NEW PATIENT REGISTRATION FORM

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

1 FULL LEGAL NAME			PREVIOUS LAST NAME
LAST	FIRST	M.I	

2 DATE OF BIRTH	MARITAL STATUS	GENDER	SSN
	❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED	❑ M ❑ F	
MM-DD-YYYY			XXX-XX-XXXX

3 ADDRESS			
STREET OR PO BOX	CITY	STATE	ZIP

4 CONTACT INFORMATION: (PLEASE CHECK YOUR PREFERRED CONTACT NUMBERS)			
❑ CELL PHONE	❑ HOME PHONE	❑ WORK PHONE	❑ E-MAIL

5 PREFERRED PHARMACY					
NAME	STREET	CITY	STATE	ZIP	PHONE

6 EMERGENCY CONTACT		
NAME	RELATIONSHIP	PHONE

7 LIST PRIMARY CARE PHYSICIAN & OTHER PHYSICIANS YOU SEE		
NAME	SPECIALTY	PHONE

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NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

8 INSURANCE INFORMATION			
PRIMARY INSURANCE COMPANY NAME	ID#	GROUP #	PHONE #
SUBSCRIBER – EMPLOYEE NAME	DOB (MM-DD-YYYY)	SSN	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY NAME	ID#	GROUP #	PHONE #
SUBSCRIBER – EMPLOYEE NAME	DOB (MM-DD-YYYY)	SSN	RELATIONSHIP TO PATIENT

9 GUARANTOR INFORMATION			
LAST	FIRST	MI	RELATIONSHIP TO PATIENT

10 DEMOGRAPHIC INFORMATION		
❑ DECLINE	❑ ASIAN	❑ BLACK OR AFRICAN AMERICAN
❑ WHITE	❑ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	❑ OTHER:

11 ETHNIC INFORMATION		
❑ DECLINED	❑ HISPANIC OR LATINO	❑ NOT HISPANIC OR LATINO

12 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 _____

ANORECTAL QUESTIONNAIRE

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY
NORTHWEST SPECIALTY HOSPITAL | PROUDLY OWNED AND OPERATED BY PHYSICIANS

Name: _____. DOB: _____. Date: _____.

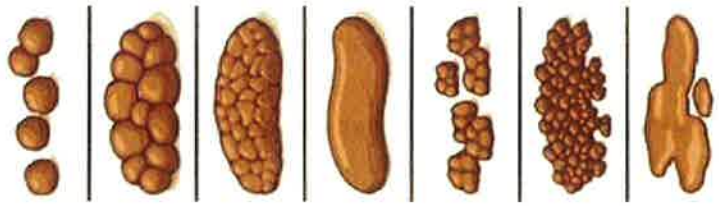
Time spent on toilet during average bowel movement: _____ minutes
Date of last colonoscopy:
Results:
Previous abdominal, rectal, or hemorrhoid surgery? Yes No
If yes, when and what type?
Do you have a history of perianal abscess? Yes No
Family history of colon cancer? Yes No
If yes, which relative?

Scoring Scale						
0 = No Symptoms	3 = Symptoms bothersome every day					
1 = Symptoms noticeable but not bothersome	4 = Symptoms affect daily activities					
2 = Symptoms noticeable and bothersome, but not every day	5 = Symptoms are incapacitating – unable to do activities					
1. How severe are your symptoms of itching or irritation at or around your anus?	0	1	2	3	4	5
2. How severe are your symptoms of pain or discomfort at or around your anus during rest?	0	1	2	3	4	5
3. How severe are your symptoms of pain or discomfort at or around your anus on opening your bowels?	0	1	2	3	4	5
Scoring Scale						
0 = Never	3 = More than once a week					
1 = Less than once a month	4 = Every day					
2 = More than once a month						
4. How often do you have rectal bleeding?	0	1	2	3	4	
5. How often do you have soiling of your undergarments?	0	1	2	3	4	
6. How often do you have the inability to hold in stool (fecal incontinence)?	0	1	2	3	4	
7. How often do have to push prolapsed tissue back into the rectum after a bowel movement?	0	1	2	3	4	
8. Do you suffer from constipation?	Yes		No		Don't know	
9. Do you suffer from diarrhea?	Yes		No		Don't know	
10. Do you have to strain when having a bowel movement?	Yes		No		Don't know	
11. Do you often feel like you're "still not done" after a bowel movement?	Yes		No		Don't know	
12. Do you take a fiber supplement?	Yes		No		Don't know	
13. On average, do you drink the equivalent of 6-8 glasses of water per day?	Yes		No		Don't know	
14. How satisfied are you with your present condition?	Satisfied		Neutral		Dissatisfied	

Total: _____.

