2020 8th Ave., #200
West Linn, OR 97068
503- 512-1212

willamette PAIN & SPINE

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Welcome to Willamette Pain and Spine

Your patient consultation appointment is scheduled for:

_____

Arrive 10-15 minutes early.

- Complete the enclosed paperwork and bring to your appointment along with your insurance card.
- Be prepared to pay your co-payment and/or co-insurance prior to your appointment.

We believe the more you know about Willamette Pain and Spine (WPS) the better we can partner with you and your other care providers to make a difference. Please take a few minutes to read and become familiar with the following information:

WPS is an Interventional Pain Management Practice. Our strengths include diagnostic/therapeutic injections and related techniques. Though we evaluate and organize medicine programs, we do not manage maintenance medicines, i.e.: blood pressure, diabetes, cholesterol, etc which will not be managed by one of our providers, but should be managed through your primary care physician.

Office Hours: Monday – Thursday, 8:00am – 4:30pm Friday, 8:00 – 12:00

Appointments: Please arrive 10-15 minutes before your scheduled appointment time for your initial consultation appointment to allow for registration. Late arrivals or those needing additional time for registration may be rescheduled. Arriving on time allows us to stay on schedule so that all patients are treated in a timely manner. **If you need to cancel your appointment please contact us 24 hours prior to your scheduled appointment time to avoid a $50 late cancellation fee.**

Telephone Calls: We attempt to be thorough and complete during your visit. The providers will rarely be interrupted by phone calls or other matters during your visit. Patients are asked to respect one another's time by holding questions for scheduled office visits. You are encouraged to write your questions down so they can be addressed during your scheduled appointment. If your questions cannot wait, you may call the office and leave a message with our clinical staff. Non-urgent medical matters will be addressed no later than the end of the next business day. Please do not leave duplicate messages unless you have not heard back from us within 48 hours.

Emergencies: Fortunately, there are few medical emergencies related to chronic pain. If you feel you are experiencing a medical emergency, please go directly to the nearest emergency room or urgent care facility. The provider at this facility will call and communicate with your pain provider at WPS.

Referral Policy: Willamette Pain and Spine is a specialty clinic and does not assume the role of a Primary Care Provider (PCP); therefore, all patients must have a relationship with a PCP.

Prescriptions: The State of Oregon requires providers to inform patients of the material risks related to the use of narcotic medicines. This information is in the provider agreement you will receive and be asked to sign at your consultation appointment. Prescription refills will only be given at your scheduled appointments. WPS does not accept telephone or fax refill requests from patients or pharmacies.

Test Results: All test results are reviewed by your provider when received. Results will be discussed with you at your scheduled follow up visit. Urgent findings will be addressed sooner, as appropriate.

Procedures: If injection treatment is appropriate, you will receive instructions when your procedure is scheduled. Please read these carefully. If instructions are not followed, your appointment will be rescheduled. If you elect to have sedation, you must have someone else drive you home. Your driver must be present in our office during your entire appointment.

Payment: Your bill is your responsibility. As a courtesy to you, WPS will bill most, but not all, insurance carriers. You are responsible for paying your portion of expenses at the time of service. Please refer to enclosed Financial Policy for additional information.

Code of Conduct: Every staff member at WPS conducts themselves with respect toward patients, family members, referring physicians and staff. We expect behavior that respects the rights of other patients and our office staff. Unacceptable behavior includes the following and will not be tolerated will result in termination of care:

- Excessive noise which is obtrusive to others
- Use of language, gestures or actions that are threatening, abusive, obscene or aggressive
- Offensive remarks of a racial, sexual or perverse nature
- Damage to property & theft
- Inappropriate behavior involving alcohol/substance misuse

YOUR APPOINTMENT IS SCHEDULED AT THIS LOCATION:
Willamette Pain and Spine Center
2020 8th Ave, #200
West Linn, OR 97068

Directions:

From Interstate 205 South, take exit # 6 (10th Street). Turn Left on 10th Street. Turn right on 8th Avenue. Turn right at third
driveway into parking lot (sign for Les Schwab Tire Center and Legacy Health). Office will be on the right. Upon entering the building, the elevator will be on the left and stairs on the right. Suite 200 will be on the second floor.

