Fourth Corner Neurosurgery & Pain Management
710 Birchwood Avenue Suite 101
Bellingham, WA 98225

Name: _____
I acknowledge receipt of the Medical Record Privacy Policy (HIPPA).

Signature: _____

Date: _____

Mr. Mrs. Ms. Miss:_____ Gender: ☐ Male ☐ Female
Last First Middle Marital Status ☐ S ☐ M ☐ W ☐ D ☐ SEP

Mailing Address: _____
Street Apt # City State Zip

Birth date: ____-_____-_____ Social Security # _____-_____-_____ Email address:_____

Home phone # _____ Cell phone # _____ Work phone # _____

Employer Name: _____ Occupation: _____

Referring Physician: _____ Primary Care Doctor:_____
First and last name First and last name

Emergency contact: _____
Name Phone Relationship

PRIMARY INSURANCE

_____
Insurance Company Name

_____
Policy number Group Number

SECONDARY INSURANCE

_____
Insurance Company Name

_____
Policy Number Group Number

If your visit is related to a **WORK INJURY**, please provide: Claim Status: **OPEN CLOSED PENDING**

_____ _____ _____
Claim Manager's name and phone number Date of Injury Employer at time of Injury

Claim # _____ If Self Insured Company Name: _____

If related to a **Motor Vehicle Accident**, please provide:

_____ _____
Insurance Company Name Date of Accident

_____ _____
Claim/Policy # Claims Adjuster Name & Phone #

_____
Insurance Company Claims Mailing Address

I hereby authorize payment directly to this medical office for the Medicare and/or group insurance benefits otherwise payable to me. I authorize release to the Centers for Medicare or Medicaid services and/or group insurances any medical information needed to determine the payments for related services. I understand that I am responsible for all costs of medical treatment. I certify that all of the above information is correct, and I have read and will subscribe to the Credit Policy attached.

Signature: _____ *Date:* _____

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Authorization for Release of Information

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to a family member or appointed individual indicated below.

I authorize *Fourth Corner Neurosurgery & Pain Management* to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Authorization to Leave Detailed Messages

Occasionally it is necessary for the staff of *Fourth Corner Neurosurgery & Pain Management* to leave messages for patients. The purpose of these messages are to notify the patient that we would like to discuss treatment needs, billing purposes or to ask a patient to call back regarding an issue or concern. To expedite the receipt of the needed information, please indicate below if you would like to give consent to leave detailed messages.

Please mark your preference below:

_____ I authorize Fourth Corner Neurosurgery & Pain Management to leave detailed voicemails.

This is the phone # I would like messages left: _____

_____ I authorize *ourth Corner Neurosurgery & Pain Management* to send detailed emails.

This is the email address I would like messages sent: _____

_____ I do not want any detailed messages left on voicemail or sent via email.

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above authorized recipient or voicemail or email is no longer protected by federal or state law and may be subject to redisclosure by the above recipient or someone who has access to your voicemail or email.

You have the right to revoke this consent in writing.

Signature:_____Date:_____

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Financial Policy

As a condition for medical service by a practitioner of Fourth Corner Neurosurgical, arrangements must be made in advance. Payment is expected for services at the time of the appointment. We accept cash, debit, personal checks, Visa, MasterCard, American Express, and Discover cards. Charge for non-sufficient fund checks is $40.00

Patients with Insurance

Fourth Corner Neurosurgical will bill your insurance carrier for services covered by your contract. (**Patients are responsible for co-pays, deductibles, and coinsurance balances not covered by your insurance at the time of your appointment or prior to surgery**.) Occasionally, there can be a debit or credit adjustment due after your insurance carrier has settled the claim.

Patients are encouraged to contact their insurer and become familiar with their policy to avoid financial surprises.

Schedule Payment Agreement

In some instances, a Schedule Payment Agreement can be arranged with a one-time administrative fee of $75.00. SPA's are required to be in place prior to the day of service. You will be required to sign an agreement and provide a 25% down payment prior to surgery.

SPA's may be extended to 90 days in duration, divided into 3 equal monthly installments. SPA's are subject to a 1% interest charge after the first 30 days. Please contact our Bookkeeping Department to discuss this policy or make arrangements.

It is the policy of Fourth Corner Neurosurgical to turn accounts over to collection that lapse over 90 days.

Cancellations

Our patients are very important to us. Missed appointments are costly and take away valuable appointment time from other patients needing care. Therefore, we ask that you give us (48) hours advance notice of need to cancel. If you fail to call us to cancel your clinical appointment within the advanced 48-hour window, you may be charged a fee of $100.00, payable prior to re-scheduling.

