CASCADE SURGEONS
875 Wesley St. Ste 230
Arlington WA 98223-1668
(360) 435-6097

M.C. WHITMAN III, M.D., FACS **PETER WOLFF, M.D., FACS**

DEAR