Choose your stool:

#1 #2 #3 #4 #5 #6 #7



#1: Separate hard lumps, like nuts (hard to pass)
#2: Sausage-shaped, lumpy
#3: Sausage-shaped, cracks on surface
#4: Sausage or snake like, smooth/soft
#5: Soft blobs with clear-cut edges (easy to pass)
#6: Fluffy pieces with ragged edges, mushy
#7: Water, no solid pieces (entirely liquid)

NW Digestive – Patient Health Questionnaire

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

Today's date:

What are you being seen for?
Drug / Food Allergies:

Medication	**Dosage**	**Frequency**

Previous Surgeries (please provide year it was done):

Social History				
Tobacco Use: ☐ Never	☐ Current – Packs per day?	☐ Former – Quit date:		
Alcohol Use: ☐ Never	☐ Social	☐ Seldom	☐ Frequent	☐ Former
Drug Use: ☐ Yes ☐ No	Which one(s):			
Caffeine Use: ☐ Yes ☐ No	How much per day?			
Carbonated Beverages: ☐ Yes ☐ No	How much per day?			

Family Medical History			
Obesity	☐ Yes ☐ No	# of deaths related to obesity?	
Heart Disease	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No

NW Digestive – Patient Health Questionnaire

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

Diabetes	☐ Yes ☐ No	Bleeding Disorder	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Gallstones	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Malignant Hyperthermia	☐ Yes ☐ No
Type(s):			
Other:			

Personal Medical History (if yes, check appropriate boxes)

Constitutional		
☐ Anemia	☐ Fatigue	☐ Hair loss
☐ Insomnia	☐ Night sweats	☐ Skin changes

Head / Neck		
☐ Difficulty swallowing	☐ Hearing difficulty	☐ Neck lump(s)
☐ Sinus drainage	☐ Vision disturbance	☐ Voice hoarseness

Heart / Blood Vessels		
☐ Angina	☐ Ankle swelling	☐ Cardiac bypass
☐ Clogged arteries	☐ Congestive heart failure	☐ Heart attack Foot ulcers
☐ Foot ulcers	☐ High blood pressure	☐ Pacemaker
☐ Palpitations	☐ Raynaud's disease	☐ Varicose veins

Breast		
☐ Breast cancer	☐ Fibrocystic disease	☐ Gynecomastia Lump(s)
☐ Lump(s)	☐ Pain	☐ Nipple discharge

Intestinal		
☐ Abdominal pain	☐ Abdominal hernia	☐ Black, tarry stools
☐ Blood in stool	☐ Cirrhosis	☐ Colitis
☐ Colon polyp(s)	☐ Crohn's disease	☐ Diarrhea
☐ Enlarged liver	☐ Fissure	☐ Gallbladder problem(s)
☐ GI cancer	☐ Hiatal hernia	☐ Heartburn
☐ Hemorrhoids	☐ Hepatitis	☐ Indigestion
☐ Irritable bowel	☐ Jaundice	☐ Pancreatic disease
☐ Rectal bleeding	☐ Ulcer(s)	

NW Digestive – Patient Health Questionnaire

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

Bladder / Kidney		
☐ Blood in urine	☐ Bladder cancer	☐ Dialysis treatment
☐ Kidney Stones	☐ Loss of bladder control	☐ History of PSA test
☐ Prostate irregularity	☐ Renal failure	

Musculoskeletal		
☐ Arthritis	☐ Back pain	☐ Cancer
☐ Fibromyalgia	☐ Hip pain	☐ Joint replacement
☐ Knee pain	☐ Muscle pain / spasm	☐ Neck pain
☐ Rheumatoid arthritis	☐ Shoulder pain	☐ Problem walking/standing

