



1839 N Government Way, Coeur d Alene, ID 83814 P: 208-765-0156 F: 208-292-3177

Date: _____

Referring Physician: _____ Primary Care Physician _____

PATIENT INFORMATION

Name: _____ Preferred Name/Nick Name: _____

First MI Last

Mailing Address: _____

Street City State Zip

Physical Address: _____

Street City State Zip

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

I prefer to be contacted on my Home Cell Work Email Is it OK to leave a detailed message Y / N

SSN: _____ Date of Birth: _____ Age: _____ Sex: M / F Identify as: M / F / _____

Marital Status: Single / Married / Divorced / Widow Preferred Language: _____

Emergency Contact: _____ Phone: _____ Relation: _____

THE FOLLOWING PERSON IS ALLOWED DISCUSS MY HEALTH RECORD INCLUDING APPOINTMENTS AND BILLING QUESTIONS:

Name Relation Patient Initials SELF ONLY

Name Relation

YOU MAY RECEIVE TEXTS OR EMAILS REGARDING BALANCE'S DUE WHICH CAN BE PAID BY FOLLOWING THE LINK PROVIDED. YOU CAN ALSO CALL OUR OFFICE TO MAKE PAYMENT BY CREDIT CARD.

EMPLOYMENT

Employer: _____ Occupation: _____

Employer Address: _____ Phone: () _____

Street City State Zip

GUARANTOR/RESPONSIBLE PARTY: Self or

Name: _____ Phone: () _____

First MI Last

Address: _____

Street City State Zip

PLEASE FILL IN THIS INFORMATION EVEN IF WE HAVE A COPY OF YOUR INSURANCE CARDS. Thank you!

Primary Insurance Medical Insurance Workers Comp Medicare Medicaid Auto (WE DO NOT BILL THIRD PARTY CLAIMS)

Carrier Name: _____ ID/Claim # _____

Does your insurance require pre-authorization for specialist visits? Y / N

Subscriber Name: Self Other _____ DOB: _____ Relation: _____
SS# _____

Insurance Address if not on card: _____ Phone: _____

Work Comp Claims Manager: _____ Phone: _____

Secondary Insurance Private Medical Insurance Medicare Medicaid NONE

Carrier Name: _____ ID/SS#/Claim # _____

Insurance Address: _____ Phone: _____

Subscriber Name: Self Other _____ DOB: _____ Relation: _____

Tertiary Insurance Private Medical Insurance Medicare Medicaid NONE

Carrier Name: _____ ID/SS#/Claim # _____

Insurance Address: _____ Phone: _____

Subscriber Name: Self Other _____ DOB: _____ Relation: _____

Is this visit a result of an accident or injury? Y / N	Date of Injury: _____ State injury occurred: _____
Is this work related? Y / N	Are you represented by an attorney? Y / N
Is this auto accident related? Y / N	Attorney Name: _____ Phone: _____

Medicare Patients ONLY: I request that payment of authorized Medicare benefits be made either to me or on my behalf of Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sports for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY: We are unable to provide you care if you are unwilling to sign the Patient Financial Responsibility

Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sports appreciates the confidence you have shown in choosing us to provide for your health care needs. The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance on your behalf. However, you are ultimately responsible for payment of your bill. An expected out of pocket can be supplied upon request; however we are unable to guarantee how insurance will process a claim prior to submission.

Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sports is contracted with the following insurance(s):
Blue Cross of Idaho | Regence Blue Shield of Idaho | First Choice Health Network | Kaiser Permanente | Medicare | Medicaid of Idaho | Cigna | IPN | Pacific Source | Aetna | Mountain Health Coop | United Healthcare | Select Health

If your insurance is **NOT** included on the list above your services will apply to your out of network benefits. I understand that I am ultimately responsible for any balance not covered by insurance. I authorize Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sports to release any information acquired in the course of my treatment to appropriate agencies as necessary for treatment or payment including appeals on my behalf.

Referrals Policy: **YOU** are responsible for obtaining referrals to our office as required by your insurance plan. Failure to do so will result in you being responsible for any balance denied by your insurance for lack of referral from your primary care.

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family, we appreciate a 24-hour cancellation notification. Patients who “no show” without advance notice may be discharged from Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sports.

Co-Pay

Your co-payment must be paid at the time of service and is required at each visit or follow-up appointment as determined by your contract with your insurance carrier.

Self-Pay

Patients that do not have health insurance will be responsible for payment of services prior to services being rendered.

Motor Vehicle Insurance

Patient’s wishing to file claims through motor vehicle carrier are responsible for ANY bills incurred that are not covered and/or paid in full using the PIP/Med Pay benefit through the patient’s motor vehicle insurance. Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sports does not accept third party insurance; services will be treated as Self Pay and payment will be collected at the time of service.

