Lynx Healthcare
New Patient Registration Form

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Gender M / F Soc. Sec. # _____-_____-_____ Date of Birth ____/____/_____

Marital Status *(circle one):* Divorced / Married / Separated / Single / Widowed

Address _____ City _____ State _____ ZIP _____

Home Phone ( )_____ Cell ( )_____ Work ( )_____

E-mail _____ Employer _____

Work Status *(circle one):* Full-time / Part-time / Not employed / On active military duty / Student / Retired / Self employed

GUARANTOR'S INFORMATION *SAME AS ABOVE* ☐

Last Name: _____ First Name: _____ Middle Initial: _____

Gender M / F Relationship to patient _____ Date of Birth ____/____/_____

Home Phone ( )_____ Cell ( )_____ Work ( )_____

Address _____ City _____ State _____ ZIP _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Policy # _____

Insurance Co. Phone ( ) _____ Group # _____

Subscriber's Name _____ DOB ____/____/____ Relationship _____

Secondary Insurance Co. *(if applicable)* _____ Policy # _____

Insurance Co. Phone ( ) _____ Group # _____

Subscriber's Name _____ DOB ____/____/____ Relationship _____

Work Related? Yes ☐ No ☐ Employer _____ ***Automobile Accident***? Yes ☐ No ☐

Claim Manager Name _____ Date of Injury____/____/_____

Claim Manager Phone ( )_____ Extension _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Home Phone ( )_____ Cell ( )_____ Work ( )_____

PHYSICIAN / PHARMACY INFORMATION

Referring Physician _____ Phone ( )_____

Primary Care Physician _____ Phone ( )_____

Pharmacy _____ Phone ( )_____

As far as I know, the information I have provided above is correct.

PATIENT / GUARDIAN SIGNATURE_____ **DATE** _____

ETHNIC BACKGROUND

RACE: ☐ *American Indian/Alaska Native* ☐ *Asian* ☐ *Black/African American*
☐ *White/Caucasian* ☐ *Native Hawaiian or Other Pacific Island* ☐ *Other Race* ☐ *Decline*

ETHNIC GROUP: ☐ *Hispanic/Latino* ☐ *Latin American* ☐ *Mexican* ☐ *Mexican/American*
☐ *Mexican/American Indian* ☐ *Not Hispanic/Latino* ☐ *Decline*

PREFERRED LANGUAGE: ☐ *English* ☐ *Spanish* ☐ *Other* _____

ASSIGNMENT OF MEDICAL BENEFITS

I, (Printed legal name of primary Insurance holder), _____
assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plan to: Lynx Healthcare. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. This may include related drug and/or alcohol abuse treatment, AIDS/HIV, or psychiatric information; including records protected by federal regulations (42 CRF Part 2) as required to qualify for health benefit payment.

I understand that I am financially responsible for all charges incurred from medical treatment at this facility, whether they are paid by my insurance carrier or not, (public assistance recipients exempt). I also understand that all charges are due upon receipt of statement from this facility unless other arrangements are made with the bookkeeping department. If, for any reason, it becomes necessary for this office to engage an attorney or collection agency to secure payment from me, I agree to pay all reasonable interest charges, attorney fees and/or collection costs.

IF YOUR INSURANCE COMPANY SENDS PAYMENT TO YOU, AND YOU HAVE A BALANCE DUE AT THIS OFFICE, PLEASE ENDORSE THE CHECK AND FORWARD IT ALONG WITH THE EXPLANATION OF BENEFITS WHEN RECEIVED.

Signed: _____ Date: _____
(Patient or Parent/Guardian)

Lynx Healthcare

HIPAA PRIVACY VERBAL AUTHORIZATION FORM

I hereby give authorization for verbal release of protected health information.

