WALKER SPINE AND SPORTS SPECIALISTS

PATIENT INFORMATION AND DISCLOSURE FORM

Referring Dr._____ Date_____

Patient's Last Name_____ First_____ Middle_____ Sex_____

Home Address: _____City_____State_____Zip_____

Patient's Social Security Number_____ Home _____Work_____

Cell_____ Text Message Reminders:Yes_____No____

Age_____ Birthdate_____ Single_____ Married _____ Divorced_____ Widowed_____

Race: ___American Indian /___Asian /___Black/ ___ Hawaiian/ ___ Unknown /___White **Ethnicity:** ___Hispanic/ ___Non-Hispanic /___Unknown

Patient's Employer_____ Language_____

Spouse's or Guardian's Name_____ Employer_____ Phone_____

Emergency Contact?_____Phone_____

Patient's Email_____Email Reminders: Yes____ No____

INSURANCE INFORMATION

Date of injury or date of onset of symptoms_____

Is this a Workman's Compensation claim: Yes_____ No_____

Place injury occurred: _____Home _____School _____Auto _____Other

PRIMARY INSURANCE COMPANY NAME_____

Subscriber's Name_____

Patient Relationship to Subscriber. Circle one (self, spouse, child) Subscriber's date of birth_____

I.D. No._____ Group _____

SECONDARY INSURANCE COMPANY NAME_____

Subscriber's Name_____

I.D. No._____ Group No._____

Patient Relationship to Subscriber. Circle one (self, spouse, child) Subscriber's date of birth_____

INFORMATION RELEASE

I hereby authorize Walker Spine and Sports Specialists to release any information acquired in the course of my examination or treatment to the insurance carriers. I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to Walker Spine and Sports Specialists.

CONSENT TO TREAT: I consent to treatment at Walker Spine and Sport's Specialists for services or supplies that have been or may be ordered by the physician. I understand that treatment may include but is not limited to: radiological examinations, injections, laboratory procedures, physical therapy, nursing care or medical and surgical treatment.

Please read and sign below: I recognized the inherent risks of transmission of contagious diseases, especially during surgery and I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/AIDS, herpes, etc. when deemed necessary by the physician. Questions should be discussed with your physician.

I hereby authorize the attending physician(s) to furnish the insured's insurance company all information which said insurance company may request from time to time, but not to exceed my indebtedness to said physicians and surgeons.

I AUTHORIZE WALKER SPINE AND SPORTS SPECIALISTS TO RECEIVE ASSIGNMENT OF INSURANCE PAYMENTS. IF THE CUSTOMARY CHARGES ARE MORE THAN THE BENEFITS ALLOWED UNDER RESPONSIBLE PARTY'S INSURANCE PLAN, I AGREE TO PAY THE DIFFERENCE. I UNDERSTAND THAT REGARDLESS OF INSURANCE COVERANGE I AM RESPONSIBLE FOR ALL CHARGES AND PAYMENTS.

I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in the doctor's files and authorize the insurance company to accept the photocopy.

I release you from all legal responsibility or liability that may arise from this authorization. This authorization shall continue and be in force and effect until revoked in writing by me.

OWNERSHIP DISCLOSURE: Please note that the physicians of Walker Spine and Sport's Specialists, L.L.C. have individual ownership interests in Mountain View Hospital and that they may refer you for services at Mountain View Hospital. If you would prefer to receive care or testing at another hospital or facility, please discuss this with your treating physician so that he or she may determine if that is possible.

RESPONSIBLE PARTY'S SIGNATURE_____ **DATE**_____

NAME_____ AGE_____ MARITAL STATUS (circle) S M D W

OCCUPATION_____ Are you right or left handed? _____

REFERING PHYSICIAN_____ PRIMARY CARE PHYSICIAN _____

HISTORY OF PRESENT ILLNESS:

1. Where do you hurt? _____
2. When did it start? (Date if known) _____
3. What caused it to start? (Car accident, work injury, sports injury, don't know, etc.)_____

_____

4. Have you ever had a similar pain problem in the past?_____
5. How would you describe the pain? (Sharp, shooting, dull, achy, cramping, etc.) _____

