Dear: ____

We would like to welcome you as a new patient to Northwest Spine &Pain Medicine. We are located at **3124 S. Regal Street** .The parking area is often quite busy; please allow yourself ample time to get to your appointment on time.

Your Physician has referred you to Northwest Spine and Pain Medicine.

Email: Medicalrecords@nwspm.com

Fax: 888-316-1928

South Hill Office: 3124 S. Regal Street, Spokane, WA 99223

- Due to the high volume of patients, if you are not on time for your appointment, with paperwork filled out, your appointment may need to be rescheduled.
- If your insurance requires a referral/authorization, please make sure your **P**rimary **C**are **P**hysician (**PCP**) has certified your appointment with a written referral or phone call.
- Please bring all your current insurance information – for example: L&I, insurance card, referral information. If this information is not provided at the time of service, you may be rescheduled.
- All Co-pays must be paid at the time of service
- **IT IS CRUCIAL TO HAVE ALL DIAGNOSTIC STUDIES AT THE TIME OF YOUR APPOINTMENT OR YOU MAY BE RESCHEDULED.** If your films were done at Inland Imaging, Rockwood Clinic, Deaconess, Columbia Imaging, it is not necessary to call us as we have access to those images via the computer. If these have been done outside of Spokane, you will need to hand-carry them to your appointment.
- If you have paperwork for us to fill out, please allow 7 – 10 working days.
- **Please call the office with routine questions and requests during business hours Monday – Friday 8:00AM – 5:00PM.**
- Please allow 24 – 48 hours for medication refills. (THERE WILL BE NO MEDICATION REFILLS DURING WEEKEND AND NON-BUSINESS HOURS.)

We look forward to working with you. If you have any questions regarding your appointment, films, or insurance, please contact the assistant at (509) 464-6208.

Your orientation is scheduled on:

Date: __________________ Check-In Time: _______________ Location: _____________________
Your Appointment is scheduled on:

Date: __________________ Check- in Time: _______________ Location: _____________________
Thank you.
Northwest Spine and Pain Medicine

Name: (Last)________________________(First)______________________(MI)_____ Female• Male•

Social Security No. ______________________________ Age:______________DOB _______________________

Mailing Address: ____

City: __________________________________ State: _________________ Zip Code: _______________________

Email Address: ____

Phone: Home_________________________________ Cell: ____

Work Number: ________________________________ Employer: _______________________________________

Referring Doctor's full name: ____

Primary care Provider's full name: ____

Pharmacy Name: _________________________ Phone: _______________________ Location: _______________

What are you being seen for today? ____

Is your pain work related? Yes • No • Claim #____________________ Date of Injury_________________

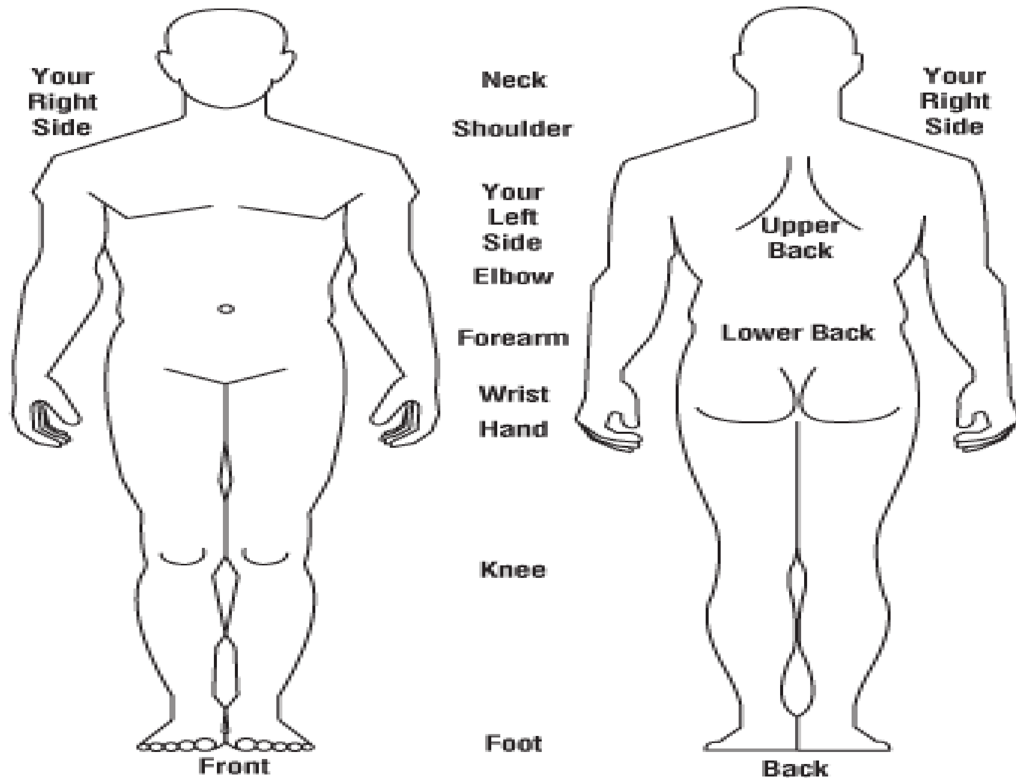
Please mark the severity of your pain on the following line:

On your **worst** days with one your **average** days with A On your **best** days with B

No pain 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-----10 Most Severe

PAIN DIAGRAM

Mark the areas on your body where you feel the described sensations. Please mark all affected areas.
Use the appropriate symbols: Numbness --- Pins/Needles OOO Burning XXX Stabbing /// Aching +++



REVIEW OF SYSTEMS

Do you currently have or have you had in the past 2 weeks?