Immune / Blood function		
☐ Anemia	☐ Bleeding disorder	☐ HIV
☐ Low platelets	☐ Lupus	☐ Lymphoma

Lung function		
☐ Asthma	☐ Bronchitis	☐ Chronic cough
☐ COPD	☐ Coughing up blood	☐ Emphysema
☐ Hypoventilation	☐ Lung cancer	☐ Pneumonia
☐ Pulmonary embolism	☐ Shortness of breath	☐ Snoring
☐ Sleep apnea	☐ Tuberculosis	☐ Use of CPAP/BiPAP
☐ Use of oxygen		

Neurological		
☐ Alzheimer's	☐ Balance problem	☐ Dementia
☐ Epilepsy	☐ Headache(s)	☐ Migraine(s)
☐ Multiple sclerosis	☐ Parkinson's disease	☐ Stroke

Psychiatric		
☐ Alcoholism	☐ Anorexia	☐ Anxiety
☐ Attempted suicide	☐ Bipolar disorder	☐ Body dysmorphia
☐ Bulimia	☐ Depression	☐ Drug dependency
☐ OCD	☐ PTSD	☐ Schizophrenia

Endocrine		
☐ Diabetes	☐ Elevated cholesterol	☐ Elevated triglycerides
☐ Goiter	☐ Hypoglycemia	☐ Hyperthyroidism
☐ Hypothyroidism	☐ Parathyroid	☐ Thyroid cancer

Maternity		
☐ Cervical cancer	☐ Currently pregnant	☐ Irregular menstruation
☐ Painful menstruation	☐ Ovarian cancer	☐ Uterine cancer
Date of last PAP smear:		
Date of last menstrual period:		
Age menses began:		
Number of pregnancies:		
Number of live births:		
Planning for more children?		

I understand that I am responsible for obtaining pertinent medical records from my physician's offices to provide to Northwest Institute for Digestive Surgery, as part of my treatment, upon request. I have verified that medical history and information provided to be true and correct.

Signature (Patient or Guardian)	Date	Relationship to Patient

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY ACT AND HIPAA RELEASE

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

I acknowledge that I have received the attached Privacy Notice.

_____
PRINTED Patient Name

_____ _____
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

I, _____, acknowledge that I have received a copy of the Northwest Specialty Hospital notice regarding the privacy of Personal Health Information.

In addition to our normal operational disclosures of privacy information, please identify whom we may release your health care information. Each name must be identified. These should be people who help you with your health care needs and may need to be knowledgeable about your condition, treatment, and options. It is still the responsibility of the party or parties listed below to request this information.

NAME	RELATIONSHIP

SIGNED DATE

For Facility use only:

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement
_____ Date: _____

CONSENT AND CONDITIONS OF TREATMENT

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

Thank you for choosing Northwest Specialty Hospital to provide for your healthcare needs. We are committed to providing exceptional healthcare. The first step in this process is to provide information regarding patient rights, risks and responsibilities. The second step is to obtain your consent to treat the patient. The admitting staff can answer any questions you may have in regards to the following agreement.

I agree to the following:

1. CONSENT TO TREAT: I consent to treatment at Northwest Institute for Digestive Surgery and for services or supplies that have been or may be ordered by a licensed professional healthcare provider. I understand that treatment may include but is not limited to: radiological examinations, laboratory procedures, anesthesia, nursing care or medical and surgical treatment. Your case may be attended by vendors and clinical students. I understand that all licensed professional healthcare providers that render service to the patient are responsible and liable for their own acts, orders and omissions. I acknowledge that the hospital has not made nor can it make a guarantee of the outcome of treatment.

2. FINANCIAL AGREEMENT: I agree to pay for all services and supplies rendered to the patient in accordance with the rates and financial policies in effect at the time of service. I authorize any overpayment made on this account to be transferred to any other account balance for which I am responsible. I agree to pay interest fees on any unpaid balance after 60 days of discharge or date of service at a rate not to exceed 18% APR. If this account is assigned to an attorney or a collection agency for collection then I agree to pay all collection agency fees, court costs, and attorney's fees.