_____

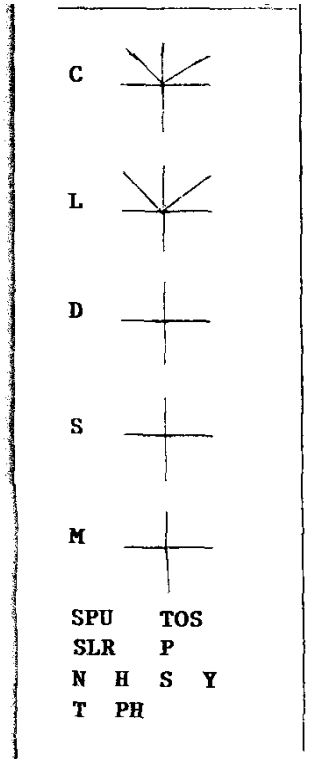
6. Does it radiate anywhere, and if so, where? _____
7. Is it constant or intermittent? _____
8. Mark on the line below your estimation of your current average pain.

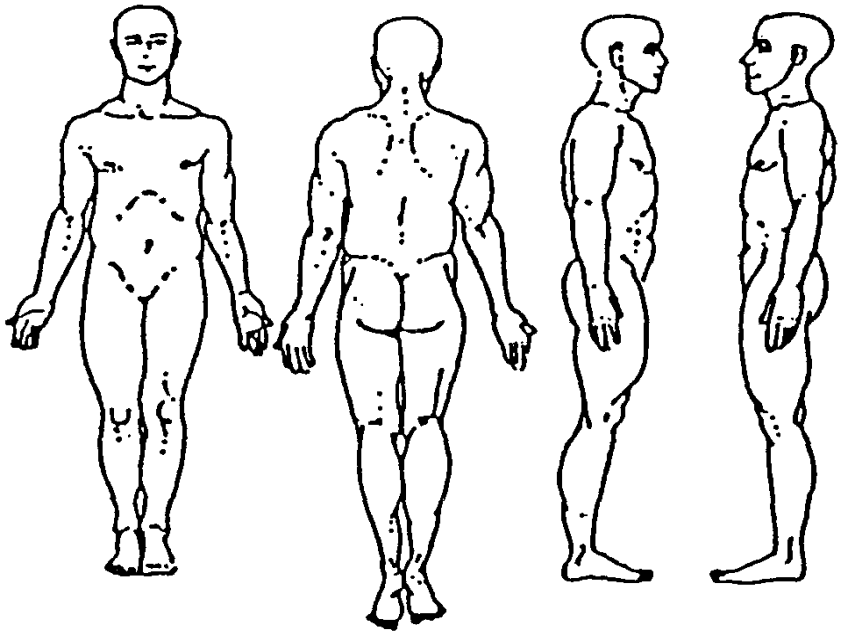
0_____10

No Pain Unbearable Pain

9. Please use the drawing below to mark the areas where you feel pain.

Office Use Only





(Over - Please complete both sides of page)

10. What makes your pain better? _____

11. What makes your pain worse? _____

12. Have you ever had surgery for your pain? _____

13. What treatments have you tried? (physical therapy, injections, chiropractor, etc.) _____

_____

14. What other doctors have you seen for your pain or injury so far? _____

_____

15. What medications have you taken for your pain in the past? _____

16. What pain medications are you taking now? (including over the counter medications)

Name	Dosage	Frequency	Date Started

1. Do you have weakness in any parts of your body? _____ Where? _____

2. Do you have any numbness (pins & needles or cold feeling) in parts of your body? _____

Where? _____

3. Do you have any problems with loss of bowel or bladder control? _____

4. Does your pain increase if you cough or sneeze? _____

_____

1. What tests have you ever had for this problem? (blood tests, x-rays, MRI, CT scan, bone scan, EMG, Myelogram, other)

_____

2. Were any of them abnormal? _____ In what way? _____

(PLEASE BRING TEST RESULTS WITH YOU TO YOUR APPOINTMENT)

3. Please check which of these symptoms, if any, you have noticed associated with your pain.

____ Headaches	____ History of cancer	____ Morning stiffness
____ Fever	____ Weight loss or gain	____ Joint swelling or redness
____ Chills, night sweats	____ Loss of appetite	____ Giveway or locking of joints
____ Trouble sleeping	____ Trouble swallowing	____ Loss of motion in joints
____ Night-time pain	____ Blurred vision	____ Other

PAST MEDICAL HISTORY:

NAME_____**DATE**_____

1. Do you have any medical problems? (cancer, diabetes, high blood pressure, heart disease, neurologic problems, arthritis,other)_____

2. Please list any medicines you are taking for any other medical conditions_____

_____

3. Are you allergic to any medicines? _____ Which ones?_____

4. Have you ever had surgery of any kind? _____ For what?_____

5. Have you ever had a fractured bone? _____ Which one? _____

FAMILY HISTORY:

