

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

I understand and acknowledge that my insurance coverage is a contract between me and my insurance company and that I am personally responsible for all medical expenses incurred during evaluation and treatment by the providers at Spine West, PLLC. I understand that as a courtesy my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims. If I am a member of a PPO or an HMO I am required to make my co-pay and co-insurance payments in a timely fashion, and I am responsible for keeping my primary care physician referrals current.

### CREDIT/DEBIT CARD ON FILE

It is the policy of Spine West, PLLC to retain on file a credit/debit card number for all active patients. **This information is kept strictly confidential** and will only be used for payment of fees to Spine West, PLLC.

Spine West will submit claims to your insurance company following your visit. Once the billing office receives final payment and/or disposition from your insurance carrier the office will bill your credit/debit card on file for any amounts not paid by your insurance carrier that are considered patient responsibility. Examples of these amounts may be unpaid co-pays, co-insurance and deductibles. In many cases you will have already received an EOB (Explanation of Benefits) from your insurance company showing the unpaid amounts. This will in no way compromise your ability to question your insurance carrier's determination of payment.

Please familiarize yourself with our **No-Show/Cancellation Policy** as this \$50 fee would be charged to your payment card on file.

**If your balance due exceeds \$100.00** Spine West, PLLC will call to inform you of the amount to be charged to your credit/debit card.

Authorization: *I authorize Spine West to charge my payment card for the balance of fees not paid by my insurance carrier. I understand that if the amount is greater than \$100.00 I will be called and informed of the amount charged to my credit/debit card.*

Name of Cardholder (print) \_\_\_\_\_ (circle one) VISA M/C DISCOVER (circle one) DEBIT CREDIT  
 Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiration Date \_\_\_\_\_  
 Signature of Cardholder \_\_\_\_\_ Date \_\_\_\_\_ verified

### CANCELLATION/ NO-SHOW POLICY

You must notify Spine West no later than 12 noon the business day prior to your appointment to change or cancel your appointment. If notification comes in less time your account will be assessed a \$50 cancellation fee. No notification of cancelling or rescheduling your appointment will cause a \$50 no-show fee to be added to your account.

*LAST MINUTE CANCELLATIONS AND NO-SHOWS PREVENT OTHERS FROM GETTING TIMELY SERVICE. THANK YOU FOR YOUR UNDERSTANDING.*

I have read and understand the *Cancellation/No-Show Policy* for Spine West. I understand there will be a \$50 fee added to my account for any appointments not cancelled or rescheduled by 12 noon the business day prior to my appointment as well as any appointments no-showed. I understand my payment card on file will be used to collect said charges.

Signature of Patient/Responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

# New Patient Intake Form

## Patient Information

Patient Name: \_\_\_\_\_  
(last name) (first name) (initial)

How do you wish to be addressed? \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex:  Male  Female Marital Status:  Single  Married  
 Divorced  Widowed  
 Significant Other

Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_

Work phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_

How did you hear about Spine West? \_\_\_\_\_

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Primary Insurance Company: \_\_\_\_\_

Name of Insured if other than patient: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group#: \_\_\_\_\_

Work Comp or Auto Claims  Work Comp  Auto

Claim #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Insurance Adjustor: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

Nurse Case Manager: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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I authorize Spine West, PLLC to release any medical information to my insurance carrier, PCP's and therapists. I assign all benefits from said claims to Spine West, PLLC. I further agree that a photocopy of this agreement shall be as valid as the original. Should my injury be work related, I also authorize release of any medical information related to that injury to my employer or their representative.

Patient or responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

# New Patient Intake Form

Name \_\_\_\_\_ Date \_\_\_\_\_  
 DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex: O M O F  
 Height \_\_\_\_ Weight \_\_\_\_ Handedness: O R O L  
 Who referred you here? \_\_\_\_\_  
 Who is your PCP? \_\_\_\_\_

## HISTORY OF CURRENT PROBLEM

Date you current problem began? \_\_\_\_\_  
 Did you ever have this problem before? O Yes O No  
 If yes, when? \_\_\_\_\_

### Is your problem the result of a (n)...

- O Auto Accident O Injury on the job  
 O Recreational Injury O No known cause  
 O Other \_\_\_\_\_

