NORTHWEST SPECIALTY HOSPITAL

QUALITY CARE SINCE 2003 | PROUDLY OWNED AND OPERATED BY PHYSICIANS

Welcome to Northwest Pulmonology!

We are looking forward to meeting you and want to provide you with this welcome letter as a resource for your first appointment with us. Our goal is to put patients first, so if there is anything we can do for you, please let us know. Thank you for choosing us for your care.

Address:

1551 E Mullan Ave Ste 200-C
Post Falls, ID 83854
Phone: (208) 618-2570
Fax: (208) 618-8779
Website: www.northwestspecialtyhospital/pulmonology

Hours:

Sunday: Closed
Monday: 8am-4:30pm
Tuesday: 8am-4:30pm
Wednesday: 8am-4:30pm
Thursday: 8am-12pm
Friday: Closed
Saturday: Closed

All paperwork must be returned to our office prior to scheduling your appointment per our office policy. You are welcome to drop off the paperwork, mail it to the address above, return it via fax or email. If you are returning the paperwork via email, please scan it as a .pdf as we are unable to accept photos of the paperwork.

APPOINTMENT DATE: _____ TIME: _____

Please be sure to bring photo identification and your current insurance card(s) if applicable.

APPOINTMENT NO SHOW AGREEMENT

NORTHWEST SPECIALTY HOSPITAL
QUALITY CARE SINCE 2003 | PROUDLY OWNED AND OPERATED BY PHYSICIANS

Northwest Specialty Service Line Clinics considers a patient a "No-Show" if they miss an appointment, or do not notify the clinic a minimum of 24 hours prior to canceling an appointment. No-show appointments are disruptive to the optimal delivery of care to you and our other patients. CMS (Center for Medicare Services) has now clarified that physicians will be allowed to charge Medicare beneficiaries for missing appointments, provided they do not discriminate against Medicare patients and charge non-Medicare patients for missed appointments.

Northwest Specialty Service Line Clinics will make every effort to remind the patient of their appointment. Phone numbers of home, work, and cellular should be obtained as often as possible. These notifications will be documented in the patient's chart. Patients can call in and cancel an appointment during normal business hours.

To cancel an appointment, please call_____

- A minimum of **24 hours cancellation** notice is required for appointments; enabling us adequate time to offer the canceled slot to another patient. If less than 24-hour cancellation is given, the appointment becomes a "No-Show" appointment.
- There will be a $50.00 fee charged for a **second** no-show or late cancellation of an office visit.
- If you incur a 3rd "No-Show" appointment within a one-year period, you may receive a letter from our office notifying you that you have been discharged from our office and must find a new care provider.

These fees must be paid prior to being seen on your next visit. You are responsible for any "No-Show" fees you are charged; your insurance company will not be billed.

We regret having to put this policy in place; however, we feel that to be fair to all our patients, we must take these measures.

I have read and understand Northwest Service Lines No-Show Appointment Policy.

_____

Patient Name (Print)

_____ _____

Patient Signature Date

NEW PATIENT REGISTRATION

NORTHWEST SPECIALTY HOSPITAL
QUALITY CARE SINCE 2003 | PROUDLY OWNED AND OPERATED BY PHYSICIANS

1) Full Legal Name			Previous Last Name
Last	First	M.I.	

2) Date of Birth	Social Security Number	Gender at Birth
		❑ Female ❑ Male
3) Preferred Pronouns	**Gender Identity**	
❑ He/Him ❑ She/Her ❑ They/Them ❑ Declined	❑ Decline to Answer ❑ Male ❑ Female ❑ Non-Binary ❑Genderqueer ❑ Transgender Female ❑ Transgender Male ❑ Other_____	
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed		

4) Mailing Address			
Street or PO Box	City	State	Zip Code

5) Contact Information (Please check your preferred contact number)			
❑ Cell phone	❑ Home phone	❑ Work Phone	❑ Email

6) Employer			
Name		Phone	
Street	City	State	Zip Code

7) Preferred Pharmacy			
Name		Phone	
Street	City	State	Zip Code

8) Emergency Contact		
Name	Relationship	Phone

9) Primary Care Provider		
Name	Address	Phone

10) Referring Provider		
Name	Address	Phone

11) Guarantor			
Last	First		M.I.
Street or PO Box	City	State	Zip Code
SSN	DOB	Phone	Relationship to patient

12) Insurance Information			
Primary Insurance Company Name	ID#	Group#	Phone
Subscriber-Employee Name	SSN	DOB	Relationship to patient
Secondary Insurance Company Name	ID#	Group#	Phone
Subscriber-Employee Name	SSN	DOB	Relationship to patient

13) Demographic Information

❑ Decline ❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American
❑ Other _____

14) Ethnic Information

❑ Declined ❑ Not Hispanic or Latino ❑ Hispanic or Latino

15) Preferred Language

❑ English ❑ French ❑ Russian ❑ Arabic ❑ German ❑ Spanish ❑ Chinese ❑ Japanese
❑ Vietnamese ❑ Other _____

I hereby authorize any insurance benefits to be paid directly to Northwest Specialty Hospital. I understand that I am responsible for paying non-covered services. I hereby authorize the release of pertinent medical information to my insurance carriers and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA). I have verified that demographics information sheet to be true and correct.