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

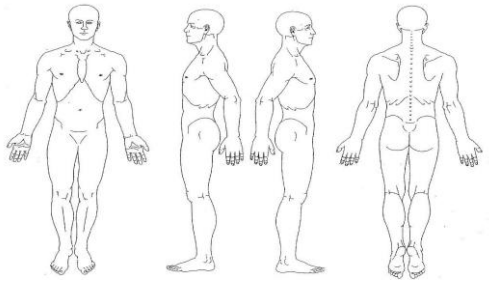
PATIENT QUESTIONNAIRE

Name:_____ Age: _____ Birth Date: _____Height: _____ Weight: _____
Referring Physician: _____PCP: _____
Reason for Visit: ( ) Evaluation ( ) Diagnostic Injection ( ) Other Therapy: _____
( ) Workers' Compensation If yes, Claim Status: ( ) Open ( ) Closed ( ) Deferred Date of Injury: _____

PAIN PROBLEMS *(List most important to least important)*
1. _____
2._____
3. _____
4._____

HISTORY OF PRIMARY PAIN PROBLEM
Onset (Date of First Symptom): _____
Description of Injury: _____
_____
_____

PAIN LOCATION *(Mark the area of pain using symbols)* Sharp xxxx Dull = = = = Tingling 00000 Numb ///////



PAIN DESCRIPTION *(Circle description of your pain)*
Sharp Burning Cold Dull Spasm Tingling
Shock Aching Numb Electrical Hot Continuous
Daily On and Off

PAIN SCORE FOR THE LAST MONTH *(Circle Number)*
0 = No Pain 10 = Worse Pain Imaginable
Average Pain 0 1 2 3 4 5 6 7 8 9 10
Worst Pain 0 1 2 3 4 5 6 7 8 9 10

PREVIOUS TREATMENT	Helped	Did Not Help
Medicine	( )	( )
Anti-Inflammatory Medicine	( )	( )
Physical Therapy	( )	( )
Electrical Stimulation	( )	( )
Chiropractic	( )	( )
Injection	( )	( )
Surgery	( )	( )

PREVIOUS TESTS *(For pain problem) Example: MRI, CT, Xray*

Test	Date	Facility

PAIN MEDICINES

Medicine	# mg	# Dose/Day

NON PAIN RELATED MEDICATIONS

Medicine	# mg	# Dose/Day

PREVIOUS SURGERIES **Date**
_____
_____
_____
_____

MEDICINE ALLERGIES/REACTON
_____
_____
_____
_____

OTHER ALLERGIES
Tape Yes No
Iodine Yes No
Latex Yes No
Contrast Dye Yes No

OTHER MEDICAL DIAGNOSIS/CONDITIONS
_____
_____
_____
_____

Cancer: Yes No Type: _____
_____

HABITS	**No**	**Yes**	**Current**
Smoking	( )	( )	( ) _____Packs/Day
Alcohol	( )	( )	( ) _____ Drinks/Day
Marijuana	( )	( )	( )
Marijuana Card	( )	( )	( )
Rx (recreational use)	( )	( )	( )
Street Drugs	( )	( )	( )
Addiction/Dependency	( )	( )	( )

HOW DOES THE PAIN AFFECT YOUR LIFE?

	Mild	Moderate	Severe
Ability to Work			
General Activities			
Self Care			
Sleeping			
Eating			
Mood			
Enjoyment			
Sexual Function			
Overall			

FAMILY HISTORY (M=Maternal, P=Paternal, B=Brother, S=Sister, Son, D=Daughter)

	Parent	Grandparent	Sibling	Child
Heart Disease				
Lung Disease				
Diabetes				
Headache				
Arthritis				
Cancer/Tumor				
Stroke				
Kidney Disease				
Mental Disease				
Neurological				

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL SYMPTOMS? (Circle all that apply)