710 Birchwood Ave #101, Bellingham, WA 98225
P: 360-676-0922 F: 360-676-4726 After Hours: 360 -676-0922 (answering service)

I have read, understand, and agree to the provisions of this policy

_____ _____

Patient Signature Date

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The Physicians at FCNSA (Fourth Corner Neurosurgical Associates) acknowledge that narcotics form an essential part of pain management before, during and after surgery or procedures. Please be advised that if you are prescribed any narcotics for pain medication as a result of surgery or procedures the following policy will apply.

1. Physicians at FCNSA will prescribe narcotics for pain related to surgery or procedures for a period of up to 12 weeks after the procedure.
2. Pain that lasts longer than 12 weeks after a procedure is performed is generally considered as chronic pain and the physicians at FCNSA recognize that chronic pain is managed by the primary physician. If you have pain lasting longer than the 12 week post procedure period, you will be referred to your primary care physician for management. Physicians at FCNSA can make recommendations if requested specifically by the primary physician to start or maintain your long acting narcotic prescriptions.
3. Physicians at FCNSA will not prescribe narcotic dosages that are more than those recommended by Washington State.
4. Physicians at FCNSA can also make recommendations for non narcotic pain management strategies such as medications, physical therapy, interventional procedures, and pain psychology treatments.
5. If you do not have a primary physician you will need to have one established prior to the end of your 12-week post procedure period, as FCNSA will not prescribe longer than 12 weeks post procedure. The Whatcom County Medical Society is a good resource when looking for a local primary care physician. Their phone number is 360-676-7630 or you can locate on the web at www.whatcom-medical.org.
6. Pain management after surgery or procedure is divided into 3 phases. Immediate acute period is managed in the hospital with larger doses of narcotics. The next phase is the post acute period then oral pain medication will be given. The last phase is the withdrawal phase when the pain medicines are withdrawn over a period of 4 weeks. Non narcotic strategies can be tried during this period if it continues to be painful.
7. Narcotic prescriptions are given in an amount to last 1-2 weeks. All narcotic requests must be made during office hours Monday –Thursday with at least 72 hours notice before the prescription expires. This will help avoid the need for a refill when the physicians are not available. On Call physicians will not refill medications during after hours.

Please sign and date below that you are in agreement with our narcotic agreement policy.

Print Name:_____

Signature: _____ **Date:**_____

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Patient Name: _____ Date of Birth: ____/____/____ Date: _____

Chief Complaint: _____

Primary Care Provider: _____ Referring Provider: _____

Height: ___ft___in Weight: _____lbs ☐ Right-handed ☐ Left-handed

Current Medications: Please list medication name and dosage:

_____

_____

_____

_____

Allergies: ☐ No Known drug allergies

Medication Name	Reaction

Past Medical History: (check all that apply) ☐ None Apply

☐ Heart attack
☐ Congestive heart failure
☐ Cardiac stents
☐ Arrhythmia
☐ Hypertension
☐ Pacemaker
☐ Defibrillator
☐ Peripheral artery disease
☐ Deep vein thrombosis
☐ Pulmonary embolism
☐ Bleeding disorder
☐ Anemia
☐ Parkinson's disease
☐ Dementia
☐ Fibromyalgia
☐ Migraines: how often? _____
☐ Muscle disease: type:_____
☐ Stroke/TIA: lasting effects?:_____
☐ Syphilis

☐ Asthma
☐ COPD
☐ Pneumonia
☐ Tuberculosis
☐ Peptic ulcer
☐ Gastric reflux
☐ Irritable bowel syndrome
☐ MRSA
☐ HIV
☐ AIDS
☐ Hepatitis B
☐ Hepatitis C

☐ Osteoporosis
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Anxiety
☐ Depression
☐ Bipolar
☐ Post-traumatic stress disorder
☐ Glaucoma
☐ Cataracts (including surgery)
☐ Thyroid disease: type: _____
☐ Diabetes: Type 1 or Type 2 (circle one)
☐ Diabetic neuropathy
☐ Cancer: Type: _____
Type of treatment_____
☐ other:_____

_____

_____

_____

Past Surgical History:

Surgery:	Date:

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Family History: (check all that apply to your blood relatives)

☐ Heart Disease ☐ Stroke ☐ High blood pressure ☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease
☐ Tuberculosis ☐ Spine surgery ☐ Neurological Problems ☐ Alcohol/Drug abuse ☐ Suicide
☐ Mental illness ☐ other:_____

