

Mt Baker Pain Clinic New Patient Registration Form

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth ___/___/___ Gender _____ Soc. Sec. # _____-_____-_____
 Marital Status (*circle one*): Divorced / Married / Separated / Single / Widowed
 Home Phone () _____ Work () _____ Cell () _____
 Address _____ City _____ State _____ ZIP _____
 E-mail _____ Employer _____
 Work Status (*circle one*): Full-time / Part-time / Not employed / On active military duty / Student / Retired / Self employed

GUARANTOR'S INFORMATION *SAME AS ABOVE*

Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth ___/___/___ Gender _____ Relationship to patient _____
 Home Phone () _____ Work () _____ Cell () _____
 Address _____ City _____ State _____ ZIP _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Policy # _____
 Insurance Co. Phone () _____ Group # _____
 Subscriber's Name _____ DOB ___/___/___ Relationship _____

Secondary Insurance Co. (*if applicable*) _____ Policy # _____
 Insurance Co. Phone () _____ Group # _____
 Subscriber's Name _____ DOB ___/___/___ Relationship _____

Work Related? Yes No Employer _____ **Automobile Accident?** Yes No
 Claim Manager Name _____ Date of Injury ___/___/___
 Claim Manager Phone () _____ Extension _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____
 Phone () _____ Phone () _____

PHYSICIAN / PHARMACY INFORMATION

Referring Physician _____ Phone () _____
 Primary Care Physician _____ Phone () _____
 Pharmacy _____ Phone () _____

As far as I know, the information I have provided above is correct.

PATIENT / GUARDIAN SIGNATURE _____ **DATE** _____

ETHNIC BACKGROUND

RACE: American Indian/Alaska Native Asian Black/African American
 White/Caucasian Native Hawaiian or Other Pacific Island Other Race Decline

ETHNIC GROUP: Hispanic/Latino Latin American Mexican Mexican/American
 Mexican/American Indian Not Hispanic/Latino Decline

PREFERRED LANGUAGE: English Spanish Other _____

ASSIGNMENT OF MEDICAL BENEFITS

I, (Printed legal name of primary Insurance holder), _____

assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plan to: Mt Baker Pain Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. This may include related drug and/or alcohol abuse treatment, AIDS/HIV, or psychiatric information; including records protected by federal regulations (42 CFR Part 2) as required to qualify for health benefit payment.

I understand that I am financially responsible for all charges incurred from medical treatment at this facility, whether they are paid by my insurance carrier or not, (public assistance recipients exempt). I also understand that all charges are due upon receipt of statement from this facility unless other arrangements are made with the bookkeeping department. If, for any reason, it becomes necessary for this office to engage an attorney or collection agency to secure payment from me, I agree to pay all reasonable interest charges, attorney fees and/or collection costs.

IF YOUR INSURANCE COMPANY SENDS PAYMENT TO YOU, AND YOU HAVE A BALANCE DUE AT THIS OFFICE, PLEASE ENDORSE THE CHECK AND FORWARD IT ALONG WITH THE EXPLANATION OF BENEFITS WHEN RECEIVED.

Signed: _____
 (Patient or Parent/Guardian)

Date: _____



HIPAA PRIVACY VERBAL AUTHORIZATION FORM

I hereby give authorization for verbal release of protected health information.

Last: _____ First: _____ Middle: _____

Other names used: _____ Date of Birth: _____ SSN: - - _____

Address: _____

Home Phone: () _____ Work: () _____ Cell() _____

I _____ give my permission to Mt Baker Pain Clinic
Your name

to release information in regards to appointment dates/times and my protected health information, including but not limited to, insurance, address, phone number(s), test results, health care information and treatment to the following participants:

Name of person: _____ Name of person: _____

Relationship to Patient: _____ Relationship to Patient: _____

Exceptions: _____ Exceptions: _____

I understand that:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be 12 months from the date of the signature (unless otherwise indicated.)
- Unless the purpose of this authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon my signing of this authorization.
- The information authorized for release may include information which may indicate the presence of a communicable disease or a noncommunicable disease.
- The information authorized for verbal release also may include protected health information related to mental health (RCW 71.05.620)
- The information authorized for verbal release also may include drug/alcohol abuse treatment records (42 CFR Part 2). By signing below, I authorize any such records included in my health information to be release.

