Inland Northwest Spine and Neurosurgery, PLLC
BRET A. DIRKS, M.D.
850 W. Ironwood Dr., Suite 300
Coeur d'Alene, ID 83814
208-667-1376
Fax 208-292-0873

Welcome to Inland Northwest Spine and Neurosurgery

The distinguishing aspects of our practice have always been prompt and excellent neurosurgical care delivered in a caring and compassionate manner. Your health and peace of mind are important to us at Inland Northwest Spine and Neurosurgery. If you have any questions, contact our office to schedule an appointment to discuss your neurosurgical health concerns. We care about you as a patient and look forward to seeing you.

IMPORTANT OFFICE POLICIES AND PROCEDURES

APPOINTMENTS

We make every effort to remain on schedule; therefore, you must arrive on time. Please arrive **30 minutes** early for your first appointment to complete paperwork. If you fail to arrive on time for an appointment, you will likely be rescheduled for a later date. Your consideration of a **48-hour notice** of cancellation is greatly appreciated so that we may utilize that time for other patients. Not notifying the office within 48 hours will result in a $50.00 charge.

X-RAYS

If you have had x-rays or other diagnostic imaging studies from sources outside of the Spokane, Washington or North Idaho area, it is your responsibility to bring a CD or hard copy of films with you to your appointment. Failure to arrive without the necessary studies may result in an additional cost to you for x-rays taken in our office, further imaging, or even rescheduling the clinic visit.

FINANCIAL INFORMATION

The financial cost of services rendered is the responsibility of the patient and/or guarantor regardless of insurance coverage. Please bring **insurance cards** along with **picture ID** to your appointment. Insurance co-payments are due at the time of your visit.

Idaho Workers' Compensation Insurance is accepted in general. You must provide our office with the following information at the time of your first appointment:

- ☐ Name and address of employer's insurance carrier.
- ☐ Exact date of your injury with a brief description.
- ☐ Insurance claim number.

This information is the only way that we can bill the Workers' Compensation Insurance. Your employer can assist you in obtaining this information. You may otherwise need to be rescheduled or be required to self-pay until such information is received.

Motor vehicle accidents, liability action, and/or litigation against a third party are not acceptable reasons for delay in payment. A deposit will be required if surgery is recommended. Payment arrangements must be made in advance of surgery scheduling. If you would like an estimate of cost for your visit, please call our office at 208-667-1376 x-25.

I agree to the above terms and conditions.

_____ _____

Patient Signature **Date**

I hereby authorize and agree by initialing the following items.

INSURANCE/ MEDICARE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance or Medicare benefits be made either to me or on my behalf to Inland Northwest Spine and Neurosurgery, PLLC for any services rendered to myself/dependent. I authorize any holder of medical information about me to release to the insurance company or CMS (Centers for Medicare and Medicaid Services, formerly known as HCFA) and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that I am fully responsible for any amount not covered by my insurance. All accounts are due in full within 90 days of service unless arrangements have been made.

_____ _____

Patient Signature **Date**

PRESCRIPTIONS/REFILLS

Narcotic medications and other prescriptions will be provided by our office in the immediate postoperative period only (usually for no more than four weeks after surgery). Chronic pain requiring more protracted courses of narcotics is best managed by a specialist trained to deal with chronic pain, or by your primary care physician. It is very important to note that prescriptions will be provided during normal office hours. We do not fill prescriptions after 4:00 PM, weekends, or holidays. Please allow **48 hours** for prescription approvals. Please be advised that **we do not replace lost or stolen prescriptions**. Some pharmacies are now offering e-prescribing. Please be advised that a feature of e-prescribing is the electronic exchange of prescription data between physician practices and pharmacies, which can potentially improve the efficiency of the prescribing process and reduce medication errors.

I understand and accept the terms of INSN Prescription Policy.

_____

Initials

NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges he/she may obtain a copy of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information.

_____

Initials

ASSIGNMENT OF PROCEEDS

I grant and assign to the physician any and all proceeds from any settlement or court determination related to injuries for which the physician has treated me. This assignment shall not exceed the amount of the physician's unpaid services and/or expenses. In consideration for the physician's examination and treatment, I agree to all promises set forth above and further agree to pay physician at the time of billing for all services rendered and for all costs and losses caused by any failure to pay this commercial transaction in a timely manner. I further agree that all the information and promises stated above are freely given with the knowledge that I am granting the physician substantial rights in the event that I fail to pay for his services in a timely manner.

