Date of Visit: _____ **Patient Health History**

PLEASE COMPLETE BOTH SIDES OF THIS SHEET

Patient's Name_____ Age _____ Sex _____ Date of Birth _____ Right or left handed_____

Referring Doctor Name and Specialty: _____

Please list all the physicians (address and phone #), in additions to the referring physician, who should receive a copy of your evaluation.

_____

_____

Briefly describe your symptoms or problems. _____

PERSONAL HISTORY:

Have <u>you</u> ever had any of the following illnesses?

High blood Pressure	No	Yes	Glaucoma	No	Yes	Cancer	No	Yes*
Diabetes	No	Yes	AIDS/HIV	No	Yes	**if yes, please explain below*		
Heart Disease	No	Yes	Stroke	No	Yes	_____		
			Anxiety	No	Yes	_____		
Seizures	No	Yes	Depression	No	Yes	_____		
Head Injury	No	Yes	Tuberculosis	No	Yes			
Migraines	No	Yes	Meningitis	No	Yes			
High Cholesterol	No	Yes	Polio	No	Yes			
Rheumatic fever	No	Yes	Thyroid Disorder	No	Yes			
Arthritis	No	Yes	Bladder Disease	No	Yes			
Asthma	No	Yes	Bowel Disease	No	Yes			
Lung Disease	No	Yes	Heart Attack	No	Yes			
Liver Disease	No	Yes	Atrial Fibrillation	No	Yes			
Kidney Disease	No	Yes	Reflux	No	Yes			

Others: _____

_____

Have <u>you</u> ever had any of the following surgeries?

Heart Surgery	No	Yes			
Brain Surgery	No	Yes	Aneurysm repair	No	Yes
Back Surgery	No	Yes			

Any other type of operation:

Type _____ Year _____

Type_____ Year_____

Do you have any metal or surgical implants? (i.e. pacemaker)

No

Yes _____

Have you ever been hospitalized for any illness? No Yes _____

Have you had any of the following tests?

CT scan No Yes **MRI** No Yes **EMG** No Yes **EEG** No Yes **Lumbar Puncture** No Yes

---

MEDICATIONS

Allergies: please list any allergies you have including any medication allergies **NONE**

_____

_____

Medications: Please list all medicines you are taking and how you actually take them. Please include all vitamins herbal supplements and birth control medications. (If you require more space, please attach additional sheets of paper or bring a list of medication with you)

	Drug Name	***Dosage***	***How many times a day?***
1			
2			
3			
4			
5			

Please turn over and complete the back. Thank you

SOCIAL HISTORY

Do you exercise? No Yes What kind of activity/how many times a week? _____
Do you smoke? No Yes How many packs per day?_____ Quit (When_____)
Do you drink alcohol? No Yes How much/ what type?_____ Quit (When_____)
Do you use street drugs? No Yes
Occupation (or former occupation if retired) _____
Education: Years in high school _____ Years in college _____ Years in post grad. _____
Marital Status: Single Married Divorced Widowed Separated Other _____

Who lives at home with you?_____

FAMILY HISTORY

Has any blood relative ever had: (circle yes or no)			**Who**
Stroke	No	Yes	_____
Epilepsy or Seizure	No	Yes	_____
Migraine	No	Yes	_____
Memory Loss	No	Yes	_____
Multiple Sclerosis	No	Yes	_____
Other Neurological Illness	No	Yes*	_____ *If yes, please explain _____
Psychiatric Illness	No	Yes	_____
Heart Attack at young age	No	Yes	_____
High Blood Pressure	No	Yes	_____
Diabetes	No	Yes	_____
Tuberculosis	No	Yes	_____

Others:
_____

REVIEW OF SYSTEMS – Please circle and provide brief detail for the medical conditions below which apply to you currently or recently.

