Coeur d'Alene Spine and Brain, PLLC

P: 208-765-9100 F: 208-765-9103

Date: _____

Referring Physician: _____ **Phone:** ( )_____ **Fax:** ( )_____

Family Physician: _____ **Phone:** ( )_____ **Fax:** ( )_____

Pharmacy Name: _____ **Address:** _____

Patient (Legal) Name: _____
First MI Last

Mailing Address: _____
City State Zip

Physical Address: _____
City State Zip

Home Ph: ( )_____ **Cell/Work:** ( )_____ **Email:** _____

Perferred Communication: _____

SSN: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** _____ Male _____ Female

Marital Status: _____ **Preferred Language:** _____

Race: **(circle one)** American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown

Ethnicity: **(circle one)** Hispanic/Latino Not Hispanic/Latino Unknown Other

Employer: _____ **Occupation:** _____

Employers Address: _____ **Phone:** ( )_____

In case of a medical emergency, who would you like us to notify?

Name: _____ **Phone:**_____

Relationship: _____

Complete if patient has insurance coverage through someone other than their self or is a dependent:

Responsible Party: _____ **Relationship to Patient:** _____

Responsible Party Address: _____
City State Zip

Phone: ( )_____ **Spouse's Name (if Applicable):** _____

Is this visit a result of an injury? Yes / No **Date of Injury:** _____

Is this work related? Yes / No **Other:** _____

Attorney (if applicable): _____ **Attorney Ph:** ( )_____

Updated 02/10/2019

Insurance Information: To be used for commercial insurance payers with OON benefits, ancillary services and authorization.

Medicare/Medicaid Patient Only: Opt Out of Medicare/Medicaid is a contract between the provider, beneficiary, and Medicare where the provider or beneficiary does not file a claim to Medicare. The provider and the beneficiary (patient) will enter into a private contract that is to be executed prior to any services rendered.

Primary Insurance Company: _____ Phone: _____

Name of the Primary on Insurance: _____ Soc. Sec. Number: _____

Date of Birth for Primary on Insurance: _____ Relationship to Patient: _____

Insurance Address: _____

Policy #: _____ Group #: _____

Does your insurance require pre-authorization for visits to a doctor? [ ] Yes [ ] No

Secondary Insurance Company: _____ Phone: _____

Name of Insured: _____ Soc. Sec. Number: _____

Insurance Address: _____

Policy #: _____ Group #: _____

Does your insurance require pre-authorization for visits to a doctor? [ ] Yes [ ] No

Worker's Compensation/Motor Vehicle Information:

Carrier: _____ Claim #: _____

Claim Office Address: _____

Adjuster: _____ Phone: _____

Date of Injury: _____ Employer: _____

Are you represented by an attorney? [ ] Yes [ ] No

Name of attorney: _____ Phone: _____

Coeur d'Alene Spine and Brain, PLLC

Policies Acknowledgement Form

Please read the following information regarding your care and patient responsibility at Coeur d'Alene Spine and Brain. You will be asked to sign on the second page indicating you have read and understand the policies, procedures and your financial responsibility as a patient.

Patient Name: _____ DOB: _____

Patient Financial Responsibility

Coeur d'Alene Spine and Brain appreciates the confidence you have shown in choosing us to provide for your health care needs. The service(s) you have elected to participate in implies a financial responsibility on your part.

Coeur d'Alene Spine and Brain is an out-of-network provider for all commercial insurance payers. Our office will accept and bill all commercial insurances with out-of-network benefits. You are responsible for the in-network cost share for services provided in an in-network facility.

Coeur d'Alene Spine and Brain has opted-out of Medicare and Medicaid. A private contract between you and the provider will be executed prior to any services where the provider or you does not file a claim to Medicare or Medicaid. You are responsible for payment in full at the time of service.