Signature of patient / guardian

Date

Patient Payment Policy

Thank you for choosing Mt Baker Pain Clinic as your pain specialist. We are committed to providing you with the highest quality of health care and strive to keep healthcare affordable in our office. As such, we provide this document to ensure your understanding of the payment policies. Please read the following office payment policy carefully and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

Payment Policy

- At the time of service, you are required to pay any applicable copay. A \$10.00 fee will be assessed to your account for a copay not paid in full at time of service. This fee will be required to be paid prior to your next visit. After your insurance is billed, you are responsible for any remaining balance.
- Payment for service is due in full at the time of service provided you have no insurance.
- We accept cash, check, Visa, and MasterCard. Any returned check is subject to a \$35.00 return check fee that will be required to be paid prior to your next visit.
- Unless canceled at least 24 hours in advance, your account will be charged \$25.00 for a missed appointment. This fee will be required to be paid prior to your next visit. Two no show or three canceled appointments will result in a discharge from the facility.
- Please note that your insurance company will not cover any of the additional fees listed above.
- Prior to procedures, you must pay a pre-procedure deposit, predetermined by your insurance.
- If you are in need of a payment plan, you can discuss options with the office staff.
- If your account is overdue for longer than 90 days, it may be referred to a collection agency. Payments over 30 days past due from the date of the invoice will include a 10% APR billing fee.

Insurance

As a courtesy, we file your insurance claims. It is your responsibility to notify us of any changes to your insurance coverage. It is your insurance policy. It is your responsibility to know your policy in regards to benefits, maximums, waiting periods, benefit year, and patient responsibility. We will provide information required by your insurance company regarding the treatment provided by us. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays.

Patient name (PRINTED)

Date

Patient/Guarantor Signature

HISTORY AND PHYSICAL (CURRENT AND PAST MEDICAL HISTORY)

NAME: _____ DATE _____

DATE OF BIRTH _____ HT _____ WT _____ AGE _____

DRUG ALLERGIES: () NONE

CURRENT MEDICATIONS: () NONE [Use additional sheet if needed]

() Latex () Iodine

() Coumadin () Warfarin () Plavix () LovenoX **List dosage below**

() X-ray Contrast

() Benadryl

| MEDICATION NAME | PRESCRIBING PHYSICIAN | DOSAGE (i.e., mg) | HOW OFTEN |
|-----------------|-----------------------|-------------------|-----------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PLEASE INDICATE IF YOU CURRENTLY HAVE OR HAD IN YOUR PAST ANY OF THE FOLLOWING MEDICAL CONDITIONS:

Patient Signature _____

Date _____

| | | | | |
|---|---|--|--|---|
| CARDIAC () Coronary Artery Disease () Heart Murmur () High Blood Pressure () High Cholesterol () Congestive Heart Failure () Deep Vein Thrombosis () Heart Attack () Arrhythmia ENDOCRINE () Diabetes Type 1 () Diabetes Type 2 () Hypothyroidism () Hyperthyroidism OTHER _____ | PULMONARY () Asthma () Bronchitis () COPD () Pulm Emboli () Pneumonia () Sleep Apnea () TB NEUROLOGICAL () MS () Stroke () Migraine Headaches () Tension Headaches () Seizures | GASTROINTESTINAL () GERD () Irritable Bowel Syndrome () Gall Bladder Disease () Hepatitis A/B/C () Ulcers () Crohn's Disease () Cirrhosis MENTAL HEALTH HISTORY () Depression () Anxiety () Bipolar | RENAL () Renal Failure () Kidney Stones () UTI's () Incontinence ENT () Hay fever () Sinus Infections () Ear Infections | MUSCULOSKELETAL () Fibromyalgia () Chronic Fatigue () Osteoarthritis () Rheumatoid Arthritis () Lupus HEMATOLOGIC () Iron Anemia () Taking Blood Thinners CANCER HISTORY () NONE _____ PRIOR SURGERIES () NONE _____ _____ _____ |
|---|---|--|--|---|

FAMILY HISTORY / please specify who: () High Blood Pressure _____ () Heart Disease _____ () Fibromyalgia _____
() Heart attack _____ () Stroke _____ () Cancer/ what kind? _____ () Depression/Anxiety _____
() Diabetes/Type 1 or 2 _____ () Bleeding Disorder _____ () Asthma _____ () Thyroid disease _____ () Migraines _____

SOCIAL HISTORY () MARRIED () SINGLE () DIVORCED () WIDOWED () CHILDREN # _____ **Do you work?** Y / N retired / disabled

TOBACCO Cigarettes / Cigars / Smokeless How many per day? _____ Current Use / Past Use / Never

ALCOHOL Rare / Occasional / Daily / Current Alcoholic / Past Alcoholic / Never

() **MARIJUANA** () **COCAINE** () **METH** () **HEROIN** () **CRACK** () **NONE** Current Use / Past Use / Experimented with?

List any **COMMUNICABLE DISEASE** (ie: Hepatitis, Venereal disease or TB) _____ Current / Past / None

Do you have a **pacemaker**? NO YES

Rate your current pain level with 0 being no pain and 10 being the worst possible pain.

1 2 3 4 5 6 7 8 9 10





Patient Name _____ DOB _____

Date _____

PART A.