Constitutional - General
NONE
Weight loss
Weight gain
Change in appetite
Fever
Fatigue
Excessive Sleepiness
Unable to Sleep

Neurological
NONE
Headache
Concussion
Atrophy
Numbness
Tingling
Trouble walking
Poor balance
Trouble swallowing
Trouble chewing
Trouble talking
Falls
Vertigo
Memory loss
Loss of consciousness
Seizures
Tremor

Eyes
NONE
Blurred Vision
Double Vision
Loss of Vision
Cataracts
Glaucoma

Psychiatric
NONE
Anxiety
Mania
Depression
Psychosis

Musculoskeletal
NONE
Weakness
Neck pain
Back pain
Joint pain
Joint swelling

Cardiovascular
NONE
Chest pain
Angina
Fainting spells
Heart Murmur
Heart Failure
Leg Swelling
High/Low Blood Pressure

Respiratory
NONE
Shortness of Breath
Emphysema
Asthma
Bronchitis
Pneumonia
Chronic cough

Endocrine
NONE
Diabetes
Impotence
Thyroid disease

Skin
NONE
Rash
Moles
Tumors
Discoloration

Genitourinary
NONE
Frequent urination
Painful urination
Urinary urgency
Getting up at night to urinate (more than 2 times a night)
Blood in Urine
Urinary incontinence
Kidney Stones
Sexually Transmitted Disease _____
Impotence
Sexual Dysfunction

Gastrointestinal
NONE
Gastric ulcer
Gastric Bleeding
Abdominal pain
Diarrhea
Hepatitis
Pancreatitis
Rectal bleeding

ENT
NONE
Ringing in the ear
Hearing loss
Sinusitis
Dizziness

Hematological
NONE
Sickle cell disease
Other blood disorders
Enlarged lymph nodes

Patient Information* – *Please complete entire form

Today's Date _____

Date of Birth _____ Sex (circle one): Male Female ❒Single ❒Married ❒Widowed ❒Divorced

Name _____ Social Security # _____

REQUIRED FOR INSURANCE BILLING

Race (circle one)
American Indian/Alaska Native
Asian
Black/African American
Native Hawaiian/Other Pacific Islander
White
Undetermined

Ethnicity (circle one)
Hispanic/Latino
Non Hispanic/Latino
Undetermined

Patient E-mail address: _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ _____ _____
Home *Work* *Cell*

Doctor who referred patient _____ **Doctor's phone #** _____

Preferred pharmacy Name _____ **Pharmacy phone #** _____

Patient employed by _____ **Patient occupation** _____

Emergency contact: Name _____ **Phone** _____

Patient Insurance

CO-PAY $_____ ***Co-pay is due at time of service. There is an additional $10 charge if not collected.***

Primary Insurance _____ **ID #** _____ **Group** _____

Secondary Insurance_____ **ID #** _____ **Group** _____

➢ ***If you are covered under another person's insurance plan (i.e. spouse or dependent), please complete the next two lines of information***

Insurance Cardholder's Name _____ Relationship to patient _____

Date of Birth (cardholder) _____ SSN (cardholder) _____

➢ ***If the patient is a MINOR or has a POA, please complete the next two lines of information***

Parent/Guardian/POA Name _____ Relationship to patient _____

Parent/Guardian/POA date of birth _____ Parent/Guardian/POA SSN _____

Northwest Neurology and Electrodiagnostic Center

CANCELLATION / NO-SHOW POLICY

Many doctors stack patients (book them into overlapping time slots) to avoid having large holes in their schedules. We are very careful not to stack appointments and try to ensure that our patients get the very best care and our full attention. When our patients cancel with little or no notice or simply do not show up for their appointment, that time is wasted and there is no one to fill the hole. (If given proper notice, we are often able to fill it with someone from our lengthy cancellation list.) Due to the increase of last-minute cancellations and no-shows in our appointment schedules, we have no choice but to implement the following:

Appointments that are cancelled less than 48 hours in advance will be billed directly to the patient as follows:

- Procedure = $150.00
- New Patient or 30 minute revisit = $100.00
- Follow up or revisit = $50.00

I have read the above policy, understand and agree to pay the penalty assigned to me if I should no-show or cancel my appointment without the required notice.

