Idaho Joint & Spine, PC

1760 N Mitchell St, Boise, ID 83704

___NEW PATIENT
___INFO CHANGE

PATIENT INFORMATION

Patient Name:_____
Address:_____
City, State, & Zip:_____
Date of Birth:_____Age:_____Sex:_____
Marital Status:_____Spouse's Name:_____
Social Security Number:_____

Cell Phone:_____
Home Phone:_____
Email:_____

Preferred Pharmacy Name:_____
Location Details:_____
_____

Employer:_____
Employer's Phone #:_____

Primary Care Provider (PCP):_____
Do you want your records sent to your PCP? □ YES □ NO

Policy Holder Info OR Responsible Party □ MYSELF

(If someone other than patient is responsible for the bill we will need the following. Don't complete the following if you are the policy holder or responsible party.)

Relationship to Patient: O Spouse O Parent O Other

Name:_____
Date of Birth:_____
Social Security Number:_____

Sponsor Social Security Number Required for Tricare

Address:_____
City, State, & Zip:_____
Cell Phone:_____
Employer:_____

EMERGENCY CONTACT INFORMATION

Name:_____
Relationship to Patient:_____
Phone Number:_____

Referred By:

INSURANCE INFORMATION

Please select one: □ Health Insurance □ Worker's Comp* □ Auto Accident* □ Self

* Is this visit due to: □ Injury on the job? ___/___/___ date of injury □ Automobile accident ___/___/___ date of injury

Primary Insurance: _____ Policy Number_____

Secondary Insurance:_____ Policy Number_____

Worker's Comp Insurance Company: _____ Claim Number_____
Worker's Comp Adjuster: _____ Phone: _____

Liable Insurance Company Name: _____ Claim Number_____
Attorney: _____ Phone: _____

By signing below, I acknowledge that the information I provided is correct to the best of my ability.
Assignment of Benefits and Release of Information: I authorize my insurance payments to be paid directly to Idaho Joint and Spine, PC. I understand that I am financially responsible for all non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.
Notice of Privacy Practices Acknowledgment: By signing below, I acknowledge that I have been shown a copy of the Notice of Privacy Practices. I understand I am entitled to receive a copy of this document.
Medicare Patients: I authorize Idaho Joint and Spine to release to the Centers of Medicare and Medicaid services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made to Idaho Joint and Spine who accepts assignment.

_____ _____
Date Patient Signature (If not the patient, please indicate legal relationship)

Office Use Only: _____Insurance Cards Copied _____ID Copied _____Practice Fusion _____AMD

Idaho Joint and Spine

James Whitaker, DO Ginger Powers, NP

Physical Medicine and Rehabilitation

1760 N Mitchell St, Boise, ID 83704 (208) 322-5922 ph (208) 576-6932 fax

FINANCIAL POLICIES

Thank you for choosing to involve us in your healthcare. We are committed to providing you with quality healthcare. Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Thus, this policy is designed to outline our financial policies. Please read it, ask any questions you may have, and sign the bottom of the form. Additional questions can be addressed to our office manager, Sarah, at (208) 322-5922 or info@idahojointandspine.com. If you would like a copy, please let us know.