Family History of Substance Abuse (parents and siblings):

- Alcohol abuse [] NO [] YES
- Illegal drug use [] NO [] YES
- Prescription drug abuse [] NO [] YES

Personal History of Substance Abuse:

- Alcohol abuse [] NO [] YES
- Illegal drug use [] NO [] YES
- Prescription drug abuse [] NO [] YES

Psychological Disease:

- Diagnosis of Attention Deficit Disorder [] NO [] YES
- Obsessive Compulsive Disorder,
Bipolar, Schizophrenia

- Diagnosis of Depression [] NO [] YES

Other:

- Are you age 16-45 years? [] NO [] YES
- History of pre-adolescent sexual abuse? [] NO [] YES

For Office Use Only
TOTAL ____ L / M / H

PART B. Choose the ONE description for each item that best describes how many days you have been bothered by each of the following over the past 2 weeks.

| | NONE | SEVERAL | 7 OR MORE | NEARLY EVERY DAY |
|--|------|---------|-----------|------------------|
| Feeling nervous, anxious, or on edge | | | | |
| Unable to stop worrying | | | | |
| Worrying too much about different things | | | | |
| Problems relaxing | | | | |
| Feeling restless or unable to sit still | | | | |
| Feeling irritable or easily annoyed | | | | |
| Being afraid that something awful might happen | | | | |

Patient Signature _____

For Office Use Only
TOTAL ____ L / M / H

PAIN ASSESSMENT FORM

NAME _____ DATE _____

HISTORY OF PAIN SYMPTOMS:

1. Please check the following symptoms that you have:

() back pain () leg pain () tingling/numbness in leg () other _____

() neck pain () arm pain () tingling/numbness in arm () pain radiates - where? _____

2. When did your symptoms begin? _____

3. Are you experiencing any problems controlling your bladder or bowel?

Bowel: () Yes () No

Bladder: () Yes () No

4. Is your sleep affected by your pain? () Yes () No

5. What makes your pain better?

() lying down () sitting () walking () standing () bending () stretching () other _____

6. What makes your pain worse?

() lying down () sitting () walking () standing () bending () coughing () sneezing () twisting--*which direction?* Right / Left / Both
 Other: _____

7. Are you currently working?

() yes () no, due to pain () retired () disabled

PAST TREATMENT HISTORY:

1. Have you ever had back or neck pain before?

() yes () no, if so when? _____

2. Have you had back or neck surgery?

() yes () no, if so when? _____

3. What diagnostic tests have you had related to your current pain?

() CT Scan () MRI () X-Ray () EMG/NCS

4. Have you had any previous treatments for your pain?

Injections: () yes () no Were they helpful? () yes () no What kind and When? _____

Physical Therapy: () yes () no Was it helpful? () yes () no When and By Whom? _____

What did it consist of? _____

Chiropractor: () yes () no Was it helpful? () yes () no

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Acupuncture: () yes () no Was it helpful? () yes () no

Massage: () yes () no Was it helpful? () yes ()

Acetaminophen () yes () no Was it helpful? () yes ()

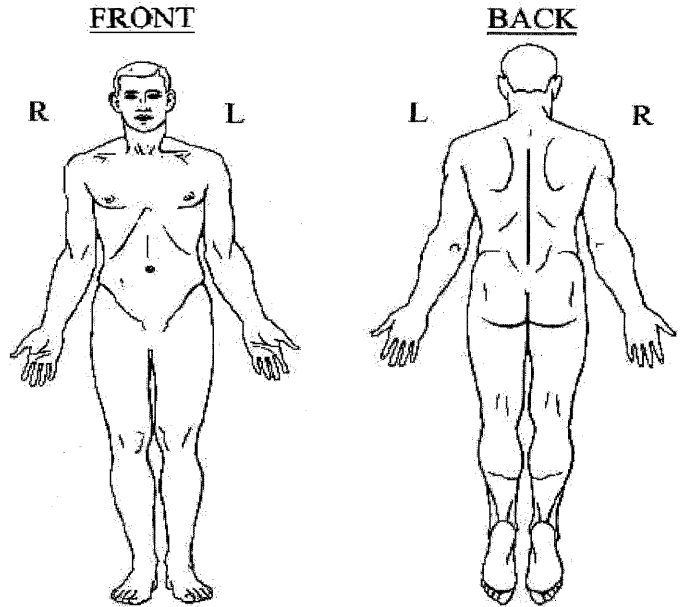
Anti-inflammatory () yes () no Was it helpful? () yes ()

Other _____

5. Mark these drawings according to where you hurt.

Please use the scale below to indicate which sensation you are feeling.

- /// Stabbing
- XXX Burning
- +++ Aching
- === Numbness
- 000 Pins & Needles



Average pain this week _____ / 10
Worst pain this week _____ / 10

Patient Signature _____

Date _____

Please bring this completed form with you to your appointment. Thanks.