_____ _____

Signature of Patient Date

****

Workman's Comp / Labor & Industries claim or Motor Vehicle Accident claim

IMPORTANT NOTICE REGARDING L&I OR INJURY CLAIMS

Reason for visit (diagnosis/symptoms):_____

Claim #: _____ Case manager Name/Phone #: _____

Please indicate which company we are billing this claim to:

- ❒ Labor and Industries
- ❒ Sedgwick
- ❒ Other self-insured _____
- ❒ Car accident insurer _____ First Party PIP or/ Third Party

Claim Mailing Address:

_____

_____

Date of injury: _____ Employer/Place of Injury: _____

Our neurologists are only consulting physicians, and do not act as attending phsycians for L&I / workman's comp claims. You will need to establish an attending physician for management of your claim.

This office will bill L&I (or worker's compensation) for your medical care that is directly related to this injury **ONLY.** It is your responsibility to discuss your appointment with your claims manager to confirm that today's visit is authorized in advance. If you discuss any other ailments with the provider while you are here, or have any routine medical care provided, this will be considered a regular medical visit and **cannot** be billed to L&I. This means that there may be two claims submitted for the same visit, with a portion being billed to L&I and a portion being billed to you or your medical insurance carrier.

If you would rather have your regular medical care managed separately from your L&I care, please make sure you discuss **only** the injury while you are here for your L&I visit. You will then need to make a separate appointment to address your other medical concerns.

If you choose to address your medical care and this injury at the same appointment, claims will be submitted to both L&I and your regular insurance carrier, and you will be responsible for whatever charges you would normally incur for an office visit (copayment, coinsurance, etc.). If your appointment is not authorized by your claim manager in advance, you will be billed for the total charges of the appointment.

I have read the above policy and understand that I may be responsible for charges billed for any medical care provided that is not directly related to the injury referenced on this L&I claim or if the claim/visit is not authorized in advance by my claims manager.

_____ _____

Signature of Patient Date

Authorizations & Notice of Privacy Practices

The following authorization permits us to provide appropriate information to your insurance company, referring doctors, other physicians, and others who are legally entitled. **PLEASE READ CAREFULLY:**

I authorize reports of my evaluations, treatments and any follow-up evaluations to be sent to my referring doctor, my family physician, insurance company that is being billed, as well as any other health care providers that I have or will identify to you. I also authorize release of all pertinent medical information to any hospital or outpatient facility or clinic.

While I am here I permit the employees, doctor, and all other persons caring for me to treat me in ways that they judge are beneficial to me. I understand that the attending physician will explain to me the nature of my condition and his recommended treatment and any associated risk involved. I understand that this care may include diagnostic testing, examinations, medical treatments, and no guarantees have been made to me about the outcome of this case**. I understand that I am responsible for following up on the diagnostic tests and future appointments. I will notify this office at least 48 hours in advance if I need to cancel or reschedule an appointment. I am aware there is a cancellation / no-show policy.**

Please be aware that some of the services that we provide may be non-covered services by your insurance company, but have been deemed to be in the best interest by your physician.

I understand that I am responsible for obtaining an authorized referral if required by my insurance; otherwise I will be billed for services obtained by Ashish M. Trivedi, MD or Meghana Doreswamy, MD.

I understand that payment is due at the time of service, unless my insurance is being billed on my behalf. If I am paying out-of-pocket, I will need to pay 50% of the cost before services are rendered to me. I understand that I am fully and legally responsible for payment of the account, which includes all outstanding balances not covered by Medicare, Employer/Workman's Compensation and/or insurance companies. In event of collection, I agree to pay all outstanding charges including costs of collections. If my account is not paid by my insurance company within 60 days, the account becomes my responsibility. Balances over 60 days are subject to 1.5% service fee. Past due accounts over 90 days are referred to a collection agency as a last resort after effort of voluntary payment have been exhausted.

I understand that this office does not bill third-party auto insurance companies or attorneys.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to a party who accept assignment. I assign all benefits for unpaid services to which I am entitled to Ashish M. Trivedi, MD or Meghana Doreswamy, MD. This assignment will remain in effect until revoked by me in writing.

I acknowledge that I have received the **Notice of Privacy Practices (HIPAA)**. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the practice and myself or others. I am entitled to my chart summary within three business days.