Prescription Refill Policy

Coeur d'Alene Spine and Brain providers will not fill prescriptions after set hours or on weekends. Post-surgical patients will receive prescriptions for a set period of time depending on their surgery and their adherence to the prescription directions. After this time period, it is the patient's responsibility to make any necessary arrangements with their primary care physician for any further refills. It is your responsibility as a patient to manage when you will need a refill and notify the office in a timely fashion. Refills for medications should be phoned into the pharmacy to request any needed refills. Prescription refills will only be filled in accordance with the office policy (which is posted and may be subject to change). Please take time at each office visit to ensure that you are current on any prescription policy changes (both state mandated and internal).

Cancellation/ No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to cancel your appointment. Patient's who "no show" without advance warning for two consecutive appointments may be discharged from care. Coeur d'Alene Spine and Brain will notify you in writing, via certified mail, if you are discharged from care.

Self Referral Notice (Pleasant View Surgical Center)

Pursuant to Section 6002 of the Patient Protection and Affordable Care Act (PPACA), with respect to transparency reports and reporting of physician ownership or investment interests, Coeur d'Alene Spine and Brain would like you to be aware that Pleasant View Surgery Center is owned in part by physicians. Jeffrey J. Larson, M.D. is part owner in the surgery center. Coeur d'Alene Spine and Brain providers may choose to refer you to have your surgery/procedure done at Pleasant View Surgery Center and may also be performing your surgery or other services in connection with your referral. Please discuss this matter with your physician so that you may exercise your right to be treated in another health care facility if desired. Upon your request, your physician will provide names and addresses of alternative facilities where you may go to obtain services.

Consent for Treatment and Authorization to Release Information

I am aware that by signing below, I authorize Coeur d'Alene Spine and Brain, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I also authorize Coeur d'Alene Spine and Brain to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

To help protect our patient's privacy, Coeur d'Alene Spine and Brain requires patient's to sign a medical records release prior to releasing any records. We understand that there are situations where another medical provider might need pertinent information in order to expedite your medical care. To help you receive timely care, Coeur d'Alene Spine and Brain will release medical information via verbal and written requests from other physician's offices without a signed release.

By signing below, I am aware that Coeur d'Alene Spine and Brain will do their best to protect my confidential information, but I understand that it is possible for someone to misrepresent themselves by telephone and/or forgery and that my right to privacy may be compromised.

Patient Initials: _____ Date: _____

Coeur d'Alene Spine and Brain, PLLC

Policies Acknowledgement Form

Notice of Privacy Practices (HIPAA)

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Lisa R. Tansy, Administrator. Our Notice of Privacy Practices (HIPAA) describes in more detail how your health information may be used and disclosed, and how you can access your information. If you would like a copy for your records you may request one from the front desk or you may download a copy on our website www.cdaspine.com.

I hereby authorize that I have read the Coeur d'Alene Spine and Brain Policies Acknowledgement Form in its entirety (2 pages) and understand my responsibilities and options as a patient.

Patient Signature: _____ Date: _____

Guarantor Signature : _____ Date: _____
(if guarantor is not the patient)

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical records system (EHR/EMR) and becomes part of your personal medical records. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plan(s), and my other healthcare provider(s).

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Printed Name Relation

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this Authorization.

Name of patient: _____ Date of Birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: **CDA SPINE AND BRAIN (CDA SPINE)**

to release to: _____

(Persons/Organizations authorized to *receive* the information) (Address, street, city, state, zip code)

The following information:

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received – **OR**

☐ Only the following records or types of health information (including any dates):

_____

_____

b. I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information[1] (A separate authorization is required to authorize the disclosure or use of psychotherapy notes.)

☐ HIV test results

☐ Alcohol/drug treatment information

PURPOSE

Purpose of requested use or disclosure: ☐ Patient request; ***OR*** ☐ Other

_____

_____

EXPIRATION

This Authorization expires _____:
(Date)

Authorization will expire in 12 months if not specified.

