

NORTHWEST ORTHOPAEDIC SPECIALISTS, P.S

Thank you for choosing our office. In order to serve you properly, we will need the following information. All information will be strictly confidential

NAME (Last) _____ (First) _____ (MI) _____ Female Male
Marital Status? _____ Spouse's Name: _____
Social Security No.: _____ Birth Date: _____ Age: _____ E-mail address: _____
Mailing Address: _____ (City) _____ (State) _____ (Zip) _____
PHONE: Home No.: (____) _____ Work No.: (____) _____ Cell No.: (____) _____
By signing this document, I am giving NWOS and their agents, permission to contact me using all phone numbers provided.
Employer: _____ Occupation: _____

Referring doctor's name: _____ Primary Care Physician name: _____

Language: English Spanish Russian Other

Ethnicity: Not Hispanic or Latino Hispanic or Latino Decline

Race: American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or other Pacific Islander Caucasian Hispanic or Latino Decline

Person Responsible For Payment (if patient is a minor, under 18): _____
Street Address: _____ (City) _____ (State) _____ (Zip) _____
PHONE: Home No.: (____) _____ Work No.: (____) _____ Cell No.: (____) _____
Relationship to Patient: _____ Employer of Responsible Party: _____ Are Calls Allowed? Yes No

NEAREST FRIEND / RELATIVE TO CONTACT IN CASE OF EMERGENCY, INCLUDE ALTERNATE PHONE NUMBER(S)

NAME (Last) _____ (First) _____ (MI) _____
Phone No.: (____) _____ Cell No.: (____) _____ Relationship to patient: _____

REASON FOR VISIT (List side): _____ INJURY DATE: _____
IS THIS PROBLEM WORK RELATED? Yes No If so, employer at time of injury: _____
Industrial Insurance carrier: _____ CLAIM NUMBER: _____
Insurance Carrier Address: _____ Insurance Phone Number: (____) _____
Is claim currently open? Yes No If no, when did claim close? ___/___/___ Disabled due to this condition? Yes No
If lost time due to this condition, what was the last date worked? _____

PRIMARY MEDICAL INSURANCE: _____ Policy # _____ Group # _____
Subscriber Name: _____ Subscriber Birth Date: ___/___/___ Subscriber Employer: _____
SECONDARY INSURANCE: _____ Policy # _____ Group # _____
Subscriber Name: _____ Subscriber Birth Date: ___/___/___ Subscriber Employer: _____

Have you had x-rays? Yes No Where? _____ When? _____
Have you had a Nerve Conduction Study? Yes No Where? _____ When? _____

I have completed the above information to the best of my knowledge. I request that payment of authorized benefits be made to me or on my behalf to Northwest Orthopaedic Specialists, P.S. for any services furnished me. I authorize Northwest Orthopaedic Specialists, P.S. to release any medical information which may be requested to determine benefits through my above named insurance carrier, prepaid medial plan, government agency or the Health Care Financing Administration. I understand that if any insurance does not pay in full for services provided by NWOS, I assume liability for the unpaid portion. This agreement shall be governed and enforced in accordance with the laws of the State of Washington. Jurisdiction and proper venue for enforcement shall lie in Spokane County, State of Washington.

By signing below, I acknowledge receipt of the *Notice of Privacy Practices of Northwest Orthopaedic Specialists, PS.*

X _____
SIGNATURE OF AUTHORIZED PERSON DATE RELATION

Notice of Privacy Practices

NORTHWEST ORTHOPAEDIC SPECIALISTS, P.S.

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working this office. This notice will inform you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the Notice of Privacy Practices that is currently in effect

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by law
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- To avert a serious threat to health and safety
- As required by the Military or Veterans Administration
- National security
- Inmates
- Workers' Compensation

Your rights regarding health information about you:

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosures
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice (*full notice is available upon request*)

Changes to Notice of Privacy Practices:

We reserve the right to change this notice. We will post a copy of the current notice in our facility with the current effective date on the first page

Complaints:

If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing. Please contact Jim Webster, HIPAA Privacy Officer to file a complaint.

Acknowledgment of Receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgment will become part of your records.

NORTHWEST ORTHOPAEDIC SPECIALISTS, PS
ORTHOPAEDIC HISTORY

DATE: ___/___/___

NAME: _____

Male Female DATE OF BIRTH: ___/___/___

Reason for appointment: Right Left Body Part: _____

If injury, how did this occur? _____

Have you had an x-ray, MRI, NCS or other testing for this problem? No Yes, Please describe what study, where, and when the study was done.