Last: _____ First: _____ Middle: _____

Other names used: _____ Date of Birth: _____ SSN: - -

Address: _____

Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

I _____ give my permission to Lynx Healthcare
Your name

to release information in regards to appointment dates/times and my protected health information, including but not limited to, insurance, address, phone number(s), test results, health care information and treatment to the following participants:

Name of person: _____ Name of person: _____
Relationship to Patient: _____ Relationship to Patient: _____
Exceptions: _____ Exceptions: _____

I understand that:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be 12 months from the date of the signature (unless otherwise indicated.)
- Unless the purpose of this authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon my signing of this authorization.
- The information authorized for release may include information which may indicate the presence of a communicable disease or a non-communicable disease.
- The information authorized for verbal release also may include protected health information related to mental health (RCW 71.05.620)
- The information authorized for verbal release also may include drug/alcohol abuse/treatment records (42 CFR Part 2). By signing below, I authorize any such records, included in my health information, to be released.

_____ _____
Signature of patient / guardian Date

Patient Payment Policy

Thank you for choosing Lynx Healthcare as your pain specialist. We are committed to providing you with the highest quality of health care and strive to keep healthcare affordable in our office. As such, we provide this document to ensure your understanding of the payment policies. Please read the following office payment policy carefully and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

Payment Policy

- At the time of service, you are required to pay any applicable copay. A $10.00 fee will be assessed to your account for a copay that is not paid in full at time of service. This fee will be required to be paid prior to your next visit. After your insurance is billed, you are responsible for any remaining balance.
- Payment for service is due in full at the time of service provided you have no insurance.
- We accept cash, check, Visa, and MasterCard. Any returned check is subject to a $35.00 return check fee that will be required to be paid prior to your next visit.
- Unless canceled at least 24 hours in advance, your account will be charged $25.00 for a missed appointment. This fee will be required to be paid prior to your next visit. Two no show or three canceled appointments will result in a discharge from the facility.
- Please note that your insurance company will not cover any of the additional fees listed above.
- Prior to procedures, you must pay a pre-procedure deposit, predetermined by your insurance.
- If you are in need of a payment plan, you can discuss options with the office staff.
- If your account is overdue for longer than 90 days, it may be referred to a collection agency. Accounts sent to collections will be assessed a 26% collections fee. Payments over 30 days past due from the date of the invoice will include a 10% APR billing fee.

Insurance

As a courtesy, we file your insurance claims. It is your responsibility to notify us of any changes to your insurance coverage. It is your insurance policy. It is your responsibility to know your policy in regards to benefits, maximums, waiting periods, benefit year, and patient responsibility. We will provide information required by your insurance company regarding the treatment provided by us. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays.

_____ _____

Patient name (PRINTED) Date

_____

Patient/Guarantor Signature

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may us or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy note; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____ Signature:_____ Date:_____

TRI-CITIES ADDRESSES
3730 Plaza Way, Suite C6100
Kennewick, WA 99336
7401 W Hood Place, Suite 200
Kennewick, WA 99336
ALLERGY & PAIN MGT

Lynx Healthcare

SPOKANE ADDRESS
12709 E Mirabeau Pkway Bldg A Ste 200
Spokane Valley, WA 99216
ALLERGY & PAIN MGT
NEW MEXICO ADDRESS
3820 Commons Ave. NE
Albuquerque, NM 87109

Patient Name:_____ DOB:___/___/_____ Reason for Visit:_____

Referring Provider: _____ Primary Care Provider: _____ Today's Date: ___/___/_____

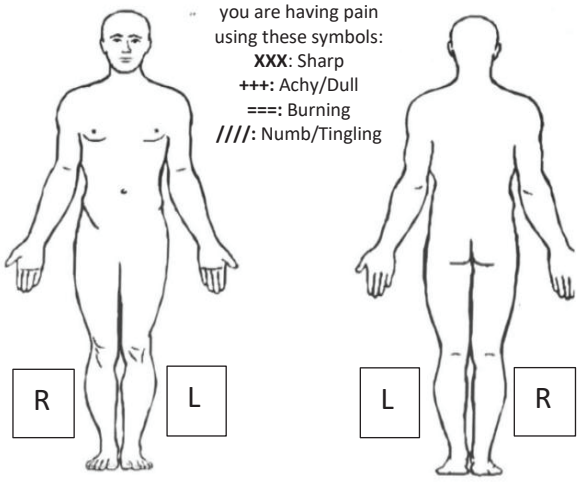
Current and Past Medical History (Complete all that apply)

