



NEW PATIENT INFORMATION

Patient _____ Today's Date _____

Address _____

Sex: Male Female Age _____ Birthdate ___/___/___ Patient SS# _____

Single Married Widowed Separated Divorced Email Address _____

Occupation _____ Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Spouse's Occupation _____ Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____ Work _____ Ext _____ Cell _____

Best time and place to reach you _____

In case of emergency, contact: Name _____ Relationship _____

Home Phone _____ Work Phone _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____ Insurance Company _____

Insurance ID # _____ Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____ Relationship to Patient _____

Birthdate ___/___/___ SS# _____

Additional Insurance Company _____

Insurance ID # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for serviced rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship Date

ACCIDENT INFORMATION

Is condition due to an accident? [] Yes [] No If Yes, type of accident: [] Auto [] Work [] Home [] Other

To whom have you made a report of your accident? [] Auto Insurance [] Employer [] Worker Comp. [] Other

Attorney Name (if applicable) _____ Date of Accident _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? [] Yes [] No [] Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: [] Sharp [] Dull [] Throbbing [] Numbness [] Aching [] Shooting
[] Burning [] Tingling [] Cramps [] Stiffness [] Swelling [] Other

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your [] Work [] Sleep [] Daily Routine [] Recreation

Activities or movements that are painful to perform:
[] Sitting [] Standing [] Walking [] Bending [] Lying Down

HEALTH HISTORY

What treatment have you already received for your condition?
[] Medications [] Surgery [] Physical Therapy [] Chiropractic [] None
[] Other _____

Name and address of other doctor(s) who have treated you for your condition

Date of Last: Physical Exam ___/___/___ Spinal X-Ray ___/___/___ Blood Test ___/___/___
Spinal Exam ___/___/___ Chest X-Ray ___/___/___ Urine Test ___/___/___
Dental X-Ray ___/___/___ MRI, CT-Scan, Bone Scan _____

HEALTH HISTORY CONT.

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other	_____	_____

EXERCISE
 None Moderate Daily Heavy

WORK ACTIVITY
 Sitting Standing Light Labor Heavy Labor

HABITS
 Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/Caffeine Drinks Cups/Day _____
 High Stress Level Reason _____

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name: _____ Pharmacy Phone: _____

FINANCIAL POLICY

Thank you for choosing Northwest Health Group as your health care provider. We are committed to timely, successful, and cost-efficient treatment of your health care needs. In order for us to maintain this high standard of health care, and at the same time, keep our fees affordable, it is necessary for us to adhere to a financial policy. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial policy, which we require you to read and sign prior to treatment.

PATIENT INFORMATION:

All patients must complete our Patient Registration Form prior to their initial visit with the doctor. It is the patient's (and/or responsible parties') responsibility to keep this office informed of any changes in information (i.e. change of address, phone number, insurance company, etc.)

PAYMENT INFORMATION:

Payment is due at time of service. For your convenience, we accept cash, personal checks, Visa and Mastercard. Any copays you have with your insurance are your responsibility. They are due at the time of service. If you do not know the amount of your co-pay, 20% of the total charges will be collected at the time of service.

INSURANCE:

As a courtesy to patients, we will bill your insurance company. In order to do so, we must have updated and accurate insurance information. If a completed claim form is required to accompany our billing, we must have the completed form at the time of visit. Please be aware that your insurance policy is a contract between you and your insurance company if we are not a party to that contract. Your account with this office is your responsibility whether or not your insurance company pays. If your insurance company has not paid your account in full within 60 (sixty) days, your account will become a cash account with the balance due and payable.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the highest standard of health care for our patients. We make every effort to align our fees with what is considered to be usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of "Usual and Customary" rates.

ADULT PATIENTS:

Adult patients are responsible for full payment of their account.

MINOR PATIENTS:

The adult accompanying a minor patient (the "responsible party") is responsible for full payment of the minor patient's account. Under no circumstances will we become involved in any domestic dispute.

MISSED APPOINTMENTS:

Because of the quality of care that we provide for each of our patients, our practice is extremely busy. Please help us better serve you by keeping all scheduled appointments.

Any account not resolved within 120 days will be forwarded to a collection agency. A \$25.00 charge will be assessed to all collection amounts.

Thank you for understanding our Financial policy. Please let us know if you have any questions or concerns. Our strict adherence to this policy serves to enhance our provider/patient relationships.

Respectfully,
NORTHWEST HEALTH GROUP

I have read, understand, and agree to this Financial Policy.

Signature of Patient or Responsible Party

Date

Northwest Health Group Tel (702) 254-0766 Fax (702) 256-9181
7398 Smoke Ranch Road, Ste 230, Las Vegas, NV 89128

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.