1. Please list medical problems in your parents, grandparents, children, siblings, or other relatives (cancer, migraines, or problems with heart, lungs, kidney, arthritis, etc.) _____

_____

FUNCTIONAL HISTORY:

1. Do you need help with any activities of daily living? _____

2. Do you use a cane, brace, corset, or other assistive devices to help with these activities? _____

What? _____

3. How frequently do you exercise? _____ What do you do?_____

4. Has your activity level been altered by your injury or pain? _____

SOCIAL HISTORY:

1. How many children do you have? _____

2. Do you drink alcohol? _____ How much? _____

3. Smoking status: ___current every day smoker ___ smoke sometimes ___former smoker ___never smoked

4. Do you use any drugs not prescribed by a physician (including steroids)? _____

5. How long have you been employed at your present employment? _____

6. When did you last work? _____

7. If you were off work due to your problems, please list the dates: _____

8. Are you on a modified or another type of work due to your problems? _____

9. Have you ever had a work-related injury before? _____ Has your spouse? _____

10. What level of education have you completed? _____

11. Are you involved in a law suit because of your pain? _____

Please circle only the symptoms that you have, do not circle the general category.

NAME: **DATE:**

Review of Systems

General/Constitutional – fevers, chills, night sweats, weight loss, weight gain, decreased appetite, sleep disturbance, night pain

Musculoskeletal – morning stiffness, swelling in joints, loss of motion in joints, painful joints

Neurologic – numbness, tingling, weakness, balance difficulties, dizziness, headache, speech difficulties, memory loss, seizures

Ophthalmologic – visual changes, double vision, blurred vision

ENT – hearing problems, dry mouth, difficulty swallowing

Cardiovascular – heart problems, irregular heartbeat, chest pain, high blood pressure, low blood pressure, shortness of breath with exertion, swelling in feet

Respiratory – shortness of breath, asthma, breathing problems

Peripheral Vascular – cold extremities, pain/cramping in legs after exertion, blood clots in legs, ulceration of feet, absent pulses in feet

Genitourinary – incontinence, urgency, burning with urination, painful urination, blood in urine, frequent urination, kidney problems

Gastrointestinal – incontinence, diarrhea, constipation, swallowing difficulties, decreased appetite, heart burn, nausea, vomiting, black stool, blood in stool, abdominal pain, nausea, vomiting, stomach problems

Hematologic – bleeding problems, use of blood thinners, anemia, easy bruising

Skin – rashes, psoriasis, hair changes, nail changes, scaly lesions of skin/scalp

Immunologic - seasonal allergies, infectious diseases

Endocrine – thyroid problems, diabetes, osteoporosis, excessive thirst, frequent urination

Psychiatric – depression, anxiety, suicidal thoughts, eating disorder, other

WALKER
Spine and Sports Specialists

Specialists in Physical Medicine & Rehabilitation
2319 Coronado St., Idaho Falls, ID 83404 (208) 227-1200 FAX (208) 227-1212

FINANCIAL POLICY

Thank you for choosing Walker Spine & Sport Specialists as your Health Care Provider. We are committed to giving you excellent medical treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment. All patients must complete our "Patient Information Form" before seeing the doctor. ****Note: Full payment or the insurance co-payment is due at the time of service unless other arrangements are made.****

SELF PAY: Payments on all accounts without insurance are due at the time of service unless you make other arrangements with a Patient Accounts Specialist in our Business Office.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We do, however, as a courtesy to our patients, bill primary and secondary insurances.

We will extend credit for 45 days on approved insurance company benefits if such benefits are assigned to the clinic and if the clinic has sufficient information to verify coverage and submit a proper claim. After 60 days if your insurance has not paid your account in full we require that you pay the balance.

Each insurance company has its own method of determining how many they will pay on each claim. Please contact one of our receptionists or business office staff if you have questions regarding the insurance companies with which we participate. We accept Medicare, Medicaid and Worker's Compensation claims as well as most of the major insurance companies.

LIABILITIES: We will extend credit for 45 days on liability accounts only if we have the necessary information to exercise our third party lieu rights. If you cannot provide this information, your account is due at the time of service unless you have made other arrangements with a Patient Accounts Specialist in our Business Office.