Do you currently have pain? **YES** or **NO**		**Pain Ratings (scale 0=none, 10=worst/complete)**
When did your pain start?	What caused your pain?	Today's Pain rating? ___/10
Approximate Date:	Describe:	**Worst** Pain this week? ___/10
		Percent Relief by Medication? ___/100%
		Average **Pain** this week? ___/10
		Pain interference with **Enjoyment** of life? ___/10
		Pain interference with **General Activity** this week? ___/10
	Work-related Incident: YES or NO	**PEG** Score: **/30**

Describe your pain: Circle all that apply

Where is your worst pain?	What does your pain feel like?		What makes it better?	What makes it worse?
Neck	Radiating	Throbbing	Sitting	Sitting
Upper back	Sharp	Numb/tingling	Standing	Standing
Lower Back	Stabbing	Devastating	Lying Down	Walking
Hips	Dull	Pressure	Rest	Bending
Knees	Shooting	Pulsing	Medication	Twisting
Joints	Cramping	Lightening	Changing position	Lying Down
Muscles	Aching	Crawling	Activity	Coughing
Other: _____ _____	Burning	Other: _____ _____	Other: _____ _____	Other: _____ _____

Indicate areas where you are having pain using these symbols:
XXX: Sharp
+++: Achy/Dull
===: Burning
////: Numb/Tingling



Please circle the medications you have used or currently use from the following:

Oxycodone	Tapentadol/Nucynta	Levorphanol	Effexor	Diclofenac
Oxycontin	Buprenorphine/Butrans	Cyclobenzaprine/Flexeril	Amytriptyline	Ibuprofen
Percocet	Suboxone	Methocarbamol/Robaxin	Cymbalta	Naproxen
Oxymorphone/Opana	Methadone	Carisoprodol/Soma	Nortriptyline	Tylenol
Tramadol	Exalgo/Dilaudid ER	Baclofen	Other:	
Morphine IR/ER	Hydromorphone/Dilaudid	Lyrica		
Hydrocodone/Norco	Fentanyl	Gabapentin		

Drug Allergies: YES or NO List:

Other Allergies (Circle): Latex Contrast Iodine Lidocaine Adhesives

Please complete the following sections by filling in the information and circling relevant interventions:

Have you had Imaging Studies performed of your painful area (facility and date):

Current Medications you are taking:

Therapy/Interventions?	Where, dates, & Sessions?
Physical Therapy	_____ _____
Chiropractic Care	_____ _____
Massage Therapy	
Acupuncture	
TENS unit	
Injections	
Other:_____	_____

Are you pregnant or is there a chance you may be pregnant? YES or NO or NA

Please Indicate if you have any of the following symptoms today (Circle all that apply):

CONSTITUTIONAL	CARDIAC	PSYCHIATRIC	HEMATOLOGIC	INTEGUMENT
Fevers	Chest Pain	Depression	Easy Bruising	Rash
Chills	Palpitations	Anxiety	Excessive Bleeding	Hives
Night Sweats	Fast Heart Rate	Suicidal Thoughts	Swollen Glands	Swelling
Slow Heart Rate	Edema (swelling)	Homicidal Thoughts	Blood Thinners	**ENDOCRINE**
Edema (swelling)	Other	Sleep Difficulty	**MUSCULOSKELETAL**	Hair Loss
Weight gain/loss	**NEUROLOGICAL**	Restlessness	Neck Pain	Excessive Thirst
EARS/NOSE/THROAT	Numbness/tingling	Crying	Low Back Pain	**GASTROINTESTINAL**
Hearing Difficulty	Seizures	Agitation	Muscle Pain	Diarrhea
Visual Changes	Memory Issues	Insomnia	Muscle Weakness	Constipation
Swallowing Difficulty	Weakness	**RESPIRATORY**	Morning Stiffness	Nausea/Vomiting
Dental Problems	Incontinence	Cough	Joint Pain	Abdominal Pain
Hoarseness	Loss of Balance	Wheezing	Joint Stiffness	Jaundice
Headache	Loss of Coordination	Shortness of Breath	Walking Difficulty	Reflux