1. **Missed and Cancelled less than 24-hour appointments**. Appointments which are cancelled with less than 24-hour notification or "No Show" will be subject to a **$40.00 fee**. We understand that situations arise in which you must cancel your appointment. It is requested that **if you must cancel your appointment you provide more than 24-hour notice**. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. The Cancellation and "No Show" fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. It is our policy that after three (3) "No Show" appointments or cancellations less than 24 hours during a 12-month period then we reserve the right to discharge you from our practice.
2. **Late Arrival**. Your time is valuable. In order to respect your time and that of other patients, we ask that you **arrive 5 minutes early**. If you are more than 5 minutes late, we may not be able to keep your appointment slot and you may have to reschedule. If this happens, you may be subject to fees. If you are regularly late to appointments then we reserve the right to discharge you from our practice.
3. **Massage Appointments**. Massage Therapy appointments which are cancelled with less than 24-hour notification or "No Show" will be subject to a **$40.00 fee** and fall under #1 above.
4. **Insurance**. We participate in most insurance plans, including Medicare and Medicaid (Idaho). If you are insured by a plan we do not participate with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment is expected in full each visit until we can verify your coverage. Knowing your insurance coverage is your responsibility. We will attempt to assist in verifying benefits and coverage, but this is not a guarantee. Please contact your insurance company with any questions you may have regarding your coverage.
5. **Co-payments, Co-insurances, and Deductibles**. All co-payments, co-insurances, and deductible amounts must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect these amounts from patients can be considered fraud and violate our contracts. Please help us in upholding the law and keeping our insurance contracts by paying your portions at each visit.
6. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of visit.
7. **Proof of insurance**. All patients must complete our patient information before seeing the doctor. We must obtain a copy of your driver's license or valid legal ID and current valid insurance to provide proof of insurance. If you fail to provide us with correct information in a timely manner, you may be responsible for the balance of your claim. If the coverage you provide is not valid, you will be responsible for the balance.
8. **Insurance Changes**. You are responsible for providing new insurance to our office in a timely manner. Providing change of insurance information may result in delayed or incorrect claims to insurance and may result in denials. You will be responsible for these charges.
9. **Claims Submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
10. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Please be aware that if your insurance company requires a referral to see a specialist and it is your responsibility to ensure that happens.
11. **Nonpayment**. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Please sign that you have read, understand and agree to this Financial Policy.

_____ _____

Patient Name (Please Print) **Date of birth**

_____ _____

Signature of Patient or Patient Representative **Date**

Idaho Joint and Spine

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COMMUNICATIONS CONSENT AND PREFERENCES FORM

PATIENT NAME (Printed):_____ **DATE OF BIRTH**: _____

I, the undersigned, authorize Idaho Joint and Spine to communicate with me regarding appointment reminders, billing information, and other healthcare operations related communications via the following methods:

1. **Text Message**
   ☐ **YES**, I consent to receive text messages. I understand that carrier charges may apply. I understand that I **cannot** cancel or change appointments by text and **must** call the office.

   Phone Number: _____
   ☐ No, I do not consent to receive text messages.
2. **Confidential Voicemail**
   ☐ **YES**, I consent to receive voicemails with confidential information.

   Phone Number: _____
   ☐ No, I do not consent to receive voicemails with confidential information. I understand that I may still receive voicemails with basic nonsensitive information.
3. **Email**
   ☐ **YES**, I consent to receive emails. I understand that there are risks with email communication.

   Email Address: _____
   ☐ No, I do not consent to receive emails.
4. **Appointment Reminder Preference**: ☐ Text Reminder ☐ Voice Reminder
   ** If none are selected, we will default to text reminder. Please reply to reminders to confirm. If confirmation of appointment is not received, we will call the day of the appointment to confirm.*
5. **Statement Preference**: ☐ Online Only ☐ Paper Only ☐ Online and Paper

Limitations voluntarily placed on communications:

_____

Risks of Communication:
I understand that while efforts will be made to protect my information, there are inherent risks in electronic communication, including potential interception of messages.

Right to Revoke Consent:
I understand that this is valid until such time as I revoke this consent. I can revoke this at any time by providing written notice. If I revoke this, my revocation will not affect prior actions taken in reliance of my authorization.

My Rights and Obligations:
I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I have a right to receive a copy of this authorization if requested.

If my phone number or email address change I must inform Idaho Joint and Spine in a timely manner.

SIGNATURE:_____ **DATE**: _____

PRINTED NAME AND RELATIONSHIP IF NOT SIGNED BY THE PATIENT:_____

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Physical Medicine and Rehabilitation
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NEW PATIENT QUESTIONNAIRE

Printed Name:_____ **DOB**: _____ **Appt Date**: _____

1. What is the location of your pain or symptoms? Please include right or left if applicable.

   _____

   _____

2. Select all that apply when describing your pain.

☐ Aching	☐ Nagging	☐ Pressure	☐ Stabbing
☐ Burning	☐ Numbness	☐ Sharp	☐ Tender
☐ Dull	☐ Pins and Needles	☐ Shooting	☐ Throbbing

