NORTHWEST MEDICAL CENTER

Patient Information

Patient Name:_____ DOB_____ Age_____

Social Security #: _____ Male_____ Female_____

Address: _____ Email:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____

Responsible Party, if a minor:_____ Relationship:_____

Patient Employment Information

Employer:_____ Occupation:_____

Business Address:_____ Work Phone:_____

Insurance Information

Name of Primary Insurance Company:_____

Subscriber's Name:_____ DOB:_____

Subscriber's SSN:_____

Relationship to Subscriber:_____

Policy #:_____ Group #_____

If L&I:
Claim Number:_____ DOI_____

Claim's Manager:_____ Phone Number:_____

Name of Secondary Insurance Company:_____

Subscriber's Name:_____ DOB:_____

Subscriber's SSN:_____
Policy #:_____ Group #_____

Emergency Contact:_____ Phone:_____

Assignment and release: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any amount not covered. I also authorize the doctor or insurance company to release my information required for the claim.

_____

Signature of Patient/Responsible Party **Date**

Revised 11/30/11

Northwest Medical Center
Privacy Notice Acknowledgement

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

DOB: _____ SSN: _____

Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Privacy Practices Notice from:

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the notice of Privacy Practices.

Patient Signature: _____ Date: _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt).

Describe your good faith effort to obtain the individual's signature on this form:_____

_____

_____

Describe the reason why the individual would not sign this form:_____

_____

_____

SIGNATURE of CLINIC REPRESENTATIVE

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Include this acknowledgement form in the individual's records.

Revised 11/30/11

Northwest Medical Center
Permission for Verbal Communication

Patient Name_____

Address_____

City, state, zip code_____

_____
(Phone Number)

I permit Northwest Medical Clinic, their physicians, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient).

This authorization is limited to discussions regarding the following medical condition(s):

_____
(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care).

	Name	Phone Number	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals mentioned above.

This authorization is limited to the following timeframe from _____ __(date) to_____(date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the Medical Records Department of Northwest Medical Clinic.

Patient Signature: _____ Date: _____

If this release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____ Relationship: _____

Updated 11/30/11

Northwest Medical Center

Thank you for choosing Northwest Medical Center for your healthcare needs. Our clinic is committed to providing our patients quality medical care. As part of that commitment our providers care for all individuals in a manner that honors and respects their dignity. We are also committed to fiscal responsibility and want to inform you of our billing practices and expectations. The following is a statement of our Financial Policy, which we ask you **read** and **sign** prior to any treatment.

- Payment is **due at the time of service** unless other arrangements are made.
- We bill your primary and secondary insurance as a courtesy. **Please bring in your insurance information to the clinic each time you visit so that we can verify that our information is accurate.**
- Please note, if we are seeing you under a motor vehicle plan and your PIP is exhausted, we will be billing your primary medical insurance.
- All co-pays and deductibles must be paid at the time of service.

We have contracts with the following insurance carriers, but please ask at the clinic because this list may not be complete.

Regence Blue Shield	Premera Blue Cross	First Choice Health	Group Health
Healthcare Management	Tricare	Cigna	Aetna
United Health Care	Great West	Medicare	

** "Usual, Customary and reasonable" fees: Each insurance carrier sets its own 'UCR' rates. They may or may not reflect the average fee charged. Every effort is made to price our services close to the average price in our geographical area. Your insurance is a contract between you and the insurance company. If you have complaints regarding your coverage, you will need to take responsibility for following up with your insurance carrier.

- Minimum monthly payments are based on the outstanding balance.
- We accept cash, personal checks, VISA and Mastercard (including debit cards).

I HAVE READ THE FINANCIAL POLICY, RECEIVED A COPY, AND ACCEPT ITS TERMS.

Signature: _____ Date: _____

If patient is unable to sign please indicate reason: _____

_____

Signature of person authorized to consent for patient Witness

_____

Revised: 3/30/12

Northwest Neurosciences

Patient Name:	DOB:	Age:	Date:

Reason for your visits / symptoms:

Past Medical History

	Y	N		Y	N		Y	N
Arthritis	☐	☐	Headaches	☐	☐	Kidney Stones	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐	Liver Disease	☐	☐
COPD	☐	☐	Heart Disease	☐	☐	Osteoporosis	☐	☐
DVT	☐	☐	Cancer	☐	☐	Cardiac Arrhythmias	☐	☐
Pace Maker	☐	☐	Angina	☐	☐	Hepatitis	☐	☐
Gastritis/GERD	☐	☐	Kidney Disease	☐	☐	High Blood Pressure	☐	☐
Seizures	☐	☐	High Cholesterol	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	HIV/AIDS	☐	☐	Stroke/CVA/TIA	☐	☐
Peripheral Artery Disease	☐	☐	Congestive Heart Failure	☐	☐			
Depression	☐	☐	Thyroid Disease	☐	☐			