Current HEIGHT: _____ Current WEIGHT: _____

Pharmacy name and location: _____

ALLERGIES: NONE KNOWN or:

- Penicillin, reaction: _____ Codeine, reaction: _____ Latex, reaction: _____
 Sulfa, reaction: _____ Oxycodone, reaction: _____ Tapes, describe _____
 Iodine contrast, reaction: _____ Hydrocodone, reaction: _____ Other: _____

CURRENT MEDICATIONS: (Include Over the Counter Products and Supplements) If insufficient space use back side of page.
INCLUDE THE DOSE AN HOW OFTEN THE MEDICATION IS TAKEN

LIST ALL BELOW, See Attached / Scanned List OR NOT TAKING ANY MEDICATIONS

Medication Name	Dose	Frequency

PERSONAL / SOCIAL HISTORY:

- Student Single Married Divorced Separated Widowed
Residence: Alone With family With friends Nursing home Retirement home Other: _____
Employed: No Yes Occupation: _____
Children: No Yes How many? _____
Smoking history: I do not smoke I have been smoking ___ packs a day for ___ years I chew tobacco
Quit Smoking: I quit smoking _____ years ago (Please list how long it has been)
Alcohol Consumption: I do not drink Rarely Occasionally Daily
History of Substance Abuse: No Yes Alcohol Oral drugs IV Drugs
History of incarceration? No Yes, when? _____
Do you exercise? No Yes, what type? _____

SURGICAL HISTORY:

- Have you had general anesthetic?* No Yes If any problems, please describe: _____
Family problems with anesthesia?* Please describe: _____
Have you had a blood transfusion in the past?* No Yes Reaction? No Yes _____
Have you had malignant hyperthermia?* No Yes Family history of Malignant Hyperthermia?* No Yes

Please describe below any orthopaedic surgeries include the procedure and the year

- HIP** Right Left Type & year: _____
KNEE Right Left Type & year: _____
SHOULDER Right Left Type & year: _____
Other Orthopaedic Surgeries Right Left Type & year: _____
SPINE SURGERY Type & year : _____

- Appendectomy Tonsillectomy Gallbladder Bypass / Heart surgery, when? _____
 Hysterectomy Oophorectomy C-section Angioplasty / Stent, when? _____
 Hernia Mastectomy Varicose Veins

Other surgeries not listed above: _____

MEDICAL HISTORY: Please mark if Current or Past problems

If applicable, please check box next to "NONE"

Current	Past	Circulation Problems	<input type="checkbox"/> NONE
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary embolus	
<input type="checkbox"/>	<input type="checkbox"/>	DVT (blood clot)	
<input type="checkbox"/>	<input type="checkbox"/>	Poor leg circulation	
Other: _____			

Current	Past	Stomach/Digestive	<input type="checkbox"/> NONE
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/reflux*	
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool / Black stools	
<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel syndrome	
<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
Other: _____			

Current	Past	Genitourinary Problems	<input type="checkbox"/> NONE
<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder infection	
<input type="checkbox"/>	<input type="checkbox"/>	Prostate problem	
<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	
Other: _____			

Current	Past	Neurologic/Psych	<input type="checkbox"/> NONE
<input type="checkbox"/>	<input type="checkbox"/>	Confusion	
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	
<input type="checkbox"/>	<input type="checkbox"/>	Balance problems	
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures / epilepsy	
<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	
<input type="checkbox"/>	<input type="checkbox"/>	Prior Nerve injury*	
<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	
<input type="checkbox"/>	<input type="checkbox"/>	Brain tumor/surgery	
<input type="checkbox"/>	<input type="checkbox"/>	Brain injury	
<input type="checkbox"/>	<input type="checkbox"/>	Depression*	
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety*	
<input type="checkbox"/>	<input type="checkbox"/>	Mental illness*	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke*	
Other: _____			

Current	Past	Respiratory	<input type="checkbox"/> NONE
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	
<input type="checkbox"/>	<input type="checkbox"/>	On oxygen	
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath*	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma*	
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis/Emphysema	
<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea* <input type="checkbox"/> CPAP	
<input type="checkbox"/>	<input type="checkbox"/>	Narcolepsy*	
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder*	
Other: _____			

Current	Past	Cardiovascular	<input type="checkbox"/> NONE
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur* / Irregular rhythm	
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure*	
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/pressure*	
<input type="checkbox"/>	<input type="checkbox"/>	Heart valve replacement	
<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator	
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease*	
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker*	
Other: _____			
Cardiologist: _____			

Current	Past	Head, Eyes, Ears, Nose & Throat	<input type="checkbox"/> NONE
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts / cataract surgery	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	
<input type="checkbox"/>	<input type="checkbox"/>	Glasses / Contacts	
<input type="checkbox"/>	<input type="checkbox"/>	Dentures*	
<input type="checkbox"/>	<input type="checkbox"/>	Partials*	
Other: _____			

Current	Past	Musculoskeletal	<input type="checkbox"/> NONE
<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	
<input type="checkbox"/>	<input type="checkbox"/>	Back pain	
<input type="checkbox"/>	<input type="checkbox"/>	Joint problems	
<input type="checkbox"/>	<input type="checkbox"/>	Ankylosing spondylitis	
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	
<input type="checkbox"/>	<input type="checkbox"/>	Gout	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis: <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/>	<input type="checkbox"/>	Prior Fractures	
List Type: _____			
Other: _____			