_____
Signature (Patient or Guardian) Date

_____
Relationship to patient

MEDICAL HISTORY

1) ALLERGIES	
MEDICATIONS	
FOOD	
ENVIRONMENT	
HAVE YOU EVER HAD ALLERGY TESTING?	❑ YES ❑ NO
ARE YOU ALLERGIC TO LATEX?	❑ YES ❑ NO

2) MEDICATIONS

Please list all of the medications you are currently taking.

MEDICATION	DOSE	FREQUENCY

3) PULMONARY HISTORY

****PLEASE ANSWER THE QUESTIONS BELOW**

Why are you seeking pulmonary care?_____

Do you have a CPAP/BIPAP machine? ❑ Yes ❑ No If yes, supplier?_____

Are you on oxygen therapy? ❑ Yes ❑ No If yes, supplier?_____Liter Flow?_____

Have you ever smoked? ❑ Yes ❑ No If yes, how many packs per day?_____ How many years?_____

Have you ever vaped? ❑ Yes ❑ No If yes, how long?_____

❑ I quit smoking/vaping How long ago?_____

4) PAST MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

- ❑ High Blood Pressure
- ❑ Headaches/Migraines
- ❑ Seizures/Epilepsy
- ❑ Numbness of face, arms hands, or legs
- ❑ COPD
- ❑ Asthma
- ❑ Chest pain or shortness of breath.
- ❑ Heart disease (murmur or valve prolapse)
- ❑ Atrial Fibrillation
- ❑ Thyroid problems
- ❑ Liver Disease
- ❑ Tuberculosis
- ❑ Weakness in the Extremities
- ❑ Emphysema
- ❑ Blood clots
- ❑ Pulmonary Embolism
- ❑ Cancer (If yes, type)_____
- ❑ Wheezing
- ❑ Depression/mental illness
- ❑ Strokes
- ❑ Anemia (low iron in your blood)
- ❑ Diabetes
- ❑ Major injuries/traumas
- ❑ Lung problems
- ❑ Emphysema
- ❑ Glaucoma
- ❑ Sleeping Issues
- ❑ Palpitations

4) PAST SURGERIES OR HOSPITALIZATIONS			
TYPE:		**DATE:**	
TYPE:		**DATE:**	
TYPE:		**DATE:**	

5) FAMILY HISTORY			
Does anyone in your family have a present or past history of the following:			
❑ Bleeding disorders	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ High blood pressure	❑ Thyroid disorders	❑ Strokes	❑ COPD
❑ Asthma			

6) PERSONAL / SOCIAL HISTORY			
Which statement describes your current tobacco use? (Choose all that apply)			
❑ I have never smoked cigarettes. (a) If you have only tried smoking check this box ❑			
❑ I stopped smoking within the past year.			
❑ I dip, chew, or use smokeless tobacco.			
❑ I smoke e-cigarettes/vapor.			
❑ I smoke regularly now.			
How many years have you used tobacco?		How much? (packs)	
Do you consume alcohol?	❑ YES ❑ NO	How many times per week?	
How many times per month?		How many drinks per time?	
Do you use any illicit drugs?	❑ YES ❑ NO		
If yes, what drugs			
Do you feel safe in your current relationship	❑ YES ❑ NO		

Over the past (2) two weeks, how often have you been bothered by any of the following problems:

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Have you ever been emotionally or physically abused?	❑ YES ❑ NO		
Do you have a support system (i.e., friends/family)?	❑ YES ❑ NO		
Date of last eye exam		Date of last dental exam	
Date of your last tetanus injection			

