NEW PATIENT INFORMATION

PATIENT INFORMATION

Date: ______/_____/______

Name:____ S.S. # ________-______-__________
LAST FIRST MI

Address:______________________ City:__________________ State:_______ Zip:______________

Home Phone:(___)_______________ Cell:(___)____________________ Email:________________

Occupation:_________________________ Employer: ______________________________

Work Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Off-Work ☐ Student

Date of Birth: ______/_____/__________ Age:________ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children: ☐ Yes ☐ No How many?_______

Spouse's Name:_______________________________________ Phone:(___)______________

Spouse's Employer:____________________________________ Phone:(___)______________

Emergency Contact:_______________________________ Phone:(___)_________________

INSURANCE/PAYMENT INFORMATION

Is your injury/illness work related? ☐ Yes ☐ No

If yes, have you reported the injury to your employer? ☐ Yes ☐ No Date of Injury: ______/_____/______

Is your injury/illness related to an automobile accident? ☐ Yes ☐ No If yes, please complete the following:

Your auto insurance company name and address:__________________________________

____

Claim #:_________________________ Policy #:______________________________

Attorney name and address:____

____

Do you have health insurance? ☐ Yes ☐ No If yes, please complete the following:

1. Primary insurance company name:_______________________________________

   Address:____

   Insured's Name:____________________ ID #:_______________ Group #:____________

2. Secondary insurance company name:_____________________________________

   Address:____

   Insured's Name:____________________ ID #:_______________ Group #:____________

ASSIGNMENT AND RELEASE

I, the undersigned assign directly to Stillwater Spine & Sports Center, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Stillwater Spine & Sports Center, Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and/or request pertaining to my physical condition, including, but not limited to, all records, reports, progress notes, reports of diagnostic tests, x-rays and/or medical opinions.

____ ______/_____/______

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

PATIENT CONDITION

Describe your major complaint(s): ______________________________

____

Date you first noticed symptoms: ____________ Describe how they began: ____________

____

Have you had these symptoms before? ☐ Yes ☐ No If yes, when: ____________

How often do you experience the symptoms?

- Constantly (76%-100% of the day)
- Frequently (51%-75% of the day)
- Occasionally (26%-50% of the day)
- Intermittently (0%-25% of the day)

PLEASE MARK BELOW WHERE YOU HAVE SYMPTOMS

How would you describe the symptoms?

Sharp	Shooting	Stabbing	Weakness
Dull	Burning	Stiffness	Throbbing
Numb	Tingling	Cramps	Achy

How are your symptoms changing?

Getting Better Getting Worse No Change

How would you rate your symptoms at their:

	None									Unbearable
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

No Complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, activity not possible
0	1	2	3	4	5	6	7	8	9	10

What makes your symptoms worse? ______________________________

What makes your symptoms better? ______________________________

Have you seen any other health care professionals for this condition? ☐ Yes ☐ No If yes, list the providers:

Name/Address: ____________ Date: ____________

Name/Address: ____________ Date: ____________

Have you had any tests done for your symptoms? ☐ Yes ☐ No If yes, please check test and give date:

☐X-Rays__________ ☐CT Scan__________ ☐MRI__________ ☐Lab__________ ☐Other:__________

Please indicate findings if known: ______________________________

Last blood tests: ____________ Last eye exam: ____________ Last dental visit: ____________

Any other diagnostic tests in past 3 years, if so what and when: ______________________________

Have you seen any other health care professionals for any other condition? ☐ Yes ☐ No If yes, please list:

Name/Address: ____________ Date: ____________

Name/Address: ____________ Date: ____________

Primary care provider:

Name/Address: ____________ Date: ____________

Name/Address: ____________ Date: ____________

*If ***child***, last well child visit:_______________ *If ***male***, last prostate exam/PSA evaluation:__________________

*If ***female***, last Pap test:_________________; Pelvic exam:_____________; Breast exam:____________________;

Last mammogram:________________; Do you do self breast exams? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If yes, Due Date:_________________________

HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition		
AIDS/HIV	Yes	No
Alcoholism	Yes	No
Anemia	Yes	No
Ankle Swelling	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Bleeding Disorder	Yes	No
Bowel/Bladder Changes	Yes	No
Breast Lump	Yes	No
Cancer	Yes	No
Chemical Dependency	Yes	No
Chest Pain	Yes	No
Chronic Cough	Yes	No
Cold Limbs	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Diarrhea	Yes	No
Digestive Problems	Yes	No
Dizziness	Yes	No
Eating Disorder	Yes	No
Epilepsy	Yes	No
Excessive Thirst	Yes	No
Fainting	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Fractures	Yes	No
General Stiffness	Yes	No
Glaucoma	Yes	No
Goiter	Yes	No
Gout	Yes	No
Headaches	Yes	No
Heartburn	Yes	No
Heart Problem	Yes	No
Hernia	Yes	No
Herniated Disc	Yes	No
Herpes	Yes	No
High Cholesterol	Yes	No
Hypertension	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Loss of Balance	Yes	No
Loss of Sleep	Yes	No
Miscarriage	Yes	No
Mononucleosis	Yes	No
Multiple Sclerosis	Yes	No
Nausea	Yes	No
Night Sweats	Yes	No
Numbness	Yes	No
Osteoporosis	Yes	No
Pacemaker	Yes	No
Pinched Nerve	Yes	No
Pins/Needles Feeling in Limbs	Yes	No
Pneumonia	Yes	No
Polio	Yes	No
Prostrate Problem	Yes	No
Prosthesis	Yes	No
Psychiatric Care	Yes	No
Rheum. Fever	Yes	No
Ringing in Ears	Yes	No
Shortness of Breath	Yes	No
STD	Yes	No
Stroke	Yes	No
Thyroid Problem	Yes	No
Tuberculosis	Yes	No
Tumors	Yes	No
Ulcers	Yes	No
Unintentional Weight Loss	Yes	No
Vaginal Infections	Yes	No
Venereal Disease	Yes	No
Visual Problem	Yes	No
Vomiting	Yes	No
Other_______________		
____________________		
____________________		

EXERCISE	**WORK ACTIVITY**	**HABITS**	
None	Sitting	Smoking:	Packs / Day:_______________
Moderate	Standing	Alcohol:	Drinks / Week:_____________
Daily	Light Labor	Caffeine:	Cups / Day:________________
Heavy	Heavy Labor	High Stress:	Reason:__________________

DIET & WATER

List any special dietary plans that you may be following (Paleo diet, Vegetarian diet, etc.):__________________

____

List any particular dietary items that you may be avoiding (dairy, gluten, etc.):___________________________

Approximately how many ounces of water do you drink a day?_______________________________________

INJURIES / SURGERIES / ACCIDENTS	Description	Date
Falls:	________________________________	______________
Head Injuries:	________________________________	______________
Broken Bones:	________________________________	______________
Dislocations:	________________________________	______________
Surgeries (Including Cosmetic):	________________________________	______________
Automobile Accidents:	________________________________	______________

MEDICATIONS

Name	Dosage

VITAMINS / HERBS / SUPPLEMENTS

Name

____
____
____
____
____

ALLERGIES

Drugs?______________________

Foods?______________________

Environmental or chemical?______________________

FAMILY HISTORY

Do you have a family history of any of the following diseases: (Check those that apply)

	Brother/Sister	Mother	Maternal GM	Maternal GF	Father	Paternal GM	Paternal GF
Asthma/Hay fever/Hives							
Arthritis							
Autoimmune Disease							
Cancer							
Dementia							
Diabetes							
Epilepsy							
Heart Disease							
High Blood Pressure							
Stroke							

Any other relevant family history?______________________

____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: In cases where Stillwater Spine & Sports Center, Inc. has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

SECTION A: PATIENT GIVING CONSENT

Name:____

Address:____

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, healthcare and practice 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 maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ashli Scales, Office Manager

Telephone: (406)756-7634

Address: Stillwater Spine and Sports Center, Inc. 3171 U.S. Hwy 93 N., Ste C, Kalispell, MT 59901

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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.

SIGNATURE

I,____, have had full opportunity to read and consider the contents of this Consent form and your 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, health care and practice operations.

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:____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in **the patient's chart.**

PATIENT WAIVER FOR NON-COVERED SERVICE

Extra-Corporeal Shockwave Therapy (ECSWT) Consent Form

WHAT DOES ECSWT DO?
Extracorporeal shockwave therapy is a non-invasive treatment in which a device is used to pass acoustic shockwaves through the skin to the affected area, it can be utilized in the treatment of tendon and bone pathology.
The shockwaves stimulate the body's own healing mechanisms to facilitate the repair of the damaged tendon and bone.

This is not considered a "covered benefit" under your health insurance plan and as such, your insurance will not pay for these services.

Your provider believes that ECSWT, although not covered by your health insurance is an important part of your care and recommends that you receive this service as part of your current treatment plan. However, since the service listed is not considered to be a covered benefit under your health insurance, should you choose to receive this service; you will be personally responsible for the payment at the time of service. The purpose of this notice is to help you make an informed choice about whether you want to receive this service.

Each shockwave treatment will be a separately billed service from your regularly scheduled appointment and will be billed at a charge of $40.00 per treatment.

Please check ONE box:

☐ I acknowledge that I have been informed in advance of receiving this service and that this service is NOT covered by my health insurance plan. I have chosen to receive this service and understand that I will be financially responsible for the charges indicated above.

☐ I acknowledge that I have been informed in advance of receiving this service and that this service is NOT covered by my health insurance plan. I have chosen NOT to receive this service.

Print Patient Name:____

Patient Signature:____

Date:_______________________

This form must be signed by the patient or legal guardian **PRIOR** to receiving ECSWT and *must be retained in the patient's medical record*.

Stillwater Spine & Sports Center, Inc.