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

3320 N Grand Mill Lane, Coeur d'Alene, ID 83814

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.[4]

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

SIGNATURE

Date: _____

Time: _____ am/pm

Signature: _____

(Circle one: patient / representative / spouse / financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: _____

_____

Witness: _____

[1] If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

[2] If any of the HIPAA-recognized exceptions to this statement apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[3] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

[4] The requestor is to complete this section of the form.

Accidental Injury Questionnaire

We cannot process your claim until you complete and return this questionnaire

Identification Number	Group Number
Patient's Name	
Provider of Service	Dates of Service

Was this condition the result of an ***injury/accident***? ❑ **YES** ❑ **NO** **If NO, sign below, date this form and return it to us.**

For a description of an injury accident check your policy.

Provide a detailed account of how and where the injury occurred and a brief description of the injury. Please use the back of this form for additional space if necessary.

Date of Injury _____ (mm/dd/yy)

Place of Injury ❑ **Home** ❑ **Work** ❑ Other (give location) (ex. auto, motorcycle, snowmobile or boat)

How Injury Occurred

WORK RELATED?

Was the injury or illness sustained while performing work required by your employment? ❑ **YES** ❑ **NO**

Are you covered by Workers' Compensation? ❑ **YES** ❑ **NO** Are you self-employed? ❑ **YES** ❑ **NO**

If Workers' Compensation has been denied, please attach a copy of denial.

Name and address of your employer

Are you covered by insurance coverage other than Workers' Compensation for work-incurred injuries? ❑ **YES** ❑ **NO**	Name and address of other insurance carrier

OTHER PARTY INFORMATION

Was another person or parties responsible for your injury? ❑ **YES** ❑ **NO**	Name and address of responsible party

Please provide responsible party's insurance carrier information

Have you received settlement from the responsible party? ❑ **YES** ❑ **NO**

Do you intend to make a claim against the responsible party? ❑ **YES** ❑ **NO** ❑ **POSSIBLY**

Have you filed or do you intend to file a claim against your own insurance coverage (e.g., automobile, homeowner's, etc.)? ❑ **YES** ❑ **NO**

Please provide adjuster's name, address, and phone number:

Is an attorney representing you in this matter? ❑ **YES** ❑ **NO**
If so, please give your attorney's name and address

Have you purchased prescription drugs related to this accident using a prescription drug card? ❑ **YES** ❑ **NO**

Signature Home Phone Business Phone Date

DETAILED INJURY ACCOUNT *(continued)*

New Patient Intake Information

***By initialing here, I understand that, although not required, filling out the non-mandatory information asked will help facilitate my consultation.**

Initials ___ Date _____

Name: _____ Preferred Name: _____
Title _____ Age ____ Gender_____

How did you find/get referred to Dr. Larson - CDA Spine? _____
Explain: _____

Description of Condition:
Symptoms/pain/condition developed: _____ Date of symptom onset: _____
Brief description of condition:
_____
_____
_____

Is your condition the result of an injury? Yes ___ No ___

Work injury: Yes ___ No ____ What state? _____
Do you have an open claim? Yes ___ No ___
Insurance Company: _____ Claim #_____
Claims Manager: _____ Attorney_____
Brief injury description: _____