Current Medications/Dosage

_____

_____

_____

_____

_____

_____

_____

_____

Are you left or right handed? _____

Other (please list) _____

Previous Surgeries: _____

List Allergies to any medications: _____

ROS	(-)	PLEASE CHECK ALL CURRENT POSITIVE FINDINGS
Constitutional		Weight Loss ☐ Fevers ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight Gain ☐ Insomnia ☐ Night Sweats ☐
Eyes		Blurry vision ☐ Eye pain ☐ Eye Discharge ☐ Eye Redness ☐ Decrease in vision ☐ Dry Eyes ☐ Double Vision ☐
ENT		Sore throat ☐ Hoarseness ☐ Ear pain ☐ Hearing Loss ☐ Ear discharge ☐ Nose bleeds ☐ Tinnitus ☐ Sinus problems ☐
Cardiovascular		Chest pain ☐ Palpitations ☐ Rapid Heart Rate ☐ Heart Murmur ☐ Poor circulation ☐ Swelling in legs or feet ☐
Respiratory		Shortness of breath ☐ Chronic cough ☐ Coughing up blood ☐ History of Tuberculosis ☐ Excess sputum production ☐
Gastrointestinal		Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Trouble swallowing ☐
Genitourinary		Increase urinary frequency ☐ Blood in urine ☐ Incontinence ☐ Painful urination ☐ Urinary retention ☐ Frequent UTI ☐
Skin		Rash ☐ Hives ☐ Hair loss ☐ Skin sores or ulcers ☐ Itching ☐ Skin thickening ☐ Nail changes ☐ Mole changes ☐
Musculoskeletal		Joint pain ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Bone pain ☐ Joint swelling ☐ Back pain ☐ Hip/groin pain ☐
Psychiatric		Anxiety ☐ Depression ☐ Alcohol or drug dependence ☐ Suicidal thoughts ☐ Panic attacks ☐ Use of anti-depressants ☐
Endocrine		Goiter ☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst ☐ Change in skin pigment ☐ Excess sweating ☐
Neurological		Seizures ☐ Migraines ☐ Numbness or tingling in feet ☐ Dizziness/Vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke ☐
Hem/Lymphatic		Low blood count ☐ Easy bruising ☐ Swollen lymph nodes ☐ Transfusions ☐ Prolonged bleeding ☐ Blood Clots ☐ MRSA ☐
Allergic/Immun		Allergic reaction ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive ☐ Positive tuberculin skin test (PPD) ☐

Social History: Martial Status _____ Do you live alone? _____ Occupation _____

Non-Smoker (never smoked) ☐ Ex-Smoker ☐ when did you quit? _____ Current Smoker ☐ Packs per day? _____ #Yrs_____

Alcohol Consumption: Never ☐ Occasional ☐ Previous Alcohol Consumption ☐ when did you quit? _____
Current Alcohol Consumption ☐ how much/often _____

Family History: (Please list any known medical problems)

Father: Living Y/N _____ Mother: Living Y/N_____

Siblings: #_____ Living Y/N_____

Your children: #_____ Living Y/N_____

Additional Information:

_____ _____

Signature of Patient Date Signature of Reviewing Physician Date

NORTHWEST MEDICAL CENTER

Patient Name _____ DOB _____ Date _____

Do you have or have you had within the past year?

NO YES Loss of memory
NO YES Confusion
NO YES Loss of judgment
NO YES Difficulty understanding words
NO YES Difficulty thinking of words
NO YES Difficulty speaking
NO YES Difficulty swallowing
NO YES Loss of consciousness
NO YES Fainting spells
NO YES Convulsion or Epilepsy
NO YES Numbness or tingling of face
NO YES Loss of vision
NO YES Double vision
NO YES Loss of smell
NO YES Loss of taste
NO YES Ringing in ears
NO YES Loss of hearing
NO YES Weakness of arm or leg (circle)
NO YES Numbness of arm or leg (circle)
NO YES Tremor of arm or leg (circle)
NO YES Numbness of hand or foot (circle)
NO YES Loss of balance
NO YES Neck pain
NO YES Pain in shoulder or arm
NO YES Back pain
NO YES Pain in back of leg
NO YES Kidney or bladder trouble
NO YES Loss of bladder control
NO YES Loss of bowel control
NO YES Chest trouble
NO YES Heart trouble
NO YES Stomach trouble
NO YES Nervousness
NO YES Problems at home
NO YES Problems at work
NO YES Serious head injury in past
NO YES Meningitis or encephalitis in past
NO YES Headache

Have the following occurred with headache?

NO YES Steady pain
NO YES Throbbing pain
NO YES Sensitive scalp
NO YES Partial blindness
NO YES Flashing lights
NO YES Redness of eye
NO YES Drooping of eye
NO YES Vomiting
NO YES Family history of headache
NO YES Awakened with headache
NO YES Daily headache
NO YES Headaches longer than 12 hours
NO YES Headaches last days to weeks
NO YES Dizziness

Have the following occurred with dizziness?

NO YES Sensation of spinning objects
NO YES Turning or tumbling sensation
NO YES Dizziness in certain positions
NO YES Dizziness when lying flat
NO YES Dizziness when upright
NO YES Dizziness when turning to the left
NO YES Dizziness when turning to the right
NO YES Constant dizziness
NO YES Attacks of dizziness
NO YES Attack of dizziness for seconds to minutes
NO YES Attack of dizziness for days to weeks

Comments:

_____

_____