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

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

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 _____

NORTHWEST ORTHOPAEDIC & SPORTS MEDICINE

PROLIANCE SURGEONS®

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

Language (please mark one)

☐ English ☐ Spanish ☐ Other (please list) _____

Ethnicity (please mark one)

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

NORTHWEST ORTHOPAEDIC & SPORTS MEDICINE

PROLIANCE SURGEONS®

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:_____

512 N Young St, Suite C
Kennewick, WA 99336
509-946-1654
509-572-2607 (fax)

NORTHWEST ORTHOPAEDIC & SPORTS MEDICINE

Melvin Wahl, MD
David Gibbons, MD
Timothy Nickolaus, PA-C
Dennis Ang, ARNP
Desiree Ang, ARNP

Name _____ Date of Birth _____ Age_____

Height _____ Weight _____

Hand Preference: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Reason for visit: _____Pharmacy:_____

Referring physician: _____Primary Care Physician: _____

Past Medical History: Indicate if you have ever had any of the following, with dates

X	Dates		Dates		Dates
	anemia		asthma		kidney failure
	depression		irregular heart beat		stomach ulcers
	high blood pressure		heart disease		high cholesterol
	AIDS/HIV		pulmonary embolus/DVT		multiple sclerosis
	hepatitis		thyroid disease		Parkinson's disease
	pneumonia		stroke		seizure disorder
	tuberculosis		diabetes		emphysema/COPD
	tumor/cancer		osteoporosis		pulmonary embolus/DVT
	heart attack		arthritis		other:

Past Surgical History: Please list all prior operations with dates:

Date	Type of Surgery	Location

Present Medications: Please, include any aspirin, over-the-counter vitamins, herbs or other supplements.

Medication	Dose	Frequency

Drug Allergies: Please list and describe reaction **No Known Drug Allergies**

Medication Allergy	**Reaction**

Family History:

	Alive (Age)	Deceased (Age at death)	Cause of death/medical problems
Mother	Yes > Age ( )	No / Yes > Age ( )	
Father	Yes > Age ( )	No / Yes > Age ( )	

Please indicate family (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Medical Condition	Relative (relationship to you)
Cancer	
Heart Disease	
Diabetes	
High blood pressure	
Epilepsy	
Malignant hyperthermia	
Congenital problems	
Aneurysms	
Brain tumor	
Stroke	
Problems with anesthesia	
Other	

Social History:

Marital status:_____ Spouse/Partner's name: _____

Are you working?		Full-time		Part-time		Modified Duty
Occupation				Employer		
Retired?		Previous Occupation				
Disabled?		Previous Occupation				
Years of Education		Highest Degree				

Tobacco Use:

Cigarettes		Never Smoked		Previous Smoker		Quit/Date		
		Current Smoker		Packs/Day		# of years		
Other tobacco		Pipe		Cigar		Snuff		Chew
Are you interested in quitting?								

Alcohol Use:

Do you drink alcohol?		No		Yes	# of drinks per week			
Type		Beer		Wine		Hard Liquor		Mixed Drink
Is your alcohol use a concern for you or others?								

Drug Use:

Do you use any recreational drugs? No Yes Have you ever used needles to inject drugs? No Yes

Have you used any of the following in the last year?

	marijuana		cocaine		heroin
	amphetamines (meth, speed)				other street drugs

REVIEW OF SYSTEMS: please check any current symptoms you have:

