



Lewis G. Zirkle, Jr., MD
 John W. Staeheli, MD
 M. Lynn Scovazzo, MD
 Gordon Hsieh, DO
 Patrick A. Dawson, MD
 Tamara S. Simpson, MD
 David J. Gibbons, MD
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875 SWIFT BLVD. • RICHLAND • WA • 99352 • 509.946.1654 • FAX 509.943.5652 • NWORTHO.COM

PATIENT INFORMATION SHEET
(Please fill out entire sheet)

Patient Name: _____ Appointment Date: ____/____/____
 (Last) (First) (MI)

Address: _____
 (Apt #) (City) (State) (Zip)

Date of Birth: ____/____/____ Age: _____ Sex: _____ Social Security #: _____ - _____ - _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Employer: _____ Occupation: _____

Primary Health Insurance: _____ Subscriber #: _____ Group #: _____

Secondary Health Insurance: _____ Subscriber #: _____ Group #: _____

Nearest Relative in Case of Emergency: _____
 (Name) (Phone) (Relationship)

We have an automatic computer system that calls and reminds patients of their appointments, do you give us permission to call you at your home phone number and remind you of your appointment? YES NO and leave a message? YES NO

By whom were you referred to this office: _____

Who is Primary Care Physician: _____

If Parent Or Spouse Is Responsible For Patient – Please Complete Guarantor Information

Guarantor Name: _____ Social Security #: _____ - _____ - _____

Home Phone:(____) _____ - _____ Work Phone:(____) _____ - _____

Employer: _____ Occupation: _____

Primary Health Insurance: _____ Subscriber #: _____ Insured Date of Birth: ____/____/____ Group #: _____

Secondary Health Insurance: _____ Subscriber #: _____ Insured Date of Birth: ____/____/____ Group #: _____

L&I AND/OR MVA INFORMATION

Did this result from an Auto Accident? YES NO Insurance Company _____ Claim # _____

Did this result from an accident at work? YES NO Date of Injury: ____/____/____ State Industrial #: _____

If yes, give the employer's name where the injury occurred: _____

At what medical office did you file your claim? _____

RELEASE OF BENEFITS AND INFORMATION: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim.

Signed (X): _____ **Date:** ____/____/____

(Read and sign back side)



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PATIENT H&P FORM

Name: _____ Age: _____

Last First M.I.

Date of Birth: _____ Date of last physical exam: _____ Height: _____ Weight: _____

CURRENT or CHIEF PROBLEM

Date of injury or onset: _____

Location/Body Part: _____

How it effects you? _____

When it effects you, how long does it last? _____

Swelling, bruising, etc.,? _____

PAST MEDICAL HISTORY Do you now or have you ever had: (check if "yes")

<input type="checkbox"/> Anemia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Skin Disease
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tumor (benign)
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tumor (malignant)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> None of the Above
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Other-

PREVIOUS OPERATIONS Yes No, please list:

Type	Year	Reason
1.		
2.		
3.		
4.		

Have you ever had a blood transfusion? Yes No What year? _____

PRESENT MEDICATIONS Yes No, please list including aspirin, laxatives, vitamins, herbs, and other supplements:

Drug Name	Dose(mg)	Frequency(times per day)
1.		
2.		
3.		
4.		
5.		

Other significant illnesses (please list): _____

Are you pregnant? Yes No Any previous fractures? Yes No Describe: _____

Have you had a Bone Density Study? Yes No If so, date of last scan ___ / ___ / ___ Where: _____

(Doctor Answer) Recommends a DEXA Scan? Yes No

DRUG ALLERGIES Yes No, please list:

Drug Name	Reaction (rash, difficulty breathing, etc.)
1.	
2.	
3.	

What is your primary pharmacy? _____ City/State _____



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SOCIAL HISTORY

Do you smoke? Yes No Past—If yes, number/day and years smoked _____ Quit when? _____

Do you drink alcohol? Yes No Type and number of drinks/week _____

Do you use drugs for reasons that are not medical? Yes No If yes, please list: _____

Do you exercise regularly? Yes No Type and amount per week: _____

Married Single Retired Living Independently Number of children: _____

FAMILY HISTORY

Do you know of any blood relative who has, have had, or died from any of the following (include age) check ALL that apply:

- Cancer _____ Diabetes _____ Epilepsy _____
- Heart Disease _____ High Blood Pressure _____ Psoriasis _____
- Congenital Problems _____ Obesity _____ Asthma _____
- Alcoholism _____ Tuberculosis _____ Thyroid Problems _____
- Rheumatic Fever _____ Rheumatoid Arthritis _____ Stroke _____
- None of the above have effected a blood relative