In witness of my agreement with the physician, Bret A. Dirks, MD.

_____ _____

Signature **Date**

WELCOME TO OUR OFFICE

BRET A. DIRKS, M.D.
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FAX # 208-292-0873

DATE OF APPOINTMENT _____

(PLEASE PRINT)

PATIENT'S LAST NAME:	PATIENT'S SOC. SEC. NO:
PATIENT'S FIRST NAME:	PATIENT'S EMPLOYER:
MIDDLE INITIAL:	PATIENT'S WORK PHONE:
ADDRESS:	PATIENT'S BIRTHDATE:
	AGE: SEX: □ MALE □ FEMALE
CITY, STATE:	MARITAL STATUS: □ S □ M □ W □ D
ZIP:	**PHYSICIAN** REQUESTING THIS CONSULT:
HOME PHONE NUMBER:	
CELL PHONE NUMBER:	**FAMILY PHYSICIAN**:
E-MAIL ADDRESS:	

SPOUSE'S NAME OR PARENT NAME IF MINOR:	
SPOUSE'S OR PARENT EMPLOYER:	SPOUSE'S OR PARENT WORK PHONE:
SPOUSE'S OR PARENT SS#:	SPOUSE'S OR PARENTS DATE OF BIRTH :

SOMEONE TO NOTIFY IN CASE OF EMERGENCY, OTHER THAN SPOUSE OR PARENT
NAME: **PHONE:**

COMPLETE THIS SECTION FOR WORKERS COMPENSATION INJURY ONLY

DATE OF INJURY:	WORKERS COMP. CLAIM NO:	
NAME OF WORKERS COMP. INSURANCE:		
ADDRESS OF WORKERS COMP:		
EMPLOYER AT THE TIME OF INJURY:		
CLAIM REP:	PHONE:	FAX:

INSURANCE INFORMATION

DO YOU HAVE MEDICAL INSURANCE? □ YES □ NO

IF NO INSURANCE, HOW DO YOU PLAN TO PAY? □ CASH □ CHECK □ CREDIT CARD

I. PRIMARY INSURANCE	II. SECONDARY INSURANCE
INSURANCE NAME:	INSURANCE NAME:
ADDRESS:	ADDRESS:
PHONE NO:	PHONE NO:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
GROUP NO:	GROUP NO:
POLICY NO:	POLICY NO:

COMPLETE THE FOLLOWING **ONLY** IF THIS IS AN ACCIDENT INJURY:
NATURE OF INJURY: _____
DATE OF INJURY: _____

YOUR MEDICAL HISTORY

DATE: _____

NAME: _____ AGE: _____

VERY IMPORTANT!

RATE YOUR PAIN ON A SCALE OF 1 TO 10: _____

1 (no pain) 5 10 (worst pain)

BRIEFLY DESCRIBE YOUR CURRENT MEDICAL PROBLEM OR PRIMARY REASON FOR THIS APPOINTMENT:

_____

_____

_____

HAVE YOU NOTICED ANY **NUMBNESS**? WHERE?

_____

HAVE YOU NOTICED ANY **WEAKNESS**? WHERE?

_____

IS YOUR DISCOMFORT WORSE OR BETTER BY ANY PHYSICAL ACTIVITY, POSITION OR BODILY FUNCTION SUCH AS SNEEZING OR COUGHING? IF SO, PLEASE DESCRIBE:

_____

HAVE YOU HAD **X-RAYS** FOR THIS COMPLAINT?

_____

ALLERGY TO MEDICATIONS (PLEASE LIST) _____

OTHER ALLERGIES?