Self-Referral Notice (Pleasant View Surgery Center)

Pursuant to Section 6002 of the Patient Protection and Affordable Care Act (PPACA), with respect to transparency reports and reporting of physician ownership or investment interests, Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sport would like you to be aware that Pleasant View Surgery Center is owned in part by physicians. Michael Ludwig MD is a part-owner in the surgery center. Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sport providers may choose to refer you to have your surgery/procedure done at Pleasant View Surgery Center and may also be performing your surgery or other services in connection with your referral. Please discuss this matter with your physician so that you may exercise your right to be treated in another health care facility if desired. Upon your request, your physician will provide names and addresses of alternative facilities where you may go to obtain services.

I hereby acknowledge that I have read the Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sports Patient Financial Responsibility in its entirety and understand my responsibilities and options as a patient. I authorize Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sports to bill my insurance on my behalf. I authorize Idaho Occupational Medicine Group to release any information acquired in the course of my treatment to appropriate agencies as necessary for treatment or payment including appeals on my behalf. I understand that Idaho Occupational Medicine Group/Coeur d’ Alene Spine and Sports will bill my insurance as a courtesy and that I am ultimately responsible for any balance not covered by insurance.

Patient/Guarantor Signature: _____ Date: _____

Printed Name: _____

Electromyogram (EMG) and Nerve Conduction Study (NCS) Patients

The amount collected at the time of service is based on your insurance benefits at the time of verification and is our best estimate based on the information we have at the time of benefits check. If insurance pays more, you will be reimbursed within 2 weeks of our receiving payment. If insurance pays less, you may receive a bill.

Patient/Guarantor Signature: _____ Date: _____

Printed Name: _____

RX Prescription Refill Policy

Refills require TWO DAYS minimum to process prescription renewal and/or pick up requests. The patient is responsible for knowing when medication(s) will need to be refilled. Hours for prescription phone-in/pick up are M-F 8am to 4pm. Prescriptions will not be filled for unauthorized "walk-in" patients. Prescription directions must be followed, and early refills are not allowed. No medication/prescription will be replaced if lost, stolen, misplaced, overused etc. Medications are for the prescribed individual's use only. It is illegal to "share" your medicine. Patients must pick up his/her written prescription(s) in person, unless pre-authorized by staff.

THESE PROTOCOLS ARE RECOMMENDATIONS OF THE US DRUG ENFORCEMENT AGENCY

I understand and accept the protocol listed above. Failure to comply may subject me to immediate termination of prescriptive medications.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____

Consent for Treatment and Authorization to Release Information

I am aware that by signing below, I authorize Idaho Occupational Medicine Group/Coer d' Alene Spine and Sports, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment, and treatment procedures. I also authorize Idaho Occupational Medicine Group/Coer d' Alene Spine and Sports to release to appropriate agencies any information acquired in the course of my or the above names patient's examination and treatment.

To help protect our patient's privacy, Idaho Occupational Medicine Group/Coer d' Alene Spine and Sports requires patients to sign a medical records release prior to releasing any records. We understand that there are situations where another medical provider might need pertinent information in order to expedite your medical care. To help you receive timely care, Idaho Occupational Medicine Group/Coer d' Alene Spine and Sports will release medical information via verbal and written requests from the other physician's offices without a signed release.

By signing below, I am aware that Idaho Occupational Medicine Group/Coer d' Alene Spine and Sports will do their best to protect my confidential information, but I understand that it is possible for someone to misrepresent themselves by telephone and/or forgery and that my right to privacy may be compromised.

Notice of Privacy Practices (HIPAA)

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dawn S Stanciu, Office Manager. Our Notice of Privacy Practices (HIPAA) describes in more detail how your health information may be used and disclosed, and how you can access your information. If you would like a copy of your records, you may request it from the front desk.

Patient/Guarantor Signature: _____ Date: _____

Printed Name: _____

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions medication that our practice providers, or other providers, have prescribed to you. A variety of sources, including pharmacies and health insurers contribute to the collection of this history.