Current	Past	Glandular	<input type="checkbox"/> NONE
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems: Type: _____	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes*	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Oral Meds <input type="checkbox"/> Insulin <input type="checkbox"/> Diet Controlled	
<input type="checkbox"/>	<input type="checkbox"/>	Steroid Use _____	
For what condition? _____			
Other: _____			

Current	Past	General	<input type="checkbox"/> NONE
<input type="checkbox"/>	<input type="checkbox"/>	AIDS / HIV positive	
<input type="checkbox"/>	<input type="checkbox"/>	MRSA	
<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Breast cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Prostate cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	
Other: _____			

** Denotes Anesthesia Review*

X _____ Date

Patient / Guardian's Signature



NORTHWEST ORTHOPAEDIC SPECIALISTS, P.S. PATIENT FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. Our Physicians are committed to providing quality care to our patients, while helping to control the rising cost of medical care. This is an agreement between Northwest Orthopaedic Specialists and the Patient/Guarantor named below. By signing this agreement, you are acknowledging that you understand our insurance and financial policies and are agreeing to pay for all services that are received.

For Physician Professional Fees

- Insurance Account: If you have insurance, /we will bill your insurance. Any outstanding balance is due in 30 days after insurance pays. If your insurance doesn't pay us, the full amount is due no later than 60 days after the date of service unless prior arrangements have been made with our business office.
- Patients covered by Labor & Industries must supply claim numbers, and if it is a self-insured company, the insurance company's name and address.
- Patients with Auto accident claims are privately responsible and a down payment of \$150 is required at the time of service. We will bill the automobile insurance given the claim number and the insurance contact name and address are supplied, however, it is the patient's responsibility to follow up with their insurance.
- Patients with State Medical Assistance must present a current coupon at the time of service.
- No Insurance: If you have no insurance, a down payment of \$150 is required at the time of service unless other arrangements have been made prior to treatment.
 - Cash Account: We offer a 15% discount for payment in full on the day of service
 - Bankcards: A 10% discount is offered if paid in full on the day of service

Account responsibility: Many people are under the impression that if they have insurance, it is the insurance company that owes NWOS for their services. This is **not** the case. The insurance contract is **between you and the insurance company**; our relationship to you is as a patient of one of our physicians or mid-level practitioners. Your insurance company requires us to collect applicable co-pays at the time of service. Estimates of coinsurance and deductibles are also due at the time of service.

Our responsibility:

- To bill all claims to your insurance carrier(s) in a timely manner on your behalf
- To assist you in resolving any problems with claim payment

Your responsibility:

- To provide us with current and accurate information to submit your claims correctly
- To make certain there is authorization for treatment if it is required by your insurance
- To pay your co-payment at the time of service
- To pay any additional amount owed as directed by your insurance carrier within 60 days of receipt of your first statement from us.

Usual and customary charges: Some insurance companies use the term "usual and customary" when setting fee limitations on services. The term implies, but does not accurately reflect the average fees charged by physicians in our community. Please be aware, your contract benefit may state your insurer will pay a percentage of their "usual and customary fees". Our actual charges may be higher.

The Orthopaedic Surgery Center Facility Fees

In order to achieve the practice goals of providing the finest medical care at the lowest possible cost, we ask your assistance and your understanding of our payment policy.

For surgeries all insurance companies will be called to verify coverage, and pre-admission requirements, deductibles and co-pays when the surgery is scheduled. A written Estimate of Patient Responsibility will be presented to you prior to your surgery. In most cases, you will have ample time to review these fees, ask questions, make payment arrangements, and/or contact your insurance carrier.

If you have insurance coverage, we are happy to help you receive your maximum allowable benefits and will file the claim for you. By State law, your insurance carrier must remit payment or deny your insurance claim within 30 days of initial filing of claim. If an insurance problem occurs, you may be asked to assist us in contacting your insurance carrier. We believe it is necessary to work together to resolve any insurance problem.

FULL PAYMENT OF YOUR **ESTIMATED** PORTION OF THE ORTHOPAEDIC SURGERY CENTER FACILITY FEE AND ANESTHESIA FEES ARE DUE A MINIMUM OF 24 HOURS PRIOR TO THE DATE OF YOUR SURGERY. IF PAYMENT IS NOT RECEIVED, YOUR PROCEDURE MAY BE RESCHEDULED.

Payment Options:

- You may pay by cash, debit, Visa, Mastercard, Discover Card, American Express and personal checks.
 - Arrangements with outside financing made be made with our Financial Counselor if you qualify.
 - Balances older than 60 days may be subject to additional collection fees and interest charges of 1% per month.
- Returned checks: A \$25.00 processing fee is charged for all returned checks.

I acknowledge receipt of Northwest Orthopaedic Specialist's patient financial policy and have read, understand and agree to comply with these policies.

Date _____

Signature: X _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PRINT NAME OF PATIENT