Please Indicate if you had the following past medical history or surgeries: (Circle all that apply)

EARS/NOSE/THROAT	NEUROLOGICAL	PULMONARY	MUSCULOSKELETAL	RENAL
Seasonal Allergies	Multiple Sclerosis	Asthma	Osteoporosis	Kidney Failure
Sinus Infection	Stroke	COPD	Fibromyalgia	Kidney Stones
Ear Infection	Migraine Headache	Sleep Apnea	Chronic Fatigue	Incontinence
Dental Problems	Tension Headache	Bronchitis	Osteoarthritis	Urinary Tract Infection
CARDIAC	Seizures	Pneumonia	Rheum. Arthritis	**GASTROINTESTINAL**
Coronary Artery Disease	Guillen-Barre	Emphysema	Lupus	Cirrhosis
High Blood Pressure	Polio	Fibrosis	Raynaud's Disease	GERD/Ulcers
High Cholesterol	**MENTAL HEALTH**	**HEMATOLOGICAL**	**ENDOCRINE**	Crohn's Disease
Heart Attack/MI	Depression	Bleeding Disorders	Diabetes I	Irritable Bowel
Pacemaker	Anxiety	Anticoagulants	Diabetes II	Gallbladder Disease
Bypass Surgery	Bipolar Disorder	Anemia	Hypothyroidism	Hepatitis A/B/C
IMMUNOLOGIC	Schizophrenia	Leukemia	Hyperthyroidism	Pancreatitis
Tuberculosis	ADHD	Clotting Disorders	Adrenal Issues	Other:
HIV	Suicidal	Thrombocytopenia	Menopause	

History of Cancer:

_____

_____

_____

Surgical History to include back and spine related surgeries:

_____

_____

_____

FAMILY MEDICAL HISTORY

Hypertension	Lupus	Hay Fever	Migraine Headaches	Asthma
High Cholesterol	Depression	Eczema	Diabetes	COPD
Heart Attacks	Anxiety	Immunodeficiencies	Fibromyalgia	Bleeding Disorders
Stroke	Bipolar Disorder	Frequent Infections	Rheumatoid Arthritis	Other:
Cancer	Food Allergies	Hives/Swelling	Medication Allergies	

PERSONAL SOCIAL HISTORY			PERSONAL SOCIAL STATUS	
Alcohol	Methamphetamine	Married	Children: _____	Disabled
THC	Ecstasy (MDMA)	Domestic Partner	Are you employed?	Occupation:
Crack/Cocaine	PCP	Divorced	Yes ◯ No ◯	
Heroin	Tobacco	Widowed	Retired	

Patient Signature: _____ Date:_____

BR: _____/_____ HR:_____ Resp:_____ O2:_____ Height: _____ Weight: _____

Lynx Healthcare

OPIOID RISK TOOL

Patient Name_____ D.O.B____/____/____

			Mark X each box that applies	Item Score If Female	Item Score If male
1.	Family History of Substance Abuse	Alcohol	{ ☐ }	{ 1 }	{ 3 }
		Illegal Drugs	{ ☐ }	{ 2 }	{ 3 }
		Prescription Drugs	{ ☐ }	{ 4 }	{ 4 }
2.	Personal History of Substance Abuse	Alcohol	{ ☐ }	{ 3 }	{ 3 }
		Illegal Drugs	{ ☐ }	{ 4 }	{ 4 }
		Prescription Drugs	{ ☐ }	{ 5 }	{ 5 }
3.	Age (Mark box if 16-45)----------		{ ☐ }	{ 1 }	{ 1 }
4.	History of preadolescence sexual abuse----------		{ ☐ }	{ 3 }	{ 0 }
5.	Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	{ ☐ }	{ 2 }	{ 2 }
		Depression----------	{ ☐ }	{ 1 }	{ 1 }

Total Score

☐

Total Score 0-3 4-7 >8

Lynx Healthcare

Patient Health Questionnaire-9 (PHQ-9)

Over the ***last 2 weeks***, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
Moving or speaking slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐
For office coding:	_____	_____	_____	_____

Patient Signature:_____ Date:_____/_____/_____

Total Score:_____