SURGERY: If you require surgery, as part of the pre-operative process we will make an estimate of the professional fees associated with the surgery. This amount is only an estimate. Actual benefits paid may differ due to your insurance company's definition of UCR (Usual, Customary and Reasonable). We require a deposit equal to the amount of your co-pay and deductible or 10% of the estimate of professional fees, whichever is less. This deposit is due at your final pre-operative appointment.

UNPAID ACCOUNTS & INTEREST CHARGES: All unpaid accounts for which payment arrangements have not been made are subject to collection procedures. Any costs incurred in the collection of those accounts are added to the accounts. We charge interest on all balances that are over 90 days past due from the date we provide services to you. We reserve the right to charge interest at the rate of 1-1/2% per month, 18% annually.

CREDIT OPTIONS AVAILABLE:

- We accept Visa, MasterCard, and Debit Cards.
- Three equal payment within 90 days from the date of service without interest.

*****I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.*****

Date: _____ **Name**: _____

Signature of patient /responsible party_____

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2. **I agree that Walker Spine and Sports Specialists may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.**

3. **I hereby acknowledge that I have been presented with a copy of Walker Spine & Sports Specialists Notice of Privacy Practices.**

Print Name_____

Signature_____

Date_____

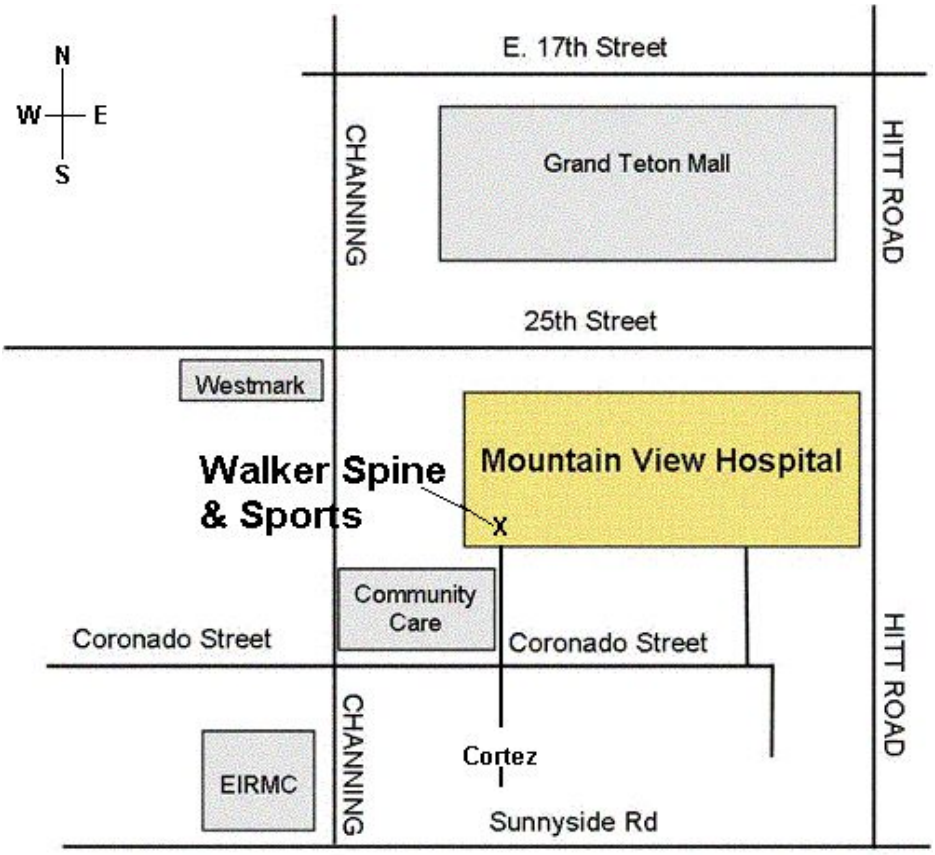
If the patient is a minor please sign below:

Print Patient Name_____

Print Parent/Guardian Name_____

Signature Parent/Guardian Name_____

Walker Spine & Sports Specialists location



Phone number: 227-1200

Driving Directions:

From 17th Street:

- Turn south onto Channing Way
- Continue south on Channing Way
- Turn left onto Coronado Street (the first street after 25th Street and immediately after Community Care)
- Turn left onto Cortez.
- Walker Spine & Sports entrance is straight ahead.

From Sunnyside:

- Turn north onto Channing Way
- Continue north and turn right onto Coronado (just before Community Care)
- Turn left onto Cortez.
- Walker Spine & Sports entrance is straight ahead.