_____

PLEASE LIST **PRESCRIPTION MEDICATIONS** AND **OVER THE COUNTER MEDICINES** YOU ARE TAKING:

MEDICATION	DOSE

ARE YOU IN A PAIN CONTRACT? YES / NO
IF SO, WITH WHOM: _____

DO YOU HAVE ANY BELIEFS THAT WOULD PRECLUDE YOU FROM RECEIVING BLOOD PRODUCTS DURING SURGERY IF AN EMERGENCY OCCURRED? YES / NO

LIST ANY **OPERATIONS**: _____

_____

LIST SERIOUS **ILLNESS** AND/OR **INJURIES:**

_____

_____

CARDIOVASCULAR

DATE OF LAST EKG _____

	YES	NO
HAVE YOU EVER HAD A HEART ATTACK?		
HAVE YOU EVER BEEN TOLD THAT YOU HAVE HEART PROBLEMS?		

DO YOU HAVE:

	YES	NO
CHEST PAIN		
AN IRREGULAR HEART BEAT (ARRHYTHMIA)		
HIGH BLOOD PRESSURE (HYPERTENSION)		
HIGH CHOLESTEROL		
POOR CIRCULATION		
HISTORY OF BLOOD CLOTS / DVT / PULMONARY EMPOLISM		

OTHER (EXPLAIN) _____

RESPIRATORY

DATE OF YOUR LAST CHEST X-RAY _____

HAVE YOU EVER BEEN TOLD YOU HAVE OR HAD:

	YES	NO
ASTHMA		
EMPHYSEMA		
TUBERCULOSIS		
LUNG CANCER		
SLEEP APNEA		
USE OF CPAP		

OTHER (EXPLAIN) _____

GI

HAVE YOU BEEN TOLD THAT YOU HAVE OR HAD:

	YES	NO
ULCERS		
DIVERTICULITIS		
ULCERATIVE COLITIS (CROHN'S DISEASE)		
GASTRITIS		
"NERVOUS STOMACH"		
COLON POLYPS		
COLON CANCER		
CHRONIC CONSTIPATION		
FREQUENT LOOSE STOOLS		
BLOOD IN YOUR STOOL		
LIVER DISEASE		

OTHER (EXPLAIN) _____

GU

HAVE YOU EVER HAD OR HAVE:

	YES	NO
FREQUENT BLADDER/KIDNEY INFECTIONS		
DIFFICULTY STARTING URINARY STREAM		
PROSTATE CANCER		
PROSTATE ENLARGEMENT		
KIDNEY STONES		
BLOOD IN URINE		

MUSCULOSKELETAL	YES	NO
DO YOU HAVE JOINT PAIN?		
HAVE YOU BEEN DIAGNOSED WITH ARTHRITIS?		

ENDOCRINE

	YES	NO
HAVE YOU BEEN DIAGNOSED WITH DIABETES?	_____	_____
HAVE YOU EVER HAD THYROID PROBLEMS?	_____	_____

REPRODUCTIVE (WOMEN ONLY)

DO YOU OR HAVE YOU EVER HAD:

	YES	NO
ENDOMETRIOSIS	_____	_____
EXCESSIVE MENSTRUAL FLOW	_____	_____
MENOPAUSAL SYMPTOMS	_____	_____
EARLY ONSET OF MENOPAUSE	_____	_____

EENT

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO
DEAFNESS	_____	_____
EAR ACHE	_____	_____
FREQUENT COLDS	_____	_____
RINGING IN EARS	_____	_____
NASAL OBSTRUCTION	_____	_____
NOSE BLEEDS	_____	_____
SINUS TROUBLE	_____	_____
HEADACHES	_____	_____

PSYCHOSOCIAL

HAVE YOU EVER BEEN TREATED FOR:

	YES	NO
DEPRESSION	_____	_____
ANXIETY	_____	_____
OTHER MENTAL ILLNESS	_____	_____

PLEASE CIRCLE

DO YOU USE TOBACCO, NICOTINE, MARIJUANA (THC) PRODUCTS? YES _____ NO_____

IF YES, HOW OFTEN/HOW MUCH? _____

DO YOU CONSUME ALCOHOLIC BEVERAGES? YES _____ NO _____

IF YES, HOW OFTEN/HOW MUCH? _____

OTHER

	YES	NO
HISTORY OF MRSA	_____	_____
OPEN SORES OR DIFFICULTY HEALING	_____	_____
AUTOIMMUNE DISORDER	_____	_____
CANCER	_____	_____

FAMILY HISTORY

_____

_____

_____

_____

_____