General: • Fever • Chills • Weight Loss • Weight Gain • Fatigue • Weakness

Vision: • Change in Vision • Pain With Light • Cataracts • Glaucoma • Recent Injury • Vision Loss • Eye Pain • Infections

Cardiovascular: • Chest pain • Heart murmur • Extremity(s) cool • History of heart attack • Ulcers on legs • Palpitations • Extremity(s) discolored • Leg pain walking • Swelling of Legs • High Blood Pressure • Thrombophlebitis

Gastrointestinal: • Abdominal Pain • Heartburn • Rectal Bleeding • Blood in Stools • Hepatitis • Excessive Hunger or Thirst • Hemorrhoids • Laxative Use • Swallowing Problems • Constipation • Nausea • Vomiting • Diarrhea • Liver Disease • Decreased Appetite • Gallbladder Disease • Vomiting Blood

Musculoskeletal: • Arthritis • Back Problems • Muscle Cramps • Restricted Motion • Joint Pain • Muscle Stiffness • Deformities • Weakness • Gout • Joint Stiffness • Paralysis

Psychiatric: • Depression • Anxiety • Disturbing Thoughts • Memory Loss • Psychiatric Disorders • Behavioral Change • Excessive Stress • Mood Changes • Disorientation • Hallucinations

Neurologic: • Loss of Consciousness • Dizziness • Headaches • Paralysis • Tingling • Numbness • Blackouts • Fainting • Memory Loss • Speech Disorders • Tremors • Burning • Head Injury • Strokes • Unsteady Gait

Endocrine: • Weakness • Cold Intolerance • Goiter • Weight Gain • Excessive Urination • Heat Intolerance • Sweats • Weight Loss • Fatigue • Increased Thirst • Thyroid Trouble

Hematologic/Lymph: • Anemia • Swollen Glands • Bleeding Easily • Lumps • Blood Clots

Ears, Nose, Throat, (Allergic/Immunologic): • Runny Nose • Recurrent Infections • Stuffy Nose • Frequent Colds • Discharge • Sinus Infection • Nose Bleeds • Hearing Aid • Ringing in Ears • Tonsils Enlarged • Lumps • Tenderness • Asthma • Bronchitis • Shortness of Breath • Cough • Coughing Blood • Positive TB Test • Wheezing

PAST MEDICAL HISTORY

Check the medical problems you currently have or have had in the past.

• Cancer, If so, what type?	• HIV
• Congestive heart failure	• Ulcers/ GERD
• Heart Disease, Cardiologist:	• History of blood transfusions
• Hypertension (high blood pressure)	• Rheumatoid arthritis
• Heart attack	• Seizures/epilepsy
• Heart murmur	• COPD
• Diabetes: • Insulin • Oral Meds • Diet Controlled	• Asthma, If yes, last hospitalization: ___________
• Hypothyroidism	• Sleep apnea, if you, do you use a CPAP? _____
• Depression/Anxiety	• Stroke
• Blood clots (DVT/Pulmonary embolus)	• MRSA
• Kidney disease	Other:
• Hepatitis A • B • C •	

ALLERGIES

Please list all allergies, including medications, iodine and contrast. None know • Or Yes, • Please list them:

____

____

FAMILY HISTORY Please list family history. If yes, list relative, if they are living, and age at death if deceased.

Problem List			Relative	Living?		
	Yes	No		Yes	No	Age at death
Blood Clotting disorders	•	•		•	•	
Cancer, what type?	•	•		•	•	
Diabetes	•	•		•	•	
Heart disease/heart attack	•	•		•	•	
Hypertension	•	•		•	•	
Stroke	•	•		•	•	
Other:						

SOCIAL HISTORY

History of substance abuse?	• YES	• NO	If yes, describe:
Do you drink alcohol?	• YES	• NO	If yes, • Occasional • Moderate • Heavy
Smoke currently?	• YES	• NO	If yes, packs/day for years
Quit Smoking?	• YES	• NO	If yes, how long ago did you quit?
Are you married?	• YES	• NO	If yes, what is your spouse's name?
Employed:	• YES	• NO	• Full-time • Part-Time • Disabled • Retired
			Occupation:
Do you have children?	• YES	• NO	If yes, number of children:
Student?	• YES	• NO	

MEDICATIONS

List ALL medications, including over the counter products, minerals, vitamins, herbals and dietary supplements.
For pain medications, please include the date started and if it provided relief.

Drug Name	Dose/How often	Drug Name	Dose/How often

PAST SURGICAL HISTORY Please list all surgeries you have had, including the date. Circle Right of Left.