The collection information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

By signing this consent form, you are giving your permission for your healthcare provider, pharmacy and health insurer to disclose information about your prescriptions that have been filled at any pharmacy or covered by and health insurance plan. This includes prescription medications to treat AIDS/HIV and medication used to treat mental health issues such as depression.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient/Guarantor Signature: _____ Date: _____

Printed Name: _____

New Patient History

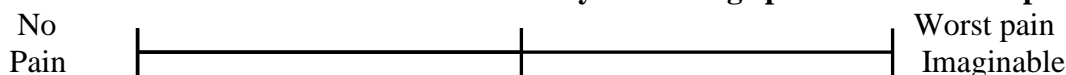
Name _____ DOB _____

Height _____ Weight _____ BMI _____

How did you find us? Chiropractor Therapist Friend/relative Internet
 Doctor referral _____ Other _____

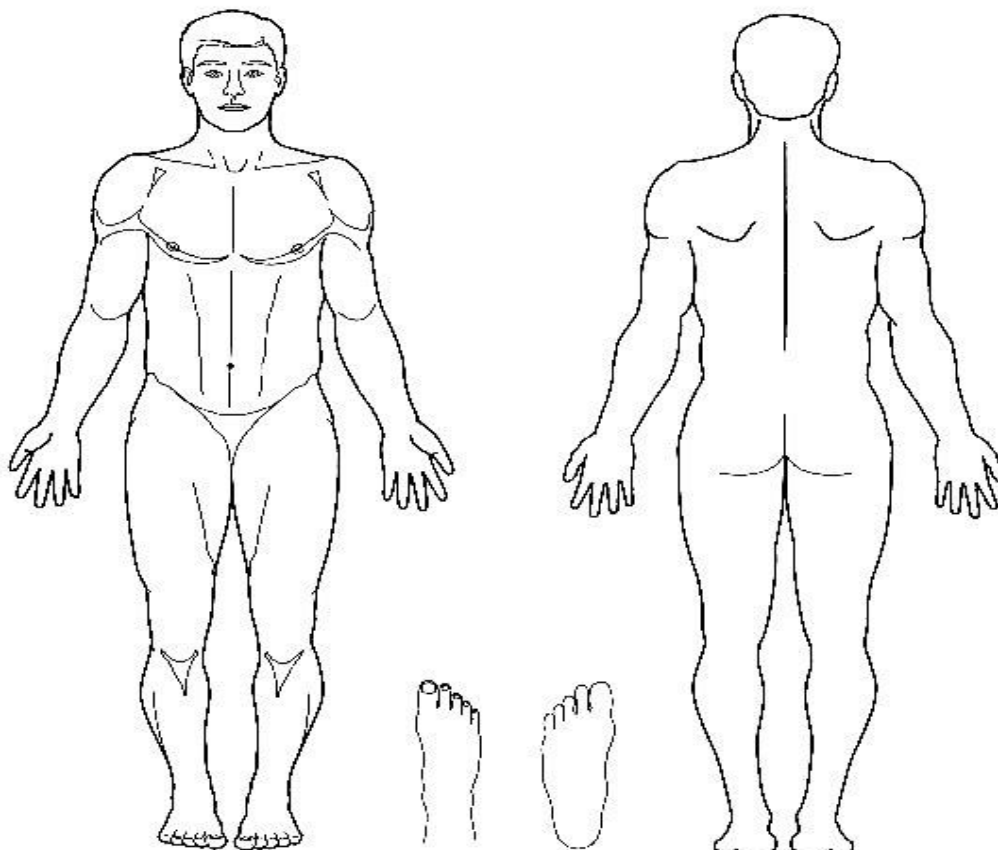
- My current pain developed:** Gradually Suddenly
- Date of onset ___/___/___ if unsure of exact date, how long have you had pain? _____
 Motor vehicle accident Attorney: _____
 Work injury: Date of injury ___/___/___

3. Please make a mark on the line below to show your average pain level over the past week.



Please use the following key to shade in the distribution of your symptoms on the figures:

Numbness Pins and Needles 00000000 Pain ////////////////



- My pain is best described as** (check all that apply):
 Dull Sharp Throbbing Constant Intermittent
 Aching Stabbing Shooting Burning Tingling
 Electrical

- My pain is worse with** (check all that apply): Bending forward Bending backward
 Sitting Standing Walking Laying down
 Looking up Looking down Turning left Turning right
 Cough/ sneeze Lifting Pushing / pulling

6. **My pain is better with:** Laying down Sitting Standing Therapy
 Changing positions Pain meds Ice Heat Nothing

7. **Do you have difficulty doing the following activities?**

- Everyday Activities Work School Home Duties
 Recreational Activities None of the above

8. **Have you experienced new bowel or bladder leakage/accidents recently?** Yes No

9. **Have you had any of the following tests for the current problem in the last 2 years?**

- X-rays: Date Completed _____ CT scan: Date Completed _____
 MRI: Date Completed _____ EMG: Date Completed _____
 Bone Scan: Date Completed _____
 Diagnostic Spinal Injections (epidural, facet/sacroiliac joint block, discogram): Date Completed _____

10. **Have you tried the following treatments for my pain (Circle those that helped):**