7) REVIEW OF SYSTEMS (LAST SIX MONTHS)	
CONSTITUTIONAL	❑ FATIGUE ❑ FEVER ❑WEIGHT LOSS_____LBS ❑ WEIGHT GAIN_____LBS
EYES	❑ BLURRED VISION ❑ DOUBLE VISION ❑ ITCHING ❑ BURNING ❑ EYE PAIN
EARS	❑ DIFFICULTY HEARING ❑ EAR PAIN ❑ VERTIGO ❑ TINNITUS ❑ EARS FEEL PRESSURED ❑ DISCHARGE FROM THE EARS
NOSE	❑ FREQUENT NOSEBLEEDS ❑ NASAL CONGESTION ❑ CHRONIC RUNNY NOSE ❑ NOSE/SINUSPRESSURE ❑ BLOCKAGE/OBSTRUCTION
MOUTH/THROAT	❑ SORE THROAT ❑ BLEEDING GUMS ❑ SNORING ❑ DRY MOUTH ❑ MOUTH ULCER ❑ POSTNASAL DRIP ❑ HOARSENESS
NEUROLOGIC	❑ FAINTING FREQUENT ❑ SEIZURES ❑ NUMBNESS ❑ WEAKNESS ❑ RESTLESS LEGS
CARDIOVASCULAR	❑ CHEST PAIN ❑ MURMUR ❑ IRREGUAR HEARTBEAT ❑ SWELLING ❑ LIGHTHEADED ON STANDING
RESPIRATORY	❑ WHEEZING ❑ SHORTNESS OF BREATH ❑ COUGHING BLOOD
GENITOURINARY	❑ DIFFICULTY URINATING ❑PAIN DURING URINATION
GASTROINTESTINAL	❑ VOMITING ❑ PAINFUL SWALLOWING ❑DIFFICULTY SWALLOWING
HEM/LYMPH	❑ SWOLLEN GLANDS ❑ EASY BRUISING ❑ EXCESSIVE BLEEDING
7) REVIEW OF SYSTEMS (LAST SIX MONTHS) contd…	
PSYCH	❑ DEPRESSION ❑ ANXIETY
MUSCULOSKELETAL	❑ MUSCLE ACHES ❑ JOINT PAIN
SKIN	❑ ITCHING ❑ RASH ❑ DRY SKIN ❑ GROWTHS/LESIONS
ENDOCRINE	❑ HAIR LOSS ❑ SENSITIVITY TO HEAT OR COLD
ALLERGY	❑ FREQUENT SNEEZING ❑ RUNNY NOSE
❑ **OTHER**	

I hereby authorize any insurance benefits to be paid directly to Northwest Specialty Hospital. I understand that I am responsible for paying non-covered services. I hereby authorize the release of pertinent medical information to my insurance carriers and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA). I have verified the demographics information sheet to be true and correct.

SIGNATURE (PATIENT OR GUARDIAN) | DATE (MM-DD-YYYY) | RELATIONSHIP TO PATIENT

RELEASE OF INFORMATION
FROM OTHER HEALTHCARE PROVIDERS

NORTHWEST SPECIALTY HOSPITAL

I,_____, _____, hereby authorize the following providers:
(PATIENT NAME) (DATE OF BIRTH)

LIST ALL PROVIDERS FROM WHOM INFORMATION IS BEING SOUGHT:

PROVIDER	ADDRESS	PHONE	FAX
PROVIDER	ADDRESS	PHONE	FAX

TO DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION TO:

Northwest Pulmonology
1551 E Mullan Ave Ste 200-C
Post Falls, ID 83854
Phone: (208) 618-2570 Fax: (208) 618-8779

INFORMATION TO BE RELEASED: **(CHECK ALL THAT ARE APPLICABLE)**

- ❑ Entire medical record.
- ❑ Copies of EKGs taken within the past five years.
- ❑ Medical history, including specific progress notes regarding any problems that would impact my surgery or procedure's progress or outcome.
- ❑ A list of allergies.
- ❑ Results of relevant diagnostic or laboratory tests.
- ❑ Other _____

EXCLUDE THE FOLLOWING INFORMATION FROM THE RECORDS RELEASED: (**PLEASE INITIAL**)

_____ Drug/Alcohol abuse/treatment and diagnosis _____Sexually transmitted disease

_____ Mental Illness or psychiatric diagnosis and treatment _____HIV/AIDS

This protected health information will be used by the Facility listed above for the purpose of treatment.

This authorization shall be in force and effect for 1 year from date of signature or until _____(date).
I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the provider(s) listed above.
I understand that a revocation is not effective to the extent that the provider(s) listed above have relied on this form to use or disclose protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy requirements law. However, the Facility is covered by federal privacy requirements and will follow them.
I understand that the provider(s) listed above will not condition treatment, payment, enrollment in a health plan or program, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____
PRINTED OR TYPED NAME OF PATIENT OR LEGAL REPRESENTATIVE

_____
DESCRIPTION OF LEGAL REPRESENTATIVE'S AUTHORITY