SYSTEMS REVIEW As you review the following list, please check ALL which have significantly affected you:

Head, Eyes, Ears, Throat

<input type="checkbox"/>	Headache	
<input type="checkbox"/>	Difficult seeing	
<input type="checkbox"/>	Difficult hearing	
<input type="checkbox"/>	Hoarsness	
<input type="checkbox"/>	Difficult Swallowing	
<input type="checkbox"/>	None of the Above	

Gastrointestinal

<input type="checkbox"/>	Diarrhea	
<input type="checkbox"/>	Constipation	
<input type="checkbox"/>	Use laxatives frequently	
<input type="checkbox"/>	Blood in stool	
<input type="checkbox"/>	Stomach pain	
<input type="checkbox"/>	None of the Above	

Musculoskeletal & Neurologic

<input type="checkbox"/>	Balance disturbance	
<input type="checkbox"/>	Weakness(arms)	
<input type="checkbox"/>	Weakness(legs)	
<input type="checkbox"/>	Joint swelling	
<input type="checkbox"/>	Joint stiffness	
<input type="checkbox"/>	Joint deformity	
<input type="checkbox"/>	Numbness(describe)	
<input type="checkbox"/>	None of the Above	

Genitourinary

<input type="checkbox"/>	Last rectal exam	
<input type="checkbox"/>	Last pelvic exam	
<input type="checkbox"/>	Kidney infections	
<input type="checkbox"/>	Bladder infections	
<input type="checkbox"/>	Kidney stones	
<input type="checkbox"/>	Blood in urine	
<input type="checkbox"/>	Incontinence	
<input type="checkbox"/>	None of the Above	

Pulmonary

<input type="checkbox"/>	Chronic cough	
<input type="checkbox"/>	Emphysema	
<input type="checkbox"/>	Infections	
<input type="checkbox"/>	None of the Above	

Cardiovascular (heart & circulatory)

<input type="checkbox"/>	Chest pain	
<input type="checkbox"/>	Irregular Heartbeat	
<input type="checkbox"/>	Shortness of breath	
<input type="checkbox"/>	Shortness of breath at night	
	# of pillows you use?	
	Swelling of feet, ankles, legs	
	None of the Above	

Physician/PA _____ Date _____



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Patient Financial Policy for Northwest Orthopaedic Associates, PLLC

Patient's Name: _____ Date of Birth: _____

Patient Financial Classification Policies:

You are required to present a valid insurance card at every visit and as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding patient balances and co-payments are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

Private Pay: We require \$100 deposit. Outstanding balances are due prior to your appointment or within 30 days.

Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CSM (Medicare System). If your secondary insurance does not crossover it is the patient's responsibility to either bill secondary themselves or provide at time of service information to bill their secondary insurance. We do not bill 3rd insurances. Any outstanding balances and deductibles are due prior to your appointments. Any non covered service will be due as service is rendered.

Medicaid: Our office is a Medicaid participating provider and we will bill Medicaid for you. Any outstanding balances, co-payments and deductibles are due prior to your appointments.

Worker's Compensation: If your visit is work-related we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company. If your workers compensation claim is not yet accepted and you have no "back-up" insurance we require a \$100 deposit that will be refunded after the claim has been opened.

Motor Vehicle Insurance (MVA): \$100 deposit is required on all MVA accounts. We will courtesy bill your MVA insurance if all information is provided at the time of service.

Methods of Payment:

Our office accepts the following payment methods:

Cash, Personal Check, Debit Cards, Visa, Master Card, Discover and Patient Financing options for those patients who are credit worthy.

For returned checks we assess a \$25.00 NSF charge.

If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

The patient is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional fees.

**24 hour cancellation notice is required, otherwise you will be
Charged a \$50 no show fee.**

COLLECTION CHARGE applied to all accounts unpaid after 60 days. **COLLECTION CHARGE** computed by a periodic rate of 1.5% per month, which is the annual percentage rate of 18.00%. Minimum charge of \$1.00. Northwest Orthopaedic Associates or its agents have permission to contact me by wireless telephone for billing or payment activities. I understand and agree that I may incur charges or airtime minutes through my wireless carrier as a result of this consent.

Print Name: _____ Signature: _____
 Date: _____



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health insurance. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print): _____

Relationship to Patient: _____
(If patient is not signing)

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason
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