GENERAL: Fever Malaise Weakness Dizziness Unsteady Gait Sweating Insomnia
Weight Loss Weight Gain Skin Condition
EYES: Pain Blurred Vision Double Vision
EARS/NOSE/THROAT: Pain Hearing Loss Sinus Condition Difficulty Swallowing Snoring
HEART: Chest Pain Irregular Heartbeat Heart Failure High Blood Pressure
LUNGS/CHEST: Cough Wheezing Shortness of Breath Chest Wall Pain Asthma
GASTROINTESTINAL: Heartburn Nausea Vomiting GERD Intestinal Bleeding Diarrhea Constipation
KIDNEYS/GU: Poor Kidney Function Endometriosis Interstitial Cystitis Stones
SKELETON: Spine Pain Joint Pain Morning Stiffness
MUSCLES: Pain Spasm Weakness
MENTAL: Depression Psychosis Anxiety Other
NEUROLOGY: Stroke Headache Nerve Pain Pinched Nerve Seizure Migraine Poor Cognition Poor Coordination

OTHER:

Are you currently pregnant? Yes No
Do you have a bleeding disorder? Yes No
Explain: _____
Are you currently taking blood thinning medication? (Including aspirin) Yes No

	Yes	No	(Office Use Only)	
Does anyone in your FAMILY have a history of substance abuse?				
Alcohol			1	3
Illegal Drugs			2	3
Prescription Drugs			4	4
Do YOU have a personal history of substance abuse?				
Alcohol			3	3
Illegal Drugs			4	4
Prescription Drugs			5	5
Do you have a history of pre-adolescent sexual abuse? (Age 5-12)			3	0
Do you have one of the following psychological diseases?				
Attention Deficit, Obsessive Compulsive, bipolar, schizophrenia			2	2
Depression			1	1

Are you currently working? Yes No
If yes, Occupation: _____ # of Years: _____
If no, reason for not working: _____
Marital Status: Single Married Separated Divorced Widowed
Do you have children? Yes No

_____ _____
Patient Signature **Date**

_____ _____
Provider Signature **Date**

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PATIENT REGISTRATION FORM

10001 SE Sunnyside Rd. Suite 100
Clackamas, OR 97015
503-512-1212

Family Physician:	**Date:**
Is treatment related to a work comp injury? **YES NO** ***If yes, Attending Physician:*** _____	

PATIENT INFORMATION

Patient Name: Last First Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Referred by (please check one box): ❑ Dr. _____ ❑ Other _____	Age:	Date of Birth:	Gender: ❑ M ❑ F
Address:	Social Security #:		Home phone:
City:	State:	Zip:	Cell Phone:
Occupation:	Current Employer:		Work Phone:

RESPONSIBLE PARTY

Name: Last First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:
Address:	Social Security #:		Home phone:
City:	State:	Zip:	Cell Phone:
Occupation:	Employer:		Work Phone:

Insurance Coverage

Primary Insurance:	Phone:		
Billing Address, City, State, Zip:	ID #:		Group #:
Subscriber Name: Last First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:
Secondary Insurance:	Phone:		
Billing Address, City, State, Zip:	ID #:		Group #:
Subscriber Name: Last First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Other phone:

The above information is true to the best of my knowledge. I understand I am financially responsible for any balance not covered by my insurance carrier.
MEDICARE - I request that payment of authorized medical benefits be made on my behalf to Willamette Pain and Spine Center (WPSC), for any services rendered to me. I hereby authorize WPSC, to release to the health care administrator and its agents any medical information needed to determine these benefits payable for related services under Title XVIII of the Social Security Act.
COMMERCIAL – I hereby authorize the release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHEWISE PAYABLE TO ME to Willamette Pain and Spine Center.

Patient/Guardian signature: _____ **Date:** _____

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Financial Policy

Thank you for choosing Willamette Pain and Spine to assist you with your health care needs. We strive to provide you with the best care possible, and, in return, we ask that you assist us not only in monitoring your health care, but also by paying for our services in a responsible and timely manner.