Describe the original injury if known: \_\_\_\_\_

### Who has treated you for this problem?

Dr. \_\_\_\_\_ City: \_\_\_\_\_  
 Dr. \_\_\_\_\_ City: \_\_\_\_\_

### TESTS you have had for this problem:

- O X-Ray O CT scan O MRI O EMG O Other

Date(s) of test(s): \_\_\_\_\_

Where done: \_\_\_\_\_

### TREATMENTS you have tried for this problem:

- O Physical Therapy O Acupuncture  
 O Chiropractor O Injections/Nerve blocks  
 O Home exercises O Psychological counseling  
 O TENS Unit O Massage  
 O Braces O Ice/heat  
 O Other \_\_\_\_\_

Have you had SURGERY for this? O Yes O No

Date and name of surgery: \_\_\_\_\_

### MEDICATION you have tried for this problem:

- O Aspirin O Ibuprofen O Naproxen(Aleve)  
 (Advil/Motrin)  
 O Tylenol O Celebrex O Vioxx  
 O Paxil O Prozac O Trazadone  
 O Amitriptyline O Nortriptyline O Neurontin  
 (Elavil) (Pamelor)  
 O Ultram O Muscle Relaxers O Lyrica  
 (Flexeril/Skelaxin/Soma)

Narcotic Name(s) \_\_\_\_\_

Other meds tried: \_\_\_\_\_

## CURRENT PROBLEM:

### How would you describe your problem?

- O Constant O Occasional but goes away  
 O Frequent but goes away O Rare

### Is your problem worse in the...

- O Morning O Evening O Nighttime

### What makes your problem worse?

- O sitting O standing O walking  
 O other \_\_\_\_\_

### What makes your problem better?

- O sitting O standing O walking  
 O other \_\_\_\_\_

## AVERAGE PAIN INTENSITY: Fill in bubble below:

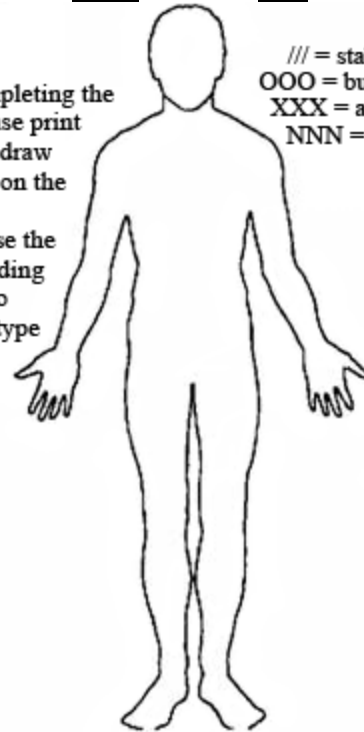
No Pain

Excruciating

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○  
 0 1 2 3 4 5 6 7 8 9 10

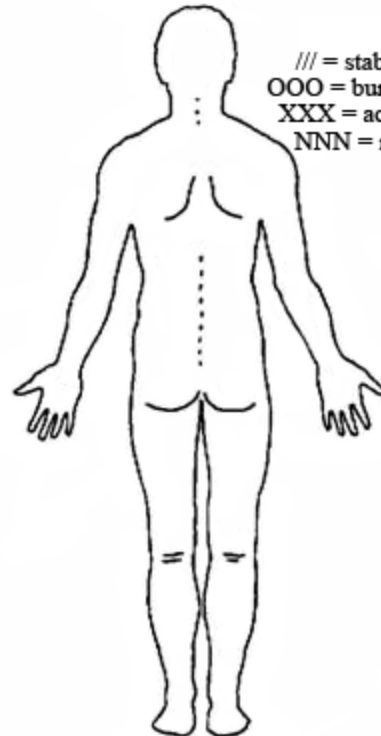
**Right** **Left**  
**Front**  
 After completing the form, please print it out and draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

/// = stabbing pain  
 OOO = burning pain  
 XXX = aching pain  
 NNN = numbness



## **Back**

/// = stabbing pain  
 OOO = burning pain  
 XXX = aching pain  
 NNN = numbness



**Left**

**Right**

# New Patient Intake Form

**Do you have...**

- Fevers or chills (unexplained)     Yes
- Weight loss (unexplained)         Yes
- Incontinence (leak urine or stool)  Yes
- Numbness in arms or legs          Yes
- Weakness in arms or legs          Yes
- Sleep problems                       Yes
- A lawyer for this problem          Yes
- How long can you sit? \_\_\_\_\_
- How long can you stand? \_\_\_\_\_
- How far can you walk? \_\_\_\_\_
- What can you NOT do because of this problem?  
\_\_\_\_\_

**OTHER MEDICAL PROBLEMS:**

Do you have or have you ever had in the past any of the following medical problems?

