

Welcome to Northwest Surgical Specialists

We would like to welcome you to our office and we appreciate the opportunity to be of service. As a new patient, we intend to make your visit with us as helpful and efficient as possible. To achieve this goal we have included for you some forms for you to complete prior to your arrival.

We are located on the Northwest Hospital and Medical Center campus in the Medical office building, 1560 N 115th, Suite 102 Seattle WA 98133. The campus does charge for parking. The first 30 minutes are FREE, 30-60 minutes \$2.00, 1-2 hrs \$3.00, 2-3 hrs \$4.00, and anything over 3 hrs \$5.00.

Please plan on arriving for your appointment with the completed "new patient" forms, and the following 10 minutes before your scheduled appointment.

- Insurance card or cards
- Copay and referral if required by your insurance
- Picture ID
- List of names and dates of major surgeries
- List of any current medications and dosages
- List of any medications that caused an allergic reaction
- Copies of studies/reports you may have regarding your condition

We must make a copy of your insurance card and Drivers License which will be securely held within your medical record. You can expect this appointment to last 30 to 60 minutes.

We welcome your comments and suggestions on your experience. Please call 206.363.4015 if you wish to offer any feedback.

Thank You

Name _____

Date _____

Welcome to Northwest Surgical Specialists. To facilitate your visit, please fill out this questionnaire. If you have any questions, please ask for clarification. Thank you!

Tell us why you are here today?

Pain or Discomfort Y ___ N ___ Where _____ Type: Sharp ___ Dull ___ Achy ___

Please list any surgeries you have had and what year.

Primary Care Provider: _____ Other Health Care Providers: _____

Please list current medications and dosages.

Allergies (Please list and note the type of reaction) Latex allergy: Y ___ N ___ Iodine Allergy Y ___ N ___

Habits

Smoker: Y ___ N ___ Past History _____ cig/packs per day? _____ quit when _____

(Circle one)

Alcohol: Y ___ N ___ Past History _____ Drinks per day/wk/yr? _____ : quit when _____

(Circle one)

Regular exercise: Y ___ N ___ Type _____

Family History of

Cancer: Y ___ N ___ who? _____ What kind? (Breast, Colon, etc) _____

Heart Disease: Y ___ N ___ who? _____

Stroke: Y ___ N ___ who? _____

Diabetes: Y ___ N ___ who? _____

Psych/Social History

Married ___ Single ___ Divorced ___ Sig. Other ___ Widower ___ Occupation _____

Children: Y ___ N ___ How many ___ What ages _____ Family supportive? Y ___ N ___

Please check all the items below that apply to you currently or have in the past.

This side office use only

Systems Review

Neurologic Seizures _____ Headaches _____ Dizziness _____ Stroke _____ Tremors _____	BP _____ P _____ R _____
Eyes, Ears, Nose, Throat Glasses/Contacts _____ Hearing Loss _____ Sinus problems _____	
Cardiac Chest pain _____ Heart Attack _____ High Blood Pressure _____ Irreg. heartbeat _____	
Respiratory: Short of Breath _____ Asthma _____ Cough _____ Infection _____	
Gastrointestinal: Heartburn _____ Ulcers _____ Constipation _____ Weight loss _____ Blood in stool _____ Black stools _____ Liver Disease _____	
Gyn/GU Kidney Stones _____ Urinary infec. _____ Breast problems _____ Prostate prob. _____ Voiding prob. _____	Menarche _____ Menopause _____ PSA _____ Mammos _____ G _____ P _____
Vascular/Heme Ankle swelling _____ Calf pain _____ Bleeding problems _____ Blood Clots _____ Varicose Veins _____	
Musculoskeletal Arthritis _____ Muscle tenderness _____	
Endocrine Thyroid disease _____ Diabetes _____	
Skin Eczema _____ Psoriasis _____ Moles _____	
Mental Health	
Other	

Thank you for filling out this questionnaire!

PROLIANCE

Surgeons, INC., P.S.

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

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 the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

Do you authorize the staff of Northwest Surgical Specialists to discuss your medical condition with any other person? Please list full name(s), date of birth and relationship to patient below:

Name _____ DOB ___ / ___ / ___ Relationship _____

Name _____ DOB ___ / ___ / ___ Relationship _____

This area for staff notes (if any):

This form will be retained in your medical record.

Last Update: March 31, 2008

Northwest Surgical Specialists Financial Policy

Northwest Surgical Specialists is committed to providing the highest level of quality medical care and personal service to our patients. We feel it is the patient or the guardians' responsibility to meet their financial obligations.

As we see patients from many different insurance plans, it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. In addition, your insurance company will not guarantee payment to us. While it is our intention to assist, it is still your responsibility to ensure that all services rendered are paid in full. In order to clarify Northwest Surgical Specialists' Financial Policy, we have listed below our financial requirements:

Financial Responsibility

You, the patient or the patient's guarantor, are ultimately responsible for all charges associated with your care regardless of insurance coverage. Co-payments and Deductibles are a contract responsibility between the patient and their insurance. These amounts are non-negotiable.

Patients Without Insurance Coverage

A deposit of \$150 at the time of service is required. We offer a 5% discount on office visits and a 20% discount on surgical procedures if paid prior to or at the time of service. If necessary, short-term payment plans are available, but must be requested prior to the services being performed. If you cannot pay at the time of service, we may ask that your appointment be rescheduled.

Participating Insurances

We participate with a variety of insurance plans. It is your responsibility to:

- Verify with your insurance that we are a contracted provider
- Bring your insurance card and picture ID to every visit
- Be prepared to pay your co-pay before each visit (cash, check, visa or mastercard)
- Bring any required referral for treatment prior to or at the time of your visit

Auto Accidents

As a courtesy to all our patients, if you have all of the necessary information, we will bill the third party insurance one time as a courtesy to you. Please note that we will not hold for third party payment longer than 90 days.

Workers Compensation Claims

If you are seeing one of our providers for an injury that occurred during the course of your employment, please be sure to advise the receptionist and have all of your claim information available. If this is your first visit to a provider for this injury, we will need you to fill out the necessary paperwork for the State of Washington Labor & Industries here in our office. If your employer is self insured with another carrier please bring the appropriate paperwork and/or billing information. Please be advised that our office is required by law to report all work related injuries.

Pre-Surgery/Pre-payment

Your insurance carrier will be contacted to verify benefits and eligibility prior to surgery. We will also assist you in estimating your costs. Pre-payment may be required. Our office policy is to collect a portion of any unmet deductible prior to surgery. We also may require prepayment for any procedure that may be considered "cosmetic" or not a plan benefit by your insurance carrier, this includes the common varicose and spider vein procedures our physicians perform.

Additional Charges

- For checks returned for Non Sufficient Funds, a \$25 fee will be charged to your account.
- A service fee of \$6.00 will be charged monthly on all balances not paid in full after 60 days
This service fee will be waived if payment arrangements have been made and the arrangements are being honored. Service fees will resume if payments are not met according to the agreement.

Collection Accounts

If your account is sent to collections, you will need to contact Physician & Dentists Credit Bureau at 206-624-1661. We may require that you pre-pay visits after having a bad debt account with us even if you have paid the amount owing with Physicians and Dentists Credit Bureau.

I sign that I understand and agree to the financial policy of Northwest Surgical Specialists.

Guarantor signature

Guarantor representative

Date