3171 U.S. Hwy 93 N.
Suite C
Kalispell, MT 59901

PAYMENT POLICIES

Insurance

- We will gladly submit insurance claims to your insurance carrier at no additional charge to the Patient or Responsible Party. We submit claims to only two insurance carriers (primary and one supplemental). The only exception is Medicare which we are legally required to bill. *Medicare* will then submit your claim to any supplemental insurance you may have.
- State law requires that your insurance submit payment to us within 30 days however, sometimes insurance can be reluctant to pay or just plain slow! Payment is due on accounts within 60 days, regardless of your insurance coverage. We will be glad to assist you in contacting your insurance company regarding your claim, but ultimately the Patient or Responsible Party is expected to contact his/her insurance company if the insurance carrier fails to respond, is late responding, pays only a portion of what is due, or denies the claim.
- We will resubmit your claim one time only at no additional charge. If your insurance carrier has not paid after resubmitting your claim, Stillwater Spine & Sports Center, Inc. cannot pursue collection of insurance accounts without additional costs to the Patient or Responsible Party. Should you notice that your insurance has not paid on your account, you are responsible for contacting your insurance carrier to determine the status of your claim.
- If a claim is returned to Stillwater Spine & Sports Center Inc. due to an improper address, incorrect identification number or any other incorrect information, we will resubmit your claim after confirming correct information with you. Claims are submitted via the United States Postal Service. In the event a claim is not received by your insurance carrier, it will be returned to us in the mail.
- Insurance coverage and deductible information will be verified before Stillwater Spine & Sports Center, Inc. considers an account an "Insurance Account". We estimate the Patient's or Responsible Party's portion or co-pay based on information from your insurance carrier. Please realize that this may contribute to a Credit on your account or a Balance Owing greater than was estimated.
- If your insurance carrier is unavailable at the time of service and cannot verify your coverage or deductible, a payment or some portion of payment is expected at the time of service.
- Some charges billed by this office **may not** be covered by your insurance. The Patient or Responsible Party is ultimately responsible for any amount over and above what your insurance will cover in addition to any co- pay that applies to your policy.

General

- Payment in full is expected at the time of service. However, we are sensitive to the fact that some Patients may not be able to pay in full. We will assist you in setting up an individual payment plan requiring a monthly payment. We do require, however, that your balance be **kept under $300.00**. In the event that your balance does exceed $300.00, you will no longer be able to receive treatment until a payment has been made. A 1.5% finance charge will be applied to any account on any balance over 60 days.
- In the unlikely event that your account is turned over to a collection agency, the Patient or Responsible Party will be responsible for payment of any and all collection fees, attorney fees and court costs incurred in the collection of your unpaid balance owed, including finance charges. Should an account be designated a "Collection" account, you will be approved as a "Cash Only" account, to be paid in full at the time of service should you require our services in the future.
- Our office can be a very busy place. If we are given plenty of notice on cancelled appointments, we can fill those appointment times. However, we have a *non-cancellation* or *no-show* policy. A $20.00 charge will be applied to your accounts for appointments not cancelled at least 4 hours prior to the scheduled time or for failure to show up for scheduled appointments. **This charge cannot be billed to insurance!**

By Signing Below, you Are Stating That You Fully Understand and Agree With The Terms Set Forth In These Payment Policies

______________________ ____

Date Signature of patient or Responsible Party

Stillwater Spine & Sports Center, Inc.

3171 U.S. Hwy 93 N.
Suite C
Kalispell, MT 59901

PAYMENT OPTIONS

Stillwater Spine & Sports Center, Inc. provides several options for payment, Cash, Credit Card (we do not accept American Express), or Check. In addition, we accept most major medical insurance (General Insurance), Personal Injury (PI), Workers Compensation and Medicare. Please inquire at the front desk regarding the option of your choice.

Cash

Payment is expected at the time of service. However, we are sensitive to the fact that some Patients may not be able to pay in full. We will be happy to assist you in setting up an individual payment plan. We do require, however, that your balance be kept under $300.00. In the event that your balance does exceed $300.00, you will no longer be able to receive treatment until a payment has been made. A 1.5% finance charge will be applied to accounts over 60 days old.

Insurance

Once your insurance coverage has been verified, Stillwater Spine & Sports Center, Inc. will submit your claim to your insurance carrier at no additional charge to you. We will submit your claim to two carriers (primary and one supplemental). If your insurance carrier fails to respond or denies coverage due to incorrect information, we will *resubmit* your claim once. Some charges billed by this office **may not** be covered by your insurance. The Patient or Responsible Party is ultimately responsible for any amount over and above what your insurance will cover in addition to any co-pay that applies to your policy.

Things We Don't Like To Do

Our office can be a very busy place. If we are given plenty of notice on cancelled appointments, we can fill those appointments times. However, we have a *non-cancellation* or *no-show policy*. A $20.00 charge will be applied to your accounts for appointments not cancelled at least 4 hours prior to the scheduled time or for failure to show up for scheduled appointments. **This charge cannot be billed to insurance.**

PLEASE FEEL FREE TO TAKE THIS PAGE HOME FOR FUTURE REFERENCE