



30544 Hwy 200, Ste 102
Ponderay, ID 83852
Office 208-265-9817
Office Fax 208-265-4533
www.niosm.com

We would like to welcome you as a new patient to North Idaho Orthopedics and Sports Medicine. We look forward to participating in your healthcare needs.

Here is a list of important information for your visit:

- Due to the high volume of patients, if you are not on time for your appointment, it may need to be rescheduled.
- We have a Medical Appointment Cancellation Policy (enclosed in New Patient Packet).
- If your insurance requires a referral or authorization, please make sure your **Primary Care Physician (PCP)** has certified your appointment with a written referral. If your referral is not available, you will be liable for payment or your appointment may be rescheduled.
- Bring with you to your appointment:
 - Current insurance information (insurance card(s), claim #'s, work comp information, updated information, etc.)
 - Your (or your guardian's) Photo ID (e.g. drivers license, government issued I.D.)
 - ALL DIAGNOSTIC STUDIES (x-ray's, MRI's, etc.) not done at Bonner General Hospital or Boundary Community Hospital must be brought with you to your appointment.
- All Co-pays must be paid at the time of service.
- If you do not have insurance you will be required to pay a \$170 deposit upon arrival. Any follow up visits will require a \$75 deposit at the time of service. The balance of your visit will either be refunded or invoiced to you.
- If you are coming in as a result of a motor vehicle accident or a victim of violence or crime, we will require a \$170 deposit upon arrival.
- Our business hours are Monday – Friday 7:30AM – 5:00PM.
- If you have paperwork for us to fill out, please allow 7 – 10 working days for this to be completed.
- We will only prescribe pain medication for the acute post fracture or postoperative period.
- Please allow 48-72 business hours for medication refills. Please have your pharmacy fax the medication refill request. **THERE WILL BE NO MEDICATION REFILLS DURING WEEKEND AND NON-BUSINESS HOURS.**

If you have any questions, please feel free to call our friendly staff, and we will be happy to assist you!

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY

Primary Care Physician _____ Referring Physician _____

Patient Name _____ Age _____

Reason for this visit _____ Date of Injury _____

How did this happen _____

Dominant Hand Right Left

PLEASE CIRCLE THE FOLLOWING WHICH APPLY

Right or Left ~ Shoulder ~ Elbow ~ Wrist ~ Hand ~ Finger ~ Back ~ Hip ~ Knee ~ Ankle ~ Foot ~ Toe

PATIENT PAST MEDICAL HISTORY

Ongoing Medical Problems _____

Prior Surgeries & Hospitalizations _____

Current Medications (List Dosages) _____

Allergies _____

Alcohol Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, amount of alcohol per week? _____

Number of packs per day _____ Number of years _____

If yes, please describe _____

REVIEW OF SYSTEMS

Check Y or N if you have any of the following symptoms

Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular Heart Beats	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sprains	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight Change	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes in Appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mood Change	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Coughing Up Blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stiffness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Visual Changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Changes in Sensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abdominal Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blurred Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hallucinations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Balance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Trauma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep Disturbances	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Memory	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Glasses/Contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Tendency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Incoordination Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Deafness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lymph Node Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hyper/Hypo Activity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sinusitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hair Changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ringing in the ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Urinary Hesitancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hoarseness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Painful Urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Latex, Drug or Other Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Menstrual Abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Inability to move arms or legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnancies # of	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty in speech or swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes in skin color, temperature, rashes, lesions, scars, masses	<input type="checkbox"/> Yes	<input type="checkbox"/> No						

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY - Page 2

CHECK ANY FAMILY HISTORY OF THE FOLLOWING

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Strokes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What type? _____		
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