Social History:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Long term partner
Children: ☐ Yes, how many?_____ ☐ No
Do you live alone? ☐ Yes ☐ No **Do you have a living will?** ☐ Yes ☐ No
Do you have a power of attorney? ☐ Yes ☐ No
Tobacco use: ☐ None ☐ Sm o ker, how many packs per day?_____For how long?____
☐ Former, how long quit?_____ ☐ Chewing tobacco
Work status: Occupation:_____ ☐ Employed ☐ Unemployed ☐ Retired
☐ Currently working ☐ Not currently working
Alcohol use: ☐ No alcohol use ☐ yes, drinks per week? _____ For how long?_____
☐ Former, how long quit?_____
Recreational drug use: ☐ No ☐ Yes, type?_____
Caffeinated beverages: ☐ No caffeine use ☐ yes, weekly amount?_____

Review of Systems: (current or recent symptoms, check all that apply) ☐ None Apply

General Health:
☐ Chills
☐ Excessive fatigue
☐ Fever
☐ Trouble sleeping
☐ Weakness
☐ Unexplained weight loss
☐ Unexplained weight gain

Respiratory:
☐ Chronic cough
☐ Recent cold
☐ Shortness of breath
☐ Sleep Apnea
☐ Wheezing

Gastrointestinal:
☐ Swallowing problems
☐ Heartburn
☐ Nausea/Vomiting
☐ Abdominal pain
☐ Bowel incontinence
☐ Jaundice
☐ Loss of appetite

Musculoskeletal:
☐ Back pain
☐ Neck pain
☐ Muscle/Joint pain
☐ Physical limits
☐ Extremity pain
☐ Stiffness

Skin:
☐ Rashes
☐ Lumps
☐ Itching
☐ Recurrent skin infectio

Psychological:
☐ Anxious
☐ Depressed
☐ Memory loss
☐ Inability to concentrate
☐ Stress

Head/Eyes/Ears/Throat:
☐ Vision loss/changes
☐ Hearing loss/changes
☐ Sinus problems
☐ Recent sore throat
☐ Headaches

Endocrine:
☐ Excessive sweating
☐ Heat/Cold intolerance
☐ Excessive thirst
☐ Excessive urination

Genitourinary:
☐ Bladder Incontinence
☐ Kidney failure
☐ Urinary infections
☐ Prostate problem
☐ Pregnant

Neurological:
☐ Frequent falls
☐ Numbness
☐ Seizures
☐ Speech difficulty
☐ Tingling
☐ Tremor
☐ Vertigo

Cardiovascular:
☐ Chest pain
☐ Irregular heart rhythm
☐ Murmur
☐ Circulation problems
☐ High blood pressure
☐ Leg cramps

Hematological:
☐ Bleeding tendency
☐ Bruises easily
☐ Anemia
☐ Blood clots

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Name: _____ DOB: _____Date: _____

What is the reason for this visit?

How long have you had your symptoms?

How did it start?

When is it worse? ☐ early morning ☐ evening ☐ getting out the car ☐ walking ☐ standing
☐ sitting ☐ twisting ☐ lifting ☐ bending forward ☐ bending backward ☐ climbing uphill ☐ climbing downhill

What makes it better? ☐ sitting ☐ standing ☐ lying ☐ leaning on shopping cart ☐ medications

Do you have any : ☐ new bowel problems ☐ new bladder problems ☐ night pain ☐ unintentional weight loss

Do you take blood thinners? ☐ no ☐ yes, name and dose:

How have you managed this pain so far? ☐ OTC medications ☐ narcotics ☐ muscle relaxer
☐ recent physical therapy ☐ chiropractic ☐ epidural injections ☐ professional psychological help

A) Current pain level _____ B) Average pain level_____
C) Least pain level _____ D) Worst pain level _____

Did you have any surgery for this pain before the onset of these symptoms? ☐ yes ☐ no

What specifically is your pain keeping you from doing?

Is this an accident related injury? ☐ no ☐ yes **if yes then answer the following:**
Date of the injury:_____
What were you doing at the time of injury? _____
How did the injury occur? _____
Do you think you can start working? ☐ yes, without limitation ☐ with limitations ☐ in the future ☐ not at all

Pain diagram: Mark areas using letters listed below
N = numbness **P =** pins and needles **T=** throbbing **A =** achy **B =** burning **S =** shooting **H=** sharp