

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 <input type="checkbox"/> Full-Time <input type="checkbox"/> 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 <input type="checkbox"/> Full-time <input type="checkbox"/> 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
- 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



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? _____

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.

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: _____

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	
Ringling 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: _____

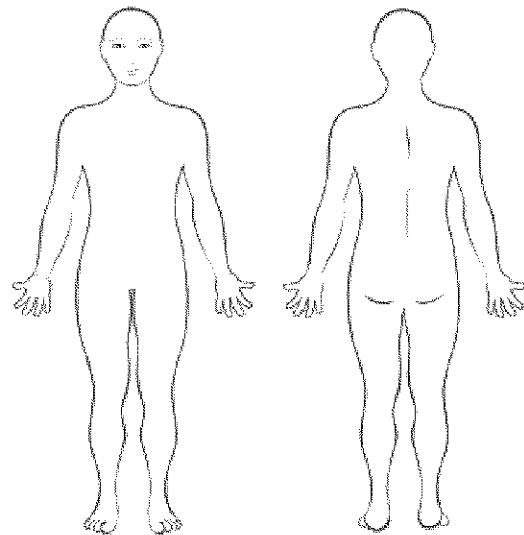
Which best describes your pain?

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

Does your pain travel anywhere? No Yes Where? _____



Please shade the area of pain



NECK PAIN / BACK PAIN

Onset: _____

Pain Duration: _____

Severity (1 – 10 (worst)): _____

Frequency of Pain:

- Intermittent Occasional
 Persistent Rare

Location of Pain (Where):

- Neck Upper Back Mid Back Lower Back Gluteal
 Left Flank Right Flank Arms Thighs Lower Leg

Radiation of Pain:

- None Back Front Leg Left Thigh Left Calf
 Left Foot Left Arm Right Thigh Right Calf Right Foot
 Right Arm

Type of pain:

- Ache Burning Deep Diffuse Discomforting
 Dull Numbness Piercing Sharp Shooting
 Stabbing Superficial Throbbing
 Other: _____

How Injury Occurred:

- Hard Fall Blow from Behind Bending Over Lifting Heavy Object
 MVA Pulling Pushing Sports
 Trauma Twisting Movement Sudden Movement No Injury/Gradual Onset
 Other: _____

Trauma: Type: _____ Where: _____ When: _____ Date: _____

Aggravated By:

- Bending Coughing Flexion Daily Activities Ascending Stairs
 Defecation Jumping Extension Running Descending Stairs
 Sitting Pushing Lifting Lying/Rest Rolling Over in Bed
 Twisting Walking Standing Sneezing Changing Positions
 Other: _____

Relieved By:

- Heat Ice Lying Down Injection Physical Therapy
 Movement OTC Medications Pain Medications Massage Spontaneously
 Rest Sitting
 Other: _____