OSTEOPOROSIS CHECK LIST

Have either of your parents broken a hip after a minor bump or fall?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you broken a bone after a minor bump or fall?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you undergo menopause before age 45?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you taken a corticosteroid tablet (prednisone, cortisone) for more than six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you lost more than 5cm (2 inches) in height?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have your periods ever stopped for 12 months or more for reasons other than pregnancy or menopause?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you regularly drink heavily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer frequently from diarrhea (caused by problems such as coeliac disease or Crohn's disease)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had obesity surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Physician Signature

Date

Patient Signature

Date

PATIENT INFORMATION

Please complete this form in its entirety as well as having your insurance and ID cards ready to copy

PATIENT INFORMATION

Referred By _____ Primary Care Physician _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Mailing Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birth Date _____ Single Married Widowed Divorced

Primary Phone _____ Secondary Phone _____ Work Phone _____

Patient Employed By _____ Occupation _____

In case of emergency, who should be notified? _____ Phone _____

Date of Injury _____ Reason for this visit _____

PERSON RESPONSIBLE FOR ACCOUNT

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birth Date _____ Soc. Sec. # _____

Address (if different from patient's) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone _____

PRIMARY INSURANCE

Insurance Company _____ Insurance ID # _____ Group # _____

Subscriber Name _____

Relationship to Patient _____ Birth Date _____ Soc. Sec. # _____

Address (if different from patient's) _____

City _____ State _____ Zip _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Y N

Insurance Company _____ Insurance ID # _____ Group # _____

Subscriber Name _____ Relationship to Patient _____ Birth Date _____

Address (if different from patient's) _____

City _____ State _____ Zip _____

WORKMANS COMPENSATION INSURANCE IF WORK RELATED INJURY

Employer _____ Employer Phone _____

Insurance Carrier Name _____ Insurance Carrier Phone _____

Date of Injury _____ Claim # _____ Adjustor Name _____

AUTOMOBILE INSURANCE IF AUTOMOBILE ACCIDENT RELATED

Insurance Carrier Name _____ Insurance Carrier Phone _____

Insurance Billing Address _____ Adjustor Name _____

Date of Accident _____ Claim # _____

PEOPLE AUTHORIZED TO RECEIVE INFORMATION

(Only people listed below will be able to receive your medical information)

Name and Relationship to Patient _____ Phone # _____

Name and Relationship to Patient _____ Phone # _____

Name and Relationship to Patient _____ Phone # _____

MEDICAL APPOINTMENT CANCELLATION POLICY

Due to busy scheduling, we require 24 hour notice of cancellation. Failure to notify the office will result in a \$50.00 fee. This charge cannot be billed to your insurance carrier, therefore you will be responsible for the payment.

If you are continually unable to notify the office of a cancellation in a timely fashion we may be unable to continue to provide services.

MEDICATION REFILL POLICY

Please allow 48-72 business hours for medication refills. Please have your pharmacy fax the medication refill request. We will only prescribe pain medication for the acute post fracture or postoperative period.

THERE WILL BE NO MEDICATION REFILLS DURING WEEKEND AND NON-BUSINESS HOURS.

ASSIGNMENT AND RELEASE

- **PLEASE BRING AND PRESENT INSURANCE CARDS AT THE TIME OF YOUR VISIT**
- **ALL CO-PAYMENTS OR DEPOSITS ARE DUE AT THE TIME OF YOUR VISIT**
- If you have no health insurance to bill, you will be required to make a deposit of \$170.00 on your first visit. A deposit of \$75.00 is required for all follow-up visits. (Auto PIP/MedPay is not considered health insurance).

North Idaho Orthopedics and Sports Medicine relies on the insurance and billing information provided to us by you or your referring provider. In the event that this information is not accurate a case deposit may be required, or your appointment may need to be rescheduled. After services are provided, we will submit our claim to your insurance carrier if applicable. In the event that payment is denied, the patient is responsible for full payment. All patient balances are due within 30 days of the statement date. It is the patient's responsibility to contact the billing department if this obligation cannot be met. North Idaho Orthopedics and Sports Medicine is committed to assisting our patients in meeting their financial responsibility; however, if arrangements are not made, we will utilize the services of a credit bureau or a collection agency. [Any fees associated with the services of these I hereby assign North Idaho Orthopedics and Sports Medicine all money due for medical and/or surgical services rendered by North Idaho Orthopedics and Sports Medicine in the event of a settlement.] I authorize North Idaho Orthopedics and Sports Medicine to send my medical information to my primary care provider and/or referring provider as necessary.