PRIOR JOINT SURGERIES			Date	Other Surgeries		Date
Hip	• No • Yes	R L		Heart surgery/stents	• No • Yes	
Knee	• No • Yes	R L		Appendectomy	• No • Yes	
Shoulder	• No • Yes	R L		Tonsillectomy	• No • Yes	
Neck	• No • Yes	R L		Gallbladder	• No • Yes	
Back	• No • Yes	R L		Hysterectomy	• No • Yes	
Other Surgeries:	Type & Date					

DIAGNOSTIC STUDIES Which of the following diagnostic tests have been done on your back/neck?

	NO YES		Date
Regular Spine X-Ray	• •		
CT Scan	• •		
Myelogram	• •		
MRI Scan	• •		
Discogram	• •		
Bone Scan	• •		
EMG	• •		
Nerve Blocks	• •		
Facet Blocks	• •		

Are you claustrophobic? Yes • No • Do you have any metal in your body? Yes • No •

CONSERVATIVE CARE What types of conservative care have you tried? (Physical therapy, Chiropractic, massage therapy)

What Type?	Where?	How Long? (Date range, # of visits	Did you get relief?

Language:			
Ethnicity	• Hispanic/Latino	• Not Hispanic/Latino	• Refuse to report
Race: • White • American Indian/Alaska Native	• Asian • Pacific Islander	• Black/African American • Refuse to report	

Weight: _________________ Height: __________________ Dominate Hand: • Right • Left

Nearest friend/relative to contact in case of an emergency, NOT living with you:

Name: (Last)________________________________(First)__________________________________(MI)_____

Street Address: ____

City: ________________________________ State: _________________ Zip Code: _______________________

Phone: Home________________________________ Relationship: _____________________________________

Patient/Guardian's Signature: ____ Date: __________________

FINANCIAL RESPONSIBILITY AND INSURANCE AUTHORIZATION

Patient Name: ____SSN#___________________________________

Guarantor Name: _____________________________________SSN#__________________________________

Guarantor Date of Birth: ________________________________ Telephone Number_______________________

Guarantor Address: ____

Primary Health Insurance: __________________________ Policy #__________________________________

Group #____

Secondary Health Insurance (if applicable: ____

Is your insurance company an HMO or Medicare Replacement/Advantage Plan? Yes_____ No_______

***Please bring all insurance cards at the time of your visit.**
***All co-payments are due at the time of your visit.**
*** If you have no health insurance to bill, returning visits you will be required to pay $125.00 at time of service.**

Northwest Spine and Pain Medicine (NWSPM) relies on the insurance and billing information provided to us by you or your referring provider. After services are provided, we will submit our claim to your insurance carrier if applicable. In the event that payment is denied, the patient is responsible for full payment. It is the patient's responsibility to contact the financial services department if this obligation cannot be met.

ASSIGNMENT: I HAVE READ, COMPLETED, AND FULLY UNDERSTAND THE INFORMATION ABOVE. I HEREBY AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN AND RELEASE OF ANY INFORMATION REQUIRED.

INSURANCE

To accommodate the needs and requests of our patients, Northwest Spine and Pain Medicine is contracted with most major insurance companies. We are pleased to be able to provide this service to you, yet it is very difficult for us to keep track of all the individual requirements of each plan as they change from time to time. It is ultimately your responsibility to check with your insurance to understand the contract and coverage.

Each plan has different restrictions regarding how often services may be rendered or more importantly, where you should obtain these services.

If your insurance company requires an insurance referral (i.e Tricare, Group Health, Premera Med Advantage, AARP,Humana) we require that prior to scheduling your appointment. Each authorization will specify the number of visits and expiration date. The patient is responsible for knowing when this authorization expires. Please contact your Primary Care Physician to find out the status of your referral before your scheduled appointment.

Providing the highest quality of care for our patients is our primary concern. We are more than willing to provide care within your insurance plan guidelines whenever possible. As a specialist office, we will contact your insurance for any pre-authorizations for procedures. We may request and collect a deposit prior to services rendered based on the amount of expected patient responsibility.

If you do not inform us of special requirements required by your plan and we perform a service that is not covered by your plan, we will bill you directly for those charges. By working together, we can assist you in receiving the benefits you are entitled to. If you have any questions, please contact our billing department at 509-464-6208 Ext 113.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Signature: ____ Date: ____________________

NO SHOW/SAME DAY CANCELLATION POLICY

We make every effort to provide prompt medical care to all of our patients. If you are unable to keep a scheduled appointment, please let us know 24 hours in advance. A no show/same day cancellation is when a patient fails to keep a scheduled appointment. A no show/same day cancellation will generate a $25.00/$50.00 (Physical Therapy, EMG's and Psychology appointments) fee and two no shows may require that you seek your medical care elsewhere. In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances.

If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled.

Notice of Privacy Practices Acknowledgment

Northwest Spine and Pain Medicine (NWSPM) has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describe how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any times, and you may contact Brandy Gump 509-464-6208 Ext 114 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

Patient Signature ____ Date________________________