   ☐ I am aware that financial counseling is available for any services that I may receive during my visit at Northwest Specialty Hospital.

3. ASSIGNMENT OF INSURANCE BENEFITS: I assign and authorize payment directly to Northwest Specialty Hospital of any healthcare benefits that the patient is entitled to receive. This assignment will not be withdrawn or voided at any time unless I pay the account in full. I understand that I am responsible for any and all charges not covered by my insurance policy(s). If the patient is entitled to Medicare or Medicaid benefits under Title XVIII of the Social Security Act, I request assignment of benefits directly to Northwest Specialty Hospital.

4. ASSIGNMENT OF PHYSICIAN BENEFITS: I am aware that physician services by Radiologist, Pathologist, Anesthesiologist, as well as medical, surgical and emergency care are not billed by the hospital but are billed separately. I understand that I am under the same obligation to those providers as stated in this agreement unless otherwise agreed to in writing with those providers. I authorize payment of any medical benefits for such claims to the appropriate provider.

I understand and accept the terms of this agreement and certify that I am duly authorized by the patient or by law to execute the above agreement in their behalf.

PATIENT NAME	PATIENT SIGNATURE	DATE	TIME
PATIENTS GUARDIAN OR REPRESENTATIVE	SIGNATURE	DATE	TIME
WITNESS NAME	WITNESS SIGNATURE	DATE	TIME

MEDICATION HISTORY CONSENT FORM

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Northwest Institute for Digestive Surgery can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to enroll me in the E-Prescribe Program that allows for retrieval of my medication history. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

☐ CONSENT

PRINT _____ SIGN _____ DATE _____

PATIENT DOB _____ PARENT OR GUARDIAN SIGNATURE _____ DATE _____

☐ DO NOT CONSENT

PRINT _____ SIGN _____ DATE _____

NOTICE OF PHYSICIAN OWNERSHIP

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

Thank you for choosing Northwest Institute of Digestive Surgery!

Northwest Institute of Digestive Surgery is owned and operated by Northwest Specialty Hospital which is a federally recognized "physician owned" specialty hospital. As a patient you have the right to receive a list of all of the physician owners in this hospital, upon request. Your physician may or may not have an ownership interest in Northwest Specialty Hospital, as not all physicians who practice here have an ownership interest. If you feel that the services that have been ordered for you are not proper or are negatively impacted by physician ownership in the facility, please notify a member of the administration immediately. Our Chief Nursing Officer can be reached by calling (208) 262-2300.

You should be aware that alternative health care facilities may be available to you.

Please sign below to acknowledge your receipt and understanding of this disclosure and that you have had an opportunity to ask and receive answers to any questions you may have about this disclosure, including your options, if any, for treatment at other facilities.

PATIENT NAME	PATIENT SIGNATURE	DATE

WITNESS NAME	WITNESS SIGNATURE	DATE

APPOINTMENT CANCELLATION AGREEMENT

NORTHWEST INSTITUTE FOR DIGESTIVE SURGERY

Failure to keep your scheduled appointments hinders our ability to provide the best care to you. In order to restrict missed appointments, we have implemented an Appointment Cancellation Policy. We ask that in the event you need to cancel your appointment, you call at least 24 hours prior to an office visit, and 72 hours prior to surgery. This will allow us the opportunity to offer that appointment to another patient.

To cancel an appointment, please call (208) 262 0945

Repeated late cancellations and missed appointments are disruptive to the optimal delivery of care to you and our other patients. As a result, 2 late cancellations or missed appointments may result in the discontinuation of your care at NWIDS. In the event you are discharged from care, your referring provider or case manager will be notified of the reason for discharge from our practice.

Fees:

At NWIDS, failure to give 24 or 72 hours notice prior to cancellation will result in an "Appointment No Show Fee". This fee cannot be billed to your insurance and will be your direct responsibility.

The No Show Appointment Fees are as follows:

Office Visit Appointment: $50

Endoscopy/Surgery Appointment: $100

I understand that NWIDS's appointment cancellation policy and understand my responsibility to plan appointments accordingly. I also agree to notify NWIDS appropriately if I have difficulty fulfilling my scheduled appointments.

_____

Patient Name (Print)

_____ _____

Patient Signature Date