3. When and how did your pain or symptoms begin? _____

   _____

4. How often do you have pain? _____

5. Do you have numbness, tingling, weakness or radiating symptoms? ☐ Yes ☐ No

   If yes, describe: _____

6. Have you had a previous injury or surgery to this area? ☐ Yes ☐ No

   If yes, describe: _____

7. What makes your pain WORSE?

☐ Sitting	☐ Standing	☐ Decreased Activity	☐ Heat	☐ Touch
☐ Walking	☐ Exercise	☐ Increased Activity	☐ Cold	☐ Nothing

   Other:_____

8. What makes your pain BETTER?

☐ Sitting	☐ Standing	☐ Decreased Activity	☐ Heat	☐ Touch
☐ Walking	☐ Exercise	☐ Increased Activity	☐ Cold	☐ Nothing

   Other:_____

9. Have you had any changes in bowel or bladder function? ☐ Yes ☐ No

10. Have you tried Physical Therapy? ☐ Yes ☐ No

    Length of Treatment: _____ Did it help? _____

11. Have you tried Chiropractic Treatment or Manipulation? ☐ Yes ☐ No

    Length of Treatment: _____ Did it help? _____

12. Select all the methods you have tried to relieve your pain. ☐ **NONE of the Below**

☐ Acupuncture	☐ Bracing	☐ Massage Therapy
☐ Cold	☐ Home Exercise Program	☐ Manipulation
☐ Heat	☐ Relation Techniques	☐ Weight Loss

☐ Other_____

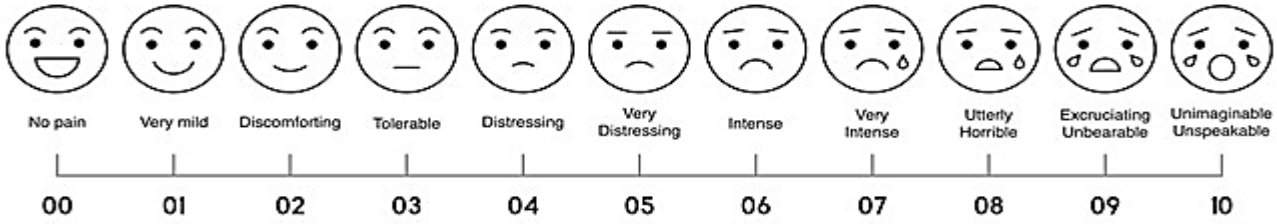
13. Have you had any nerve blocks, injections, or procedures performed? ☐ Yes ☐ No

	How Many?	Date Last Performed
☐ Cervical Epidural Steroid Injection	_____	_____
☐ Thoracic Epidural Steroid Injection	_____	_____
☐ Lumbar Epidural Steroid Injection	_____	_____
☐ Cervical Facet Block	_____	_____
☐ Thoracic Facet Block	_____	_____
☐ Lumbar Facet Block	_____	_____
☐ Cervical Facet Denervation (RFA)	_____	_____
☐ Thoracic Facet Denervation (RFA)	_____	_____
☐ Lumbar Facet Denervation (RFA)	_____	_____
☐ Sacroiliac (SI) Joint Injections	_____	_____
☐ Spinal Cord Stimulator	_____	_____
☐ Intrathecal Pump	_____	_____
☐ Trigger Point Injections	_____	_____

Other:_____

14. Using the pain scale below, rate your current pain level using a scale 0-10: _____

15. What number best describes your pain <u>on average</u> in the past week? _____



16. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

17. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

18. Do you have any of the following medical conditions? ☐ Yes ☐ No

☐ COPD	☐ Kidney Problems	☐ Psoriasis
☐ Depression	☐ Liver Problems	☐ Rheumatoid Arthritis
☐ Diabetes	☐ Lupus	☐ Seizures
☐ Fibromyalgia	☐ Multiple Sclerosis	☐ Sleep Apnea
☐ Heart Attack	☐ Osteopenia	☐ Stroke
☐ High Blood Pressure	☐ Osteoporosis	☐ Thyroid Disease

Other _____

19. List any surgical or injury history not included at the beginning? ☐ **NONE**

_____

20. Do you use any of the following? ☐ **NONE of the Below**

☐ Single Point Cane	☐ Front Wheel Walker	☐ Electric Wheelchair
☐ Quad Cane	☐ Rollator Walker	☐ Manual Wheelchair
☐ Artificial Limb	☐ Brace/Splint	