NEEDED INFORMATION FOR ANY AUTHORIZATIONS

- Physical Therapy: Date and place completed: _____
 Chiropractic: Date and place completed: _____
 Acupuncture: Date and place completed: _____
 Massage: Date and place completed: _____
 Injections: Date and place completed: _____
 Dr supervised home/gym exercises: Date and Dr who ordered: _____
 Surgery: Date and place completed: _____
 Traction: Date and place completed: _____

11. **Have tried the following medications for my pain (Circle those that helped, X out those that didn't):**

- Anti-inflammatories (Ibuprofen, Aleve, Naproxen, Mobic, Celebrex, Diclofenac, Steroids)
 Muscle relaxants (Soma, Flexeril, Carbamazepime, Zanaflex, Skelaxin, Robaxin, Methocarbamol)
 Nerve pain drugs (Neurontin, Gabapentin, Lyrica, Amitriptyline, Nortriptyline, Cymbalta)
 Narcotics (Lortab, Hydrocodone, Oxycodone, Oxycontin, Ultram, Vicodin, Percocet, Methadone)

12. **Medication Allergies:** None Iodine Contrast dye Steroids Local Anesthetics

Latex Other: _____

Allergic Reaction that occurred: _____

13. **Are you currently taking any blood thinning/anticoagulation medications?** YES NO
(Coumadin, Warfarin, Pradaxa, Plavix, Aggrenox, Aspirin, Flax seed, Fish Oil etc.)

14. **Medications/OTC/Supplements/Herbals currently taken with dosages (include separate sheet if needed)**

NO Medications or Supplements Taken

15. **Medical History:**

Please check the following medical problems you have now, or have had:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Colon disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | <input type="checkbox"/> Vascular problems | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis/HIV | <input type="checkbox"/> Bladder problem |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> History of Falls | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Other _____ | |

Have you had previous back or neck problems? Yes No

Have your received care from a mental health professional? Yes No Still seeing

Have you ever had an infection with MRSA? Yes No

Do you have an advanced care plan? Yes No

Have you had a pneumococcal vaccine? Yes No Unable to due to allergy/reaction

16. Surgical History:

Spine surgery? None Neck/Cervical Mid-back/ Thoracic Spine Low back/lumbar
Orthopedic surgery? None Shoulder Elbow Wrist Hand Hip Knee Ankle Foot
Heart surgery or lung surgery? No Yes
Cardiac or peripheral stents? No Yes

17. Family History: Please check those illnesses that your family members have had

	Hypertension	Diabetes	Neurologic Problems	Heart Disease	Cancer	Arthritis
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Father: Living Deceased (Age) _____ Mother Living Deceased (Age) _____

18. Social History:

Do you now, or did you ever smoke? No Yes Packs per day? _____ When did you Quit? _____
Do you now, or did you ever use other tobacco products? No Yes When did you Quit? _____
Do you drink alcohol? No Yes Daily Rarely
Do you now, or have you ever had a drug or alcohol problem? No Yes
Please explain: _____

Marital Status: Single Married Divorced Widowed

19. Vocational History:

Employed Full Time Employed Part time Retired
 Regular Duty Light Duty Disability (reason) _____

Employer: _____

Job Description: _____

Years at current job: _____ Date last worked: _____

Rate your current job satisfaction: Very Satisfied Satisfied Indifferent Dissatisfied

Have you ever been on disability? No Yes: _____

How physically demanding is your job? Check one.

Very heavy (lifting > 100 pounds) Heavy (lifting > 60 pounds) Moderate (lifting > 30 pounds)
 Light (lifting > 10 pounds) White collar (no lifting)

20. Review of Symptoms:

Please check any of the symptoms you have had during the past year.

<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Unintentional weight loss of >10 #
<input type="checkbox"/> Rashes	<input type="checkbox"/> Skin infections	<input type="checkbox"/> Itching of skin
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Double vision <input type="checkbox"/> Loss of vision
<input type="checkbox"/> Ear infections	<input type="checkbox"/> Mouth sores	<input type="checkbox"/> Sore throat <input type="checkbox"/> Nasal congestion
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Leg swelling	<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Short of breath	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Difficulty urinating
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures	<input type="checkbox"/> Ringing in ears <input type="checkbox"/> Memory loss
<input type="checkbox"/> Face numbness	<input type="checkbox"/> Arm numbness	<input type="checkbox"/> Leg numbness <input type="checkbox"/> Sudden weakness
<input type="checkbox"/> Joint pain	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Difficulty walking
<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> High blood sugar	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Anemia

The information I have provided in this document is true and accurate to the best of my knowledge.

Patient Signature

Date