	Constitutional:		Gastrointestinal:		Psychiatric:
	Recent fever/sweats		Heartburn/reflux		Confusion
	Unexplained weight gain		Blood or change in bowel movements		Nervous/anxious
	Unexplained weight loss		Nausea		Sleep disturbances
	HEENT:		Vomiting		Hallucinations
	Change in vision		Diarrhea		Suicidal ideas
	Difficulty hearing		Pain in abdomen		Agitation
	Ringing in ears		**Genitourinary:**		**Neurologic:**
	Congestion		Painful/bloody urination		Headaches
	Trouble swallowing		Leaking urine		Tremors
	Respiratory:		Nighttime urination		Weakness
	Coughing/wheezing		Urgency		Numbness
	Shortness of breath		**Musculoskeletal:**		Seizures
	Apnea		Back pain		Dizziness/Lightheadedness
	Cardiovascular:		Joint pain		**Endocrine:**
	Chest pain/discomfort		Muscle pain		Cold/Heat intolerance
	Palpitations		**Skin:**		Increased thirst/appetite
	Leg swelling		Rash		**Hematologic:**
			Pallor (pale skin)		Easy bruising/bleeding
			New or changing mole		

Have you tried or been prescribed any of the following medications in the past for your pain:

	Celebrex		Baclofen (Lioresal)		Neurontin (gabapentin)
	Darvon/Darvocet		Codeine/Tylenol #3 or #4		OxyContin (Oxycodone)
	Desyrel (trazodone)		Dilaudid (Hydromorphone)		Percocet/Percadan/Tylox
	Effexor (venlafaxine)		Duragesic (Fentanyl Patch)		Serzone (nefazodone)
	Lexapro		Elavil (amitriptyline)		Sinequan (doxepin)
	Lyrica		Ibuprofen (Motrin/Advil)		Tofranil (imipramine)
	Paxil		Klonopin (clonazepam)		Valium (diazepam)
	Prozac		MS Contin/Kadian/Avinza (morphine)		Vicodin/Lortab/Norco
	Soma		Naprosyn (naproxen)		Wellbutrin (bupropion)
	Ultram/Ultracet		Steroids (prednisone, Medrol Dosepak)		Zoloft (sertraline)

Check any non-drug therapies you have tried for relief of pain:

Type of therapy	Helped	Did Not Help	Type of therapy	Helped	Did Not Help
Biofeedback			Chiropractic Treatment		
TENS (electrical stimulation)			Acupuncture		
Heat/Cold therapy			Massage		
Traction			Bed Rest		
Osteopathic Treatment			Other:		
Psychotherapy/Counseling					

Have you had nerve blocks/injections for pain relief? ☐ No ☐ Yes

If yes, name of Doctor who performed:_____ Date of last block? _____

How did block affect your pain? ☐ Better for a while, how long? _____
☐ No Change ☐ Made pain worse

Describe the condition/pain problem for which you are being seen: _____

_____

When did your condition start or when did you first notice your pain:_____

Describe in detail how your injury/accident occurred:_____

_____

_____

When did you first see a doctor for your condition/pain?_____

Have you ever had a similar condition/pain before? ☐ No ☐ Yes-please describe: _____

_____

Under what circumstance did your condition/pain begin?

☐ Following illness/surgery ☐ Reason Unknown

☐ Accident/Injury (**not work-related**) Date of injury _____

☐ Accident/injury (**work-related**) Date of injury _____

Claims Manager Name/phone # _____

Have you received financial compensation related to your condition/pain?

☐ Yes ☐ No ☐ N/A

Have you sued/planning to sue for compensation for your condition/pain?

☐ Yes ☐ No ☐ N/A

Since your pain began, has it: ☐ Increased ☐ Decreased ☐ Stayed the same

What time of day is your pain the worst?

☐ Morning on arising ☐ Late morning ☐ Afternoon ☐ Evening ☐ Bedtime ☐ Sleeping hrs.

Please rate your pain on a scale of 1-10 (10 being severe):

Your pain at the **current time**:_____ Your pain is **usually**:_____

When your pain at its **worst:**_____ When your pain at its **least** severe:_____

Which best describes your pain?

	Varies, not worse at any particular time.
	Always present, always same intensity.
	Always present, intensity varies.
	Usually present/short periods without pain.
	Often present but have pain-free periods lasting one to several hours.
	Occasionally present, but am pain-free.
	Occasionally present for brief periods, a few seconds to a few minutes.
	Rarely present-have pain every few days or weeks.

Does your pain travel anywhere? ☐ No ☐ Yes Where? _____