Palouse Surgeons, LLC

PLEASE PRINT

PATIENT INFORMATION

Name: ____

Mailing Address______________________________________

City: ______________________State:________ZIP:______________

SS#:______________________Phone: Home: __________________

Cell: ______________

Birthdate: _________Age:_____ Sex: M F Marital Status: ______________

If patient is a minor, parent/guardian name: _____________________

Employer: ___________________Occupation:__________________

Employer's Address: ___________________City:________________

State: ______________ZIP:_______Work phone: _________________

Spouse: __________________SS#_________________DOB:______

Employer: __________________Work phone: ________________

Employer's Address: ______________________________________

Who to Contact in Case of Emergency: _________________________

Address: ______________________Phone:____________________

Relationship: ____________

Family Doctor: _______________Referring Doctor: _______________

Insurance Card: (Both sides)

Authorization:

I hereby authorize Palouse Surgeons, LLC or its designated billing agent to furnish information to insurance carriers concerning this illness/accident, and I hereby assign to the doctor all payments for medical services rendered.

I understand that I am financially responsible for all charges, whether or not covered by insurance.

Patient/Parent Signature: ________________________Date:________

Current Medical History

Patient name ____________________________________

Date of birth_____________________

Referred by ______________________________________

Major concern ________________________Other concerns_____________________________

How long ago did this concern begin? (Be specific)_____________________________________

Have you had this diagnosed? ____If so, what was the diagnosis? ________________________

What treatment have you tried? ____

Review of Systems

Please circle any symptoms that are bothersome to you **now**

General

Poor appetite	Bleeding/bruise easily	Poor balance	Fevers
Poor sleeping	Weight loss	Weight gain	Chills
Fatigue	Strong thirst	Night Sweats	Other

Skin & Hair

Rashes	Loss of hair	Recent moles	Ulcerations	Itching	Other

Head, Eyes, Ears Nose & Throat

Dizziness	Concussions	Jaw clicks	Teeth problems
Eye pain	Recurrent sore throats	Ringing in ears	Cataracts
Sinus problems	Nose bleeds	Spots in front of eyes	Trouble with night vision
Grinding teeth	Facial pain	Hearing aids	
Glasses	Earaches	Other________________________	

Cardiovascular

High blood pressure	Varicose veins	Chest pains	Irregular heartbeat
Low blood pressure	Fainting	Cold hands and feet	
Swelling feet	Swelling hands	Blood clots	Difficulty breathing

Respiratory

Cough	Coughing blood	Difficulty breathing when lying down	
Asthma	Bronchitis	Pneumonia	Pain with deep breath

Gastrointestinal

Nausea	Abdominal pain/cramps	Indigestion	Hemorrhoids
Constipation	Vomiting	Diarrhea	Rectal pain

Genitourinary

Pain on urination	Frequent urination	Blood in urine	Urgency to urinate
Kidney stone	Sores on genitals	Impotency	Sexual-transmitted disease

Musculoskeletal

Neck pain	Foot/ankle pain	Muscle weakness	Knee pain	Hip pain
Back pain	Muscle pain	Hand/wrist pain	Shoulder pain	Other

Neuropsychological

Seizures	Loss of balance	Poor memory	Depression	Anxiety

Past Medical/Family History

Patients name ____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease						
High blood pressure						
Stroke						
Cancer						
Diabetes						
Asthma/allergies						
Epilepsy/convulsions						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Osteoporosis						
Alcohol/drugs/mental illness						

Your Past Medical History (Please check problems you have had)

	Headache		Hepatitis		Rheumatic fever
	Shortness of breath		Prostate disease		Mumps
	Heart palpitations		Gallbladder disease		Measles
	Heart murmur		Incontinence		Rubella
	Chest pain		Sexual/menstrual problem		Polio
	Dizziness/fainting		Venereal disease		Diphtheria
	Peripheral vascular disease		Frequent infections		Tetanus
	Allergies/hay fever		Arthritis		Asthma
	Osteoporosis		Bronchitis		Dental problems
	Ulcer		Gout		Additional problems
	GI disorder		Scarlet fever		Bowel irregularity

Hospitalizations ____

Surgeries____

Anesthesia ____

Current Medications ____

Allergies ____

Palouse Surgeons

Notice of Privacy Practices

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your physician or others working in this office. This notice will inform you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of you health information.

We are required by law to:

Make sure that health information that identifies you is kept private.
Give you this notice of our legal duties and privacy practices with respect to health information.
Follow the terms of the Notice of Privacy Practices that is currently in effect.

How we may use and disclose health information about you:

For treatment	For appointment reminders
For payment	As required by law
For health care operations	Public Health risks
Health oversight activities	Lawsuits and disputes
Law enforcement	To avert a serious threat to health and safety
Worker's Compensation	

Your rights regarding health information about you:

Right to copy of records	Right to an account of disclosure
Right to request confidential Communications	Right to a copy of this notice

Changes to Notice of Privacy Practices: We reserve the right to change this notice.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing.

Acknowledgement of receipt of this notice:
We will request that you sign this form acknowledging you have received a copy of this notice. This acknowledgement will become part of your medical record.

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I understand & will sign	I do not understand & will sign	I disagree, but will sign

Date________________

Patient Financial Policy for Palouse Surgeons

Patient Name: ____

Date of Birth: ____

Patient agrees to pay for all portions of services due in full at the time services are provided by our office. Statement balances are due in full within 14 days of receipt of statement.

Patient Financial Class Policies:

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

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

Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances, if that information is provided to us. Any outstanding balances and deductibles are due prior to your appointment. Any co-insurance and 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-pays and deductibles are due prior to your appointment.

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.

Methods of Payment: Our office accepts the following payment methods: Cash, personal check, credit cards and Care Credit financing options for those patients that qualify.

For returned checks, we assess a $25.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

Accounts not paid according to the terms set above, the patient understands that our office reports to an outside collection agency. In the event your account is turned over for collections, the patient agrees to pay all additional fees assessed 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 agree to the above financial policy for payments and professional fees.

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Signature Date