The following is a statement of our financial policy. Our office requires that each patient read and sign a copy of this policy before we provide any treatment. Therefore, please read through this statement carefully and feel free to ask us any questions you may have relating to our policy before you sign:

- **Insurance cards must be presented at <u>each</u> and <u>every</u> visit.**
- **We do not accept personal checks. We do not accept personal checks or American Express, other payments accepted, Cash, Visa, Discover and MasterCard.**
- **It is your responsibility as the insurance holder to know your benefits. As a specialty office, not all services provided by our office are covered by every plan, therefore any service determined to not be covered will be patient responsibility.**
- **According to your insurance plan, you are responsible for <u>any</u> and <u>all</u> copayments, deductibles and coinsurances, are due at the time of service.**
- **If our providers do not participate in your insurance plan or you have no coverage, payment is due in full at time of service**.
- **All current and prior patient balances including coinsurance and deductibles are due at time of service; appointments will be rescheduled if payment is not collected. Please call your insurance company if you have any questions related to coinsurance and deductibles.**
- **An upfront service charge of $50 is required for filling out and processing any paperwork, if an appointment is not required by the provider, including, but not limited to:**
- **Disability**
- **FMLA**
- **Workers Compensation**
- **Forms will not be processed until payment is received in full**

Missed Appointments: You will be charged for missed appointments; follow-up appointments that are not cancelled at least 24-hours in advance, **is $50.00**. A New Patient Appointment or Procedure that is not cancelled or missed with less than 24-hours advance notice will be **charged $100.00**. **If you are late, 10 minutes or more for your appointment you could be rescheduled and charged a $50 missed appointment fee. Three or more missed appointments are grounds for termination of the patient/provider relationship.**

Patient Responsibility balances over 120 days will be discharged from care.

Print Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

INVITATION TO SELF-IDENTIFY

Federal guidelines require that we request the following information. Please mark ONE BOX that describes the race/ethnicity category with which you primarily identify.

❑	**Hispanic or Latino**: a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture of origin, regardless of race.
❑	**White**: a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
❑	**Black or African American:** a person having origins in any of the black racial groups of Africa.
❑	**Native Hawaiian or other Pacific Islander**: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
❑	**Asian**: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
❑	**American Indian or Alaska Native**: a person having origins in any of the original peoples of North and South American (including Central America), and who maintains tribal affiliation or community attachment.
❑	**Two or More Races**: all persons who identify with more than one of the above five races.
❑	**Decline to Answer**

****For Patient Portal, please provide your email address to access your chart online****

Email:

Contact Telephone Numbers

Please complete relevant information and indicate the number at which you wish to be contacted first.

Phone Messages OK?

		Yes	No	Primary Contact Number
Home:	( )	❑	❑	❑
Cell:	( )	❑	❑	❑

Authorization to Release Information

❑ By checking this box, I have acknowledged that I wish to give consent to the individuals listed below to have access to my medical information (appointments, lab results, etc.) This includes mental health, drug and/or alcohol abuse and sexual content.

Name: Relation: Phone:

Name: Relation: Phone:

❑ By checking this box, I authorize Willamette Pain and Spine to release my medical records to my other health care providers and I authorize my other providers to release medical records to Willamette Pain and Spine, for the purposes of a managed treatment plan and/or continuity of care. The type of information to be disclosed may include: history and physical, medications, therapy, lab / pathology / imaging reports, clinician notes, problem list, and operative reports.

This authorization will remain in effect while I am under the care of Willamette Pain & Spine. I understand that I can change this authorization at any time. I understand that any changes must be in writing.

Print Patient Name: Date of Birth:

Signature: Date Signed:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of Willamette Pain & Spine Notice of Privacy Practices.

Name: _____ Date: _____

Signature: _____

I hereby acknowledge that I was offered and declined a copy of Willamette Pain & Spine Notice of Privacy Practice. I agree that Willamette Pain & Spine made a good faith effort to provide me with this information. I understand that I may request a copy of Willamette Pain & Spine Notice of Privacy Practices at any time and may also find it on their website at www.willamettepain.com

Name: _____ Date: _____

Signature: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

☐ Other: _____

Name of Patient: _____