- glaucoma                                 kidney disease
- cataracts                                    diabetes
- sinus infections                          hypothyroidism
- anemia                                       hyperthyroidism
- bleeding problems                       arthritis
- AIDS/HIV                                  polio
- high blood pressure                     psoriasis
- high cholesterol                         melanoma
- rheumatic fever                          cancer
- lung disease                               stroke
- asthma                                      seizures
- heart disease                              migraine headache
- aspirin sensitivity                       nerve problems
- ulcers                                       depression
- hepatitis                                  bipolar disorder
- constipation                              osteoporosis
- diarrhea

Other: \_\_\_\_\_

**ANY PAST:** Name type and date (month/yr), if known.

**SURGERIES:** \_\_\_\_\_

**CAR ACCIDENTS:** \_\_\_\_\_

**WORK INJURIES:** \_\_\_\_\_

**SOCIAL HISTORY:** Do you currently ...

- Smoke?             Yes, How much? \_\_\_\_\_  No
- Drink alcohol?    Yes, How much? \_\_\_\_\_  No
- Drink caffeine:    Yes, How much? \_\_\_\_\_  No
- Use recreational drugs:  Yes                                 No

Marital status:    S     M     D     W     SO

Do you have any children:  Yes - Ages: \_\_\_\_\_  No

Who lives with you? \_\_\_\_\_

List your **hobbies**? \_\_\_\_\_

How **often** do you exercise? \_\_\_\_\_

What do you do for exercise? \_\_\_\_\_

Highest Level of education:

- Grade School    Junior High     High School/GED
- Some College    College Grad    Post Graduate

Past Jobs: \_\_\_\_\_

**WORK HISTORY:**

Which of the following best describes you currently?

- Currently working:**  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
How long working there? \_\_\_\_\_  
Any current work restrictions? \_\_\_\_\_
- Not working because of this problem:**  
Date last worked? \_\_\_\_\_  
How long working there until your injury? \_\_\_\_\_
- Not working due to another health problem:**  
Describe \_\_\_\_\_
- Unemployed**                                 **Student**                                 **Homemaker**
- Retired:** When \_\_\_\_\_ Occupation \_\_\_\_\_

**AVERAGE DAILY STRESS LEVEL:**

- None             Mild             Moderate             Extreme

**FAMILY HISTORY:**

Have any of your parents (or close relatives) had...

- Neck or back problems
- Other muscle or bone or nerve problems
- Bleeding problems
- Cancer – Describe: \_\_\_\_\_
- Disability from work
- Diabetes
- Other \_\_\_\_\_

**MEDICATION ALLERGIES:**

Attach additional sheets if necessary.

DRUG	REACTION

**CURRENT MEDICATIONS, vitamins, herbs**

List every thing you take daily or as needed.

Attach additional sheets if necessary.

NAME	DOSE	FREQUENCY

**PHARMACY:** \_\_\_\_\_

**Location/Phone:** \_\_\_\_\_

List any other concerns you have: \_\_\_\_\_

What do you hope we can accomplish in today's visit?  
\_\_\_\_\_  
\_\_\_\_\_

# New Patient Intake Form

## CONSENT FOR USE, DISCLOSURE & RELEASE OF HEALTH INFORMATION

### SECTION A – PATIENT GIVING CONSENT

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Telephone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### SECTION B – TO THE PATIENT

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we obtain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting this office.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

### SECTION C – CONSENT TO RELEASE

I give my permission for Cliff Gronseth, MD, John Tobey, MD and Mindy Gehrs, MD to discuss any of my medical information with:

(Other than Physicians or Insurance companies as listed above)

Name(s): \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

I understand that I must provide written change to the office of Cliff Gronseth, MD, John Tobey, MD and Mindy Gehrs, MD to change/delete this information.

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_