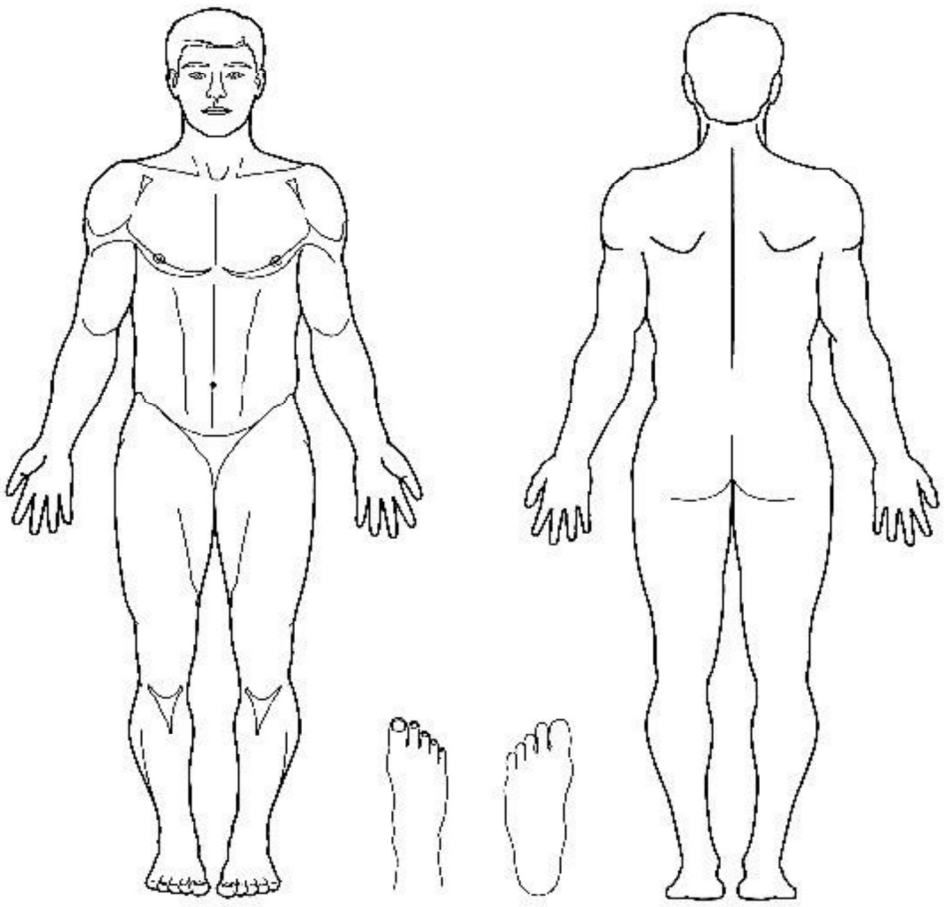
Motor Vehicle Accident: Yes ___ No ___
Auto Insurance Co.: _____ Attorney: _____
Explain: _____

Other Injury: _____
_____

About your current condition:
Pre-condition level of function: _____
Current condition level of function: _____
Goal condition level of function: _____
What activities do you, or would you like to do?
_____
_____

On a scale of 1-10 (1 least, 10 worst) what is your average pain? _____
On a scale of 1-10 (1 least, 10 worst) what is your worst pain? _____
On a scale of 1-10 (1 least, 10 wors) what is your current pain? _____

Please use the following key to shade in the distribution of your pain on the figures:
Numbness …….. **Pins and Needles** 00000000 **Pain** ///////////////



Describe your pain: (check all that apply): □ Constant □ Intermittent □ Dull □ Sharp □ Throbbing □ Burning □ Tingling □ Aching. □ Stabbing □ Shooting □ Electrical
□ Other (explain)_____

What aggravates your pain? (check all that apply): □ Bending forward □ Bending backward □ Sitting □ Standing □ Walking □ Laying down □ Looking up □ Looking down □Turning head right □ Turning head left □ Twisting right □ Twisting left □ Cough/ sneeze □ Lifting □ Pushing/pulling
□ Other (explain)_____

What helps your pain? (check all that apply): □ Laying □ Sitting □ Standing □ Changing position □ Physical Therapy □ Chiropractic □ Massage □ Acupuncture □ Heat □ Cold □ Muscle relaxers □ Pain medications (list in medication section) □ Nothing
□Other (explain)_____

Have you experienced new bowel or bladder problems? Yes ___ No ___

Have you had any of the following imaging for the current problem? Yes ___ No ___
□ X-rays □ CT scan □ MRI □ Bone scan

Name/address/phone number of Imaging Center:

_____
_____

Have you had any of the following treatments/tests for the current problem?
□ Diagnostic Spinal Injections e.g. □ Epidural/ESI □ Facet joint □ Intervertebral disc □ SI joint
□ Nerve block □ EMG/NCVs
□ Orthopedic Injections □ Arthrogram
If yes, explain: _____
_____

Have you had documented PT and/or Chiropractic treatment for your condition? Yes ___ No ___
Which treatment(s)? _____
When was the most recent documented treatment? _____
How long was the treatment? _____
Name and address of where you had the treatment?
_____
_____

Have you had any of these treatments for your condition?
□ Acupuncture □ Massage □ Home/gym exercises □Cervical traction □Lumbar decompression

Have you had the following treatments?
Surgery: Yes ___ No ___ Description: _____
Spine Injection(s): Yes ___ No ___ Description: _____
Stem cell/PRP/Regenerative Injection: Yes ___ No ___ Description: _____
Joint Injection(s): Yes ___ No ___Description: _____

Have you tried the following medications? Please check all that apply.
□ Narcotics □ Lortab □ Hydrocodone □ Oxycodone □ Oxycontin □ Ultram □ Vicodin □ Percocet
□ Norco □Fentanyl □ Dilaudid □ Methadone □ Other _____
□ Anti-inflammatories □ Ibuprofen □ Aleve □ Naproxen □ Mobic □ Celebrex □ Diclofenac □ Steroids
□ Other _____
□ Muscle relaxants □ Soma □ Flexeril □ Carbamazepine □ Zanaflex □ Skelaxin
□ Robaxin/Methocarbamol □ Other _____
□ Neuropathic drugs □ Neurontin/Gabapentin □ Lyrica □ Other _____
□ Anti-depressants □ Paxil □ Zoloft □ Nortriptyline □ Amitriptyline □ Other _____

Are you on a pain medication contract? Yes ___ No ___
With whom? _____

Are you currently taking any blood thinning/anticoagulation medications? Yes ___ No ___
If yes which medication(s)? □ Coumadin □ Warfarin □ Pradaxa □ Plavix □ Aggrenox □ Aspirin
□ Eliquis □ Flax seed oil □ Fish Oil □ Other _____

Do you use GLP-1 (Semaglutide, Ozempic, Tirzepatide, Mounjaro, Trulicity)? Yes ___ No ___
***If yes, anesthesia requires that you stop 10 days before any surgery.**

Current Medications:

_____

_____

Medication Allergies: Yes ___ No ___

□ Iodine □ Contrast dye □ Steroids □ Local Anesthetics □ Latex

□ Other: _____

□ Allergic Reaction that occurred: _____

Medical History: Please check the following medical problems you have now, or have had:

□ Anemia	□ Heart Problems	□ Easy bleeding	□ Osteoarthritis.
□ Asthma	□ Thyroid problems	□ Colon disease	□ Ulcers
□ Cancer	□ Epilepsy	□ High blood pressure	□ Kidney disease
□ Stroke	□ Migraines	□ Hepatitis/HIV	□ Bladder problem
□ Anxiety	□ Depression	□ Fibromyalgia	□ Lung Disease
□ Depression	□ Osteoporosis	□ Rheumatoid arthritis	□ Vascular Problems

□ Diabetes Type 1 (insulin dependent) □Diabetes Type 2

□Parkinson's Disease □Dementia □Alzheimer's Disease

□Other: _____

Cardiac History: Yes ___ No ___. **If yes, check those that apply.**

□ Hypertension □ Coronary Artery Disease (CAD) □ Myocardial Infarction (MI) □ Atrial Fibrillation

□ Congestive Heart Failure (CHF) □ Cardiac stents □ Peripheral stents □ Mitral Valve Prolapse

□ Aortic Stenosis □ Aortic Valve Disease □ Mitral Valve Disease □ Pacemaker □ Defibrillator

□ AAA (Abdominal Aortic Aneurysm) □ Abnormal Heart Rhythm □ Heart Palpitations □ Heart murmur

Other heart conditions: _____

Have you had an Echocardiogram? Yes ___ No ___

When and where? _____

Pulmonary History: Yes ___ No ___

If yes, check those that apply.

□ Asthma □ COPD □ Emphysema □ Oxygen Dependency □ Home Oxygen(O2) □ Sleep apnea □ CPAP

□ Tuberculosis □ Dental Appliance

□ Other lung conditions: _____

Have you had previous back or neck problems? Yes ___ No ___

Explain: _____

Have you received care from a mental health professional? Yes ___ No ___ □ Still seeing ___

Have you ever had an infection with MRSA? Yes ___ No ___

Have you had COVID-19? Yes ___ No ___ How many times? ___

Surgical History:

Have you had Spine Surgery? Yes ___ No ___

□ Cervical □ Thoracic □ Lumbar □ Laminectomy □ Discectomy □ Cervical Fusion □ Cervical ADR

□Lumbar Fusion □Lumbar ADR □Scoliosis Surgery □ Other

Description: _____

Surgeon(s)_____

Have you had Orthopedic Surgery? Yes ___ No ___

□ Shoulder □ Elbow □ Wrist □ Hand □ Hip □ Knee □ Ankle □ Foot □ Other _____

Have you had any anesthesia complications? Yes ___ No ___
Explain: _____

Family History: Please check those illnesses that your family members have had

	Hypertension	Diabetes	Neurologic Problems	Heart Disease	Cancer	Arthritis
Father	□	□	□	□	□	□
Mother	□	□	□	□	□	□
Siblings	□	□	□	□	□	□
Grandparents	□	□	□	□	□	□

Father: □ Living □ Deceased (Age) ___ Mother: □ Living □ Deceased (Age) ____

Social History:
Do you now, or did you ever smoke? Yes ___ No ___ Packs per day? ____ Quit? Yes ___ No ___
Do you drink alcohol? Yes ___ No ___ □ Daily □ Weekly □ Rarely
Do you now, or have you ever had a drug or alcohol problem? Yes ___ No ___
Please explain:_____

Marital Status: _____

Occupational History:
Employer:_____
Job Description: _____
□ Employed Full Time □ Employed Part time □ Regular Duty □ Light Duty □ Retired
□ Currently off work:
Years at current job: _____ Date last worked: _____
How physically demanding is your job? _____
Rate your current job satisfaction: □ Very Satisfied □ Satisfied □ Indifferent □ Dissatisfied
Have you ever been on disability? Yes ___ No ___
Explain: _____

Review of Systems: Please check any of the symptoms you have had during the past year.

□ *Fever*	□ *Chills*	□ *Unintentional weight loss of >10 #*	
□ *Rashes*	□ *Skin infections*	□ *Itching of skin*	
□ *Cataracts*	□ *Glaucoma*	□ *Double vision*	□ *Loss of vision*
□ *Ear infections*	□ *Mouth sores*	□ *Sore throat*	□ *Nasal congestion*
□ *Chest pain*	□ *Leg swelling*	□ *Irregular heartbeat*	
□ *Short of breath*	□ *Cough*	□ *Wheezing*	
□ *Nausea*	□ *Vomiting*	□ *Abdominal pain*	
□ *Blood in urine*	□ *Painful urination*	□ *Difficulty urinating*	
□ *Dizziness*	□ *Seizures*	□ *Ringing in ears*	□ *Memory loss*
□ *Face numbness*	□ *Arm numbness*	□ *Leg numbness*	□ *Sudden weakness*
□ *Joint pain*	□ *Muscle pain*	□ *Difficulty walking*	
□ *Depression*	□ *Anxiety*	□ *Hallucinations*	
□ *High blood sugar*	□ *Thyroid disorder*	□ *Anemia*	

The information I have provided in this document is true and accurate to the best of my knowledge.

_____ _____
Patient Signature Date