Other _____

21. Do you need assistance with any the following: ☐ **NONE of the Below**

☐ Bathing	☐ Eating	☐ Meal Preparation	☐ Toilet Use
☐ Dressing	☐ Hair Care	☐ Shaving	☐ Walking
☐ Driving a Car	☐ House Work	☐ Shopping	☐ Yard Work

Other _____

22. Do you have any MEDICATION ALLERGIES? ☐ Yes ☐ No If yes, please list below.

_____

23. Do you have any other allergies? ☐ Yes ☐ No If yes, please list below.

_____

24. What Medications do you take? ☐ **NONE**

Name of Medication	Dosage / Amount	Frequency / How Often?

25. Please select any additional medications that you have previously tried. ☐ **NONE**

☐ Amitriptyline	☐ Cymbalta	☐ Ibuprofen/Naproxen	☐ Fentanyl
☐ Nortriptyline	☐ Effexor	☐ Celebrex	☐ Hydrocodone
☐ Gabapentin	☐ Trazadone	☐ Meloxicam	☐ Oxycodone
☐ Lyrica	☐ Muscle Relaxers	☐ Low Dose Naltrexone	☐ Tramadol

Other _____

OPIOID PAIN MEDICATION

26. Do you have some form of pain now that requires opioid medication each and every day? ☐ Yes ☐ No

If NO, skip to Family History

27. Do you take your medication as prescribed? ☐ Yes ☐ No ☐ Uncertain

28. How frequently do you take pain medication in a 24-hour period?

☐ Not Every Day ☐ 1-2 Times ☐ 3-4 Times ☐ 5-6 Times ☐ More than 6 Times

29. How do you prefer to take pain medicine?

☐ Regular Basis ☐ When Necessary ☐ Does Not Take Pain Medication

30. When did you last take the pain medication? _____

31. What percent of relief do your opioids provide?

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

32. If you take pain medication, how many hours does it take before the pain returns? _____

33. Are you any more functional from using opioids? ☐ Yes ☐ No

If yes, describe: _____

34. Do you feel that your mood has improved from opioid therapy? ☐ Yes ☐ No

If yes, describe: _____

35. Has your quality of life improved? ☐ Yes ☐ No

If yes, describe: _____

36. Do you have any side effects from your opioids? ☐ Yes ☐ No

If yes, describe: _____

FAMILY HISTORY

37. List any illnesses in your family. (Ex. diabetes, heart disease, high BP, cancer) _____

_____

SOCIAL HISTORY

38. Tobacco Status: ☐ Non-smoker ☐ Ex-smoker ☐ Light (1-9) ☐ Mod (10-19) ☐ Heavy (20+) ☐ Chew

How many years have you used tobacco? _____ If quit, date: _____

39. How often you do drink alcohol per week?

☐ None ☐ 3 or Less Drinks ☐ 4-7 Drinks ☐ 8-12 Drinks ☐ 13 or More Drinks

40. Was there ever a time in your life when you may have had or do have an alcohol problem? ☐ Yes ☐ No

41. Did you ever or do you now use illegal drugs? ☐ Yes ☐ No

If yes, which ones? _____

42. Current marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

43. Select your highest level of education.

☐ High School ☐ Some College ☐ College Degree ☐ Advanced Degree ☐ Trade School ☐ Other

Other: _____

44. Are you currently employed? ☐ Yes ☐ No

If **Yes**, current employment: _____

☐ Full Time ☐ Part Time

If **No**, select one of the following:

☐ Unemployed ☐ Retired ☐ Stay at Home Parent ☐ Disabled ☐ Other

If **Unemployed**: How long have you been out of work? _____

What was your occupation? _____

How do you spend your days? _____

Is unemployment due to pain? ☐ Yes ☐ No

If **Retired**, what was your previous career/employment? _____

If **Disabled**: How long have you been out of work? _____

What was your occupation? _____

How do you spend your days? _____

Are you currently on disability? ☐ Yes ☐ No

If no, are you applying for disability? ☐ Yes ☐ No

If **None** of the above apply, please explain: _____

45. List your hobbies and interests: _____

_____

46. Any other information the providers may need to know: _____

_____

**** I attest that this information is true and accurate to the best of my knowledge.***

PATIENT SIGNATURE _____ **DATE** _____