NORTHWEST
SPINE & PAIN MEDICINE

Dear: _____

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

- Please bring this paperwork filled out, a copy of your insurance card, and photo ID to your appointment.
- 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.

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

Date: _____ Check- in Time: _____ Location: _____

Thank you.
Northwest Spine and Pain Medicine

NORTHWEST
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Name: (Last)_____(First)_____(MI)_____ Female☐ Male☐

Social Security No. _____ Age:_____DOB:_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone: Home_____ Cell: _____

Is your pain work related? Yes No Claim #_____ Date of Injury_____

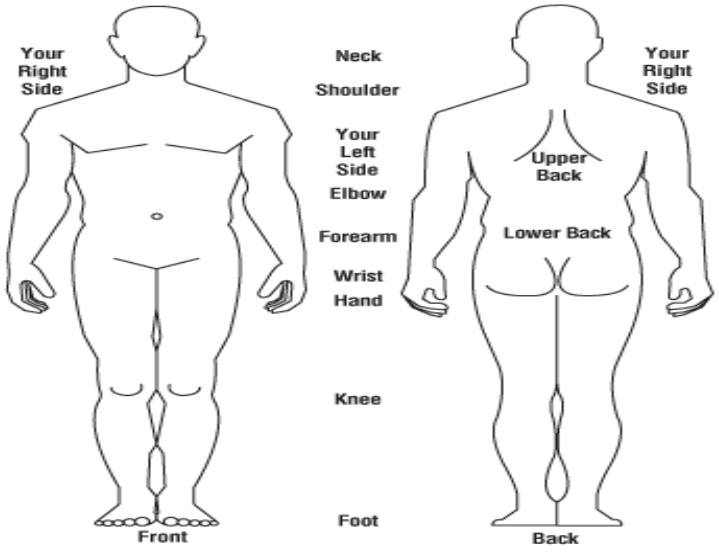
Is your pain due to a Motor Vehicle Accident? Yes ☐ No Who was at fault?_____

What activities or positions increase symptoms?

What time of day are your symptoms the worst?

PAIN DIAGRAM

Mark the areas on your body accordingly.
Pain XXX Numbness OOO Weakness WWW



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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	• Rheumatoid arthritis
• Hypertension (high blood pressure)	• Seizures/epilepsy
• Heart attack	• COPD
• Diabetes: • Insulin • Oral Meds • Diet Controlled	• Asthma, If yes, last hospitalization: _____
• Hypothyroidism	• Stroke
• Depression/Anxiety	Other:
• Blood clots (DVT/Pulmonary embolus)	
• Hepatitis A • B • C •	

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
ALS	☐	☐		☐	☐	
Myasthenia Gravis	☐	☐		☐	☐	
Multiple Sclerosis	☐	☐		☐	☐	
	☐	☐		☐	☐	
Other Neurological:	☐	☐		☐	☐	
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?

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SPINE & PAIN MEDICINE

MEDICATIONS

List ALL prescription medications or provide attached list:

Drug Name	Drug Name

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

PRIOR JOINT SURGERIES			Date			Date
Hip	☐No ☐Yes	R L		Elbows	☐No ☐Yes	
Knee	☐No ☐Yes	R L		Wrist/Hand	☐No ☐Yes	
Shoulder	☐No ☐Yes	R L		Ankle/Foot	☐No ☐Yes	
Neck	☐No ☐Yes	R L			☐No ☐Yes	
Back	☐No ☐Yes	R L			☐No ☐Yes	

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

	NO	YES		Date
CT Scan	☐	☐		
MRI Scan	☐	☐		
Bone Scan	☐	☐		
EMG	☐	☐		
Nerve Blocks	☐	☐		
Facet Blocks	☐	☐		
	☐	☐		

Do you have anxiety about the test today? Yes ☐ No ☐

Do you have any metal in your body? Yes ☐ No ☐ Pacemaker Yes ☐ No ☐ Spinal cord Stimulator Yes ☐ No ☐

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SPINE & PAIN MEDICINE

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)_____

City: _____ State: _____

Phone: _____ Relationship: _____

Patient/Guardian's Signature: _____ Date: _____

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SPINE & PAIN MEDICINE

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 752.

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

Signature: _____ Date: _____

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CONSENT FOR TREATMENT

By signing below, I (or my authorized representative) authorize Northwest Spine and Pain Medicine (NWSPM) to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my treating healthcare providers to explain to me the reasons for any diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION FOR FINANCIAL PURPOSES

I hereby assign the benefits of any applicable insurance coverage to Northwest Spine and Pain Medicine to be applied towards the payment of the services rendered for which I acknowledge financial responsibility. I hereby authorize NWSPM to release information to settle my insurance claims for treatment (to include drug, alcohol, and mental diagnosis).

NO SHOW POLICY

I understand that I may be charged a fee for "no-showing" for a scheduled appointment if I do not give the clinic 24 hours' notice. The fee for Clinic visits is $25.00. Procedures/Physical Therapy and Psychology visits is $50.00. Two no show/same day cancelations in a rolling 12 month period will result in discharge from NWSPM.

COMMUNICATION

I hereby authorize NWSPM to contact me by SMS text message and email. I understand that message/data rates may apply to messages sent to me under my cellular service plan.

PHOTOGRAPHING AND VIDEOGRAPHING

I hereby consent to the photographing and/or videotaping for the purpose of identification and/or documentation of my care. I understand photographs, video, and/ or audio monitoring/recording may be taken for patient care, security, or for the purpose of healthcare operations. (e.g., quality improvement or risk management activities).

STUDENTS/RESIDENTS

I hereby consent to the observation and participation of health care students and certified emergency medical technicians in the medical care provided to me while I am a patient at NWSPM.

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS & RESPONSIBILITIES

I hereby acknowledge that I have received and understand the NWSPM "Notice of Privacy Practices for Health Information" and "Patient Rights and Responsibilities". I understand that unless I object, NWSPM may disclose protected health information to a member of my family, relative, close friend, or other person who is involved in my healthcare or payment of my healthcare.

Patient Name_____Signed_____

Relationship to Patient_____ Date_____