ASSIGNMENT: I HAVE READ, COMPLETED, AND FULLY UNDERSTAND THE ENTIRE PATIENT INFORMATION PACKET. I HEREBY AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN AND RELEASE OF ANY INFORMATION REQUIRED.

Responsible Party Signature

Relationship

Date

INSURANCE POLICY

To accommodate the needs and requests of our patients, we participate with certain insurance plans. We are pleased to be able to provide this service to you, yet it is very difficult for us to keep track of all the individual requirements of each plan as they change from time to time. It is ultimately your responsibility to check with your insurance to understand the contract and coverage.

Each plan has different restrictions regarding how often services may be rendered or more importantly, where you should obtain these services.

North Idaho Orthopedics and Sports Medicine contracts/participates with the following insurance payers:

Blue Cross*	Medicaid**	Idaho Physicians Network
Regence	North Idaho Health Network	First Health (Altius and Coventry)
Medicare	First Choice Health Network	

You must have a referral to our facility with all managed care plans. Each authorization will specify the number of visits and expiration date. The patient is responsible for knowing when this authorization expires. Please contact your **primary care physician (PCP)** to find out the status of your referral before your scheduled appointment.

Providing the highest quality of care for our patients is our primary concern. We are more than willing to provide care within your insurance plan guidelines whenever possible. As a surgeon's office, we will contact your insurance for any pre-authorization for surgical procedures. To be sure there are no surprises, please check with your insurance regarding your benefits.

If you do not inform us of special requirements required by your plan and we perform a service that is not covered by your plan, we will bill you directly for those charges.

By working together, we can assist you in receiving the benefits you are entitled to. Any questions, please contact our office at (208) 265-9817.

I have read and understand the office policy stated above and agree to accept responsibility as described.

*Although we are contracted with *most* of these insurance plans, there are still some that we are either not contracted with and/or will need a written referral for prior to your first appointment. These include (but are not limited to) HMO, Managed Care, and Medicare Advantage plans. If you aren't sure about your plan, please don't hesitate to ask us!

**All Medicaid patients will need a Healthy Connections Referral from their PCP prior to their first appointment with us.

PATIENT CONSENT

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 healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 to obtain a current copy of the *Notice of Privacy 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 requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Responsible Party Signature

Relationship

Date



30544 HWY 200 – SUITE 102, PONDERAY, ID 83852 • PHONE: 208-265-9817 • FAX: 208-265-4533

Authorization to Release Health Care Information

Patient's Name: _____

Previous Name: _____

Date of Birth: _____

SSN: _____

I hereby authorize: _____ to release my individually identifiable health information to North Idaho Orthopedics and Sports Medicine.

OR

I hereby authorize: North Idaho Orthopedics and Sports Medicine to release my individually identifiable health information to _____.

Method of receipt/transmission (check one and complete):

- Mail – Address _____
- Fax – # _____
- Patient Pick Up

Purpose for which information is to be used (check all that apply):

- Treatment
- Insurance
- Personal
- Follow Up
- Legal
- Other: _____

Specific description of information (including dates):

- Health care information relating to the following treatment, condition, or dates of treatment
- All health care information
- Other _____

Please check "Include" or "Exclude" for each of the following:

- Include Exclude Health information related to chemical dependency. (i.e. drug and/or alcohol)
- Include Exclude Health information related to HIV/AIDS.
- Include Exclude Health information related to mental health conditions/treatments.

Signature of patient or patient's authorized representative

Date signed

Relationship or status if signed by anyone other than patient
(parent, legal guardian, personal representative, etc.)