
☐ Seasonal Allergies

Physician/PA____ Date_______________________________

This form will be retained in your medical record.