By signing below, I consent for medical treatment and/or diagnostic testing and that I acknowledge that I have read, understand, and agree to the above authorizations. I have received a copy of the Notice of Privacy Policies and Disclosure of Physician Financial Relationships, detailing my health information rights and health care services under Cascade Surgery Associates, PLLC dba NW Neurology & EDX Center. I authorize my insurance benefits to be paid directly to Ashish Trivedi, MD or Meghana Doreswamy, MD (dba Cascade Surgery Associates, PLLC).

Please Sign Below

_____ _____

Patient signature (or legally authorized individual) ***Date***

_____

Patient Name - Print

_____

Name & Relationship if signed on behalf of Patient (parent, legal guardian, personal rep)

CONTINUED ON NEXT PAGE →

GENERAL CREDIT POLICY

Welcome NW Neurology & Electrodiagnostic Center. Our goal is to provide you the highest quality medical care in the most professional manner possible. The following is our policy regarding financial arrangements. If you have any questions whatsoever, please ask. We will be happy to assist any way we can.

The Clinic will bill your insurance company. We ask, however, that you present your identification card and sign any necessary forms. The insurance co-pay is due and payable at the time of service. A Service charge of $10 will be added to the co-pay if you cannot pay the co-pay at the time of service. Any balance, after the insurance payment has been made, is due upon receipt of your statement. If for any reason your insurance carrier rejects your claim, you will be responsible for full payment of your account. IF YOU ARE A MEMBER OF A MANAGED CARE PLAN THAT REQUIRES A REFERRAL FROM A PRIMARY CARE PHYSICIAN (PCP), YOU ARE RESPONSIBLE FOR PRESENTING THE REFERRAL AT THE TIME OF THE APPOINTMENT. WITHOUT THIS REFERRAL FORM IT MAY BE NECESSARY TO RESCHEDULE YOUR APPOINTMENT, or to have you sign a financial responsibility waiver stating that you assume complete responsibility for medical fees incurred.

OTHER INSURANCES OR PRIVATE PAY:

If you do not have insurance, we require payment of your bill at time of service. We will require $250.00 at time of check-in and any remaining charges to be paid at time of check-out. If you are unable to pay your bill in full at the time of service, we will reschedule your appointment. We will assign delinquent accounts to the collection agency at our discretion.

If you have no insurance, a discount is offered when services are paid in cash, check or by VISA/MASTERCARD at the time of service (*CareCredit and 3rd Party Reimbursement is not available for this discount). All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The PATIENT is RESPONSIBLE for all fees, REGARDLESS of insurance coverage. It is customary to pay for services WHEN RENDERED unless other arrangements have been made in advance.

ASSIGNMENT: I hereby authorize payment of the surgical and/or medical benefits directly to the physician. I authorize consent for treatment and release of medical information to my insurance company. THE UNDERSIGNED WILL ULTIMATELY BE RESPONSIBLE FOR ANY BILL INCURRED IN THIS OFFICE.

I authorize the following people full access to my medical information including the ability to pickup written prescriptions for me, discussing my condition or treatment, or have access to my medical records.

_____	_____
Name (please print)	***Relationship (Parent, relative, legal guardian, personal rep)***
_____	_____
Name (please print)	***Relationship (Parent, relative, legal guardian, personal rep)***
_____	_____
Name (please print)	***Relationship (Parent, relative, legal guardian, personal rep)***

_____ **_____**

Patient or legally authorized individual signature ***Date*** ***Time***

This form will be retained in your medical record. To get copies of your records contact 253-333-1637. Please allow 48 hours for any records request.

Our health care providers may recommend that you use, as part of a treatment program, one or more health related products. Our practitioners recommend these products because they believe that your health will benefit from them. We want you to know that because of our belief in the integrity and quality of these products, our clinic is a distributor of some of them and, in that role, may receive economic benefit from the sale of these items. Many of these items are available through our clinic for your convenience, but there are other sources for these items that you are welcome to use. Please ask to speak with our practitioners or administrators if you have any concerns about product recommendations in light of this information.