1120 N Pines Road. Ste. 102, Spokane Valley, WA 99016. Tel: 509-828-7288. Fax: 509-463-3635.

HIPAA Compliance Patient Consent Form

This Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- You will not share the personal health information of other patients in the clinic.

This was signed by:

(Type or Print Name)

Signature: ____ Date:

Consent for Treatment

- I authorize the physicians of Northwest Pain Specialists to provide myself (or dependent) with reasonable and proper medical care. This may include a physical exam of painful areas. I understand that examining these areas could lead to a temporary pain flare. I also understand that any procedures performed could result in a temporary pain flare.

- I authorize my health insurance company or third-party payer to pay my insurance benefits directly to Northwest Pain Specialists.

- I authorize Northwest Pain Specialists to release any information required to process my insurance claim.

- I understand that I am ultimately financially responsible for any balance remaining on the account after insurance payment has been received. I also understand that I am responsible for the total charges if the insurance has been denied.

This was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date: ______________________

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Patient Registration Form

Patient's Name (Last, First, MI): ____

Patient's Home Phone Number: ________________ Alternate Phone Number (☐ cell or ☐ work): ____________________

E-Mail Address: ____

Address: ____ Apt. # _________

City: ________________________ State: _____________ Zip: ____________

Date of Birth: _______________ Age: _____ Sex: M F Social Security Number: ____________________

Marital Status: Married Single Divorced Widowed

Patient's Employer: ______________________

Employment Status: Full time Part time Unemployed Retired Student Other: ______________

Emergency Contact: _________________________________ Relationship to Patient: ______________________

Address: ____ Phone number: ____________________

INSURANCE INFORMATION

Primary Insurance: _______________

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _______________

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _______________________________ Relationship to Patient: __________________

Address: ____

Social Security Number: _________________________

Date of Birth: ________________________________

His or Her Employer: ___________________________ Work Phone Number: _________________________

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): ___________________________________ Relationship to Patient: _________________________

Inova Medical Group reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice
2. Are missed without calling to cancel (no show)

Cancellation Fee schedule: New Patient $50.00; Established Patient: $35.00

Patient / Parent or Guardian Signature: ______________________________________ Date: ______________

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PAIN SPECIALISTS

Name:_______________________________ Date of Birth:____________________ Today's Date:___________________

REASON FOR VISIT

____

____

CURRENT MEDICAL PROBLEMS

____

____

____

ALLERGIES

____

____

PREVIOUS SURGERIES

____

____

CURRENT MEDICATIONS

Medication Name	Dosage	Frequency	How Long

FAILED MEDICATIONS **FOR THIS PAIN**

(i.e. anti-inflammatory, muscle relaxers, opioids, nerve pain medications, other pain medication)

Medication Name	Dosage	Frequency	How Long

PHARMACY INFORMATION

Pharmacy Name:______________________ Address:____

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Confidential Review of Systems

Please check "√" if you are **currently experiencing** the following.

General

- O Chills
- O Fatigue
- O Fever
- O Unexplained weight loss

Head

- O Dizziness
- O Fainting
- O Pain
- O Headaches

Eyes

- O Blurry vision
- O Pain with Light
- O Vertigo

Respiratory

- O Difficulty breathing
- O Pain with breathing
- O Short of breath

Cardiovascular

- O Chest Pain
- O Pacemaker or similar device
- O Swelling of Legs

Gastrointestinal

- O Abdominal Pain
- O Diarrhea
- O Nausea
- O Vomiting

Allergic/Immunologic

- O Hepatitis
- O AIDS

Musculoskeletal

- O Arthritis
- O Back Pain
- O Joint Pain
- O muscle pain
- O Neck Pain
- O Other Pain

Psychiatric

- O Anxiety
- O Depression
- O Emotional Problems
- O Excessive stress
- O Irritability
- O Mood Changes
- O Nervousness

Skin

- O easy bruisability
- O Nail texture change
- O Rashes

Neurological

- O Burning
- O Dizziness
- O Numbness
- O Pins and Needles
- O Tingling
- O Weakness

Hematologic/Lymph

- O Bleeding Easily
- O Blood disorder
- O Current blood thinner use