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

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 MD: _____
First and last name First and last name

Emergency contact: _____
Name Phone Relationship

PRIMARY INSURANCE ***SECONDARY INSURANCE***

_____ _____
Insurance Company Name Phone number Insurance Company Name Phone number

_____ _____
Policy number Group number Policy number Group number

Responsible party: _____ Responsible party: _____

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

Name of Insurance Co: _____

Date of injury __/__/__ Claim # _____ Employer at time of injury _____

_____
Claim Manager's name and phone number Billing Address

Attending Provider: _____ Allowed diagnosis _____

If related to a **Motor Vehicle Accident**, please provide: _____ __/__/__
Insurance Company Name date of accident

_____
Insurance Company Address Claims Adjuster Name & Phone #

_____
Party responsible for payment Claim # Policy #

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:* _____

Revised 11/15
Revised 3/15

Fourth Corner Neurosurgical-Authorization to Use or Disclose Protected Health Information

Patient name:_____ Previous name:_____ Date of birth:_____

I. My Authorization

Fourth Corner Neurosurgical may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition:_____
- ☐ Health care information in my medical record for the date(s):_____
- ☐ Other (e.g., X-ray,bills) -specify date(s):_____

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV/AIDS
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health or Illness
- ☐ Drug and/or alcohol abuse
- ☐ Reproductive Care (minors only)

Minors- a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older),HIV/AIDS (if age 14 and older),drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 or older).

You may disclose this health care information to:_____

Name (or title) and organization or class of persons:_____

Address (optional):_____City:_____State:_____Zip:_____

Reason (s) for this authorization to use or disclose my health care information (check all that apply):

- ☐ at my request
- ☐ check here if (insert name of practice or facility) will be paid for providing health care information for marketing purposes by the third party whose product or service is described in the marketing
- ☐ other (specify) _____

This authorization ends: ☐ on (date):_____ ☐ when the following event occurs:_____

☐ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment).

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies or
   - to receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Fourth Corner Neurosurgical in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   - Fill out a revocation form-a form is available from Fourth Corner Neurosurgical or
   - Write a letter to Fourth Corner Neurosurgical

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

Patient or legally authorized individual signature_____Date:_____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)_____

Minor patient's signature, If applicable_____Date:_____

Fourth Corner Neurosurgery

To Our Patients:

Please read and sign the following:

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. Thank you.

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. 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. 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 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, when 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.

Print Name:_____

Signature: _____ **Date:**_____

3-15

Fourth Corner Neurosurgical Associates
Financial Policy

As a condition for medical service by a practitioner of Fourth Corner Neurosurgical Associates, 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 Associates 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 others 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

_____ Date: _____

Patient Signature

Fourth Corner Neurosurgical Associates
710 Birchwood Avenue Suite 101
Bellingham, WA 98225

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

☐ Asthma
☐ COPD
☐ Pneumonia
☐ Tuberculosis

☐ Peptic ulcer
☐ Gastric reflux
☐ Irritable bowel syndrome

☐ Osteoporosis
☐ Osteoarthritis
☐ Rheumatoid arthritis

☐ Anxiety
☐ Depression
☐ Bipolar
☐ Post-traumatic stress disorder

☐ Peripheral artery disease
☐ Deep vein thrombosis
☐ Pulmonary embolism
☐ Bleeding disorder
☐ Anemia

☐ MRSA
☐ HIV
☐ AIDS
☐ Hepatitis B
☐ Hepatitis C

☐ Glaucoma
☐ Cataracts (including surgery)

☐ Parkinson's disease
☐ Dementia

☐ Thyroid disease: type: _____
☐ Diabetes: Type 1 or Type 2 (circle one)
☐ Diabetic neuropathy
☐ Cancer: Type: _____
Type of treatment_____
☐ other:_____

☐ Fibromyalgia
☐ Migraines: how often? _____
☐ Muscle disease: type:_____
☐ Stroke/TIA: lasting effects?:_____
☐ Syphilis

Past Surgical History:

Surgery:	Date:
_____	_____
_____	_____
_____	_____
_____	_____

Fourth Corner Neurosurgical Associates
710 Birchwood Avenue Suite 101
Bellingham, WA 98225

Patient name:_____Date of Birth:___/___/___Date:_____

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 □ Smoker, 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 infections

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

Fourth Corner Neurosurgery & Pain Management
710 Birchwood Avenue Suite 101
Bellingham, WA 98225
(360) 676-0922

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
On a scale of 0 to 10, 0 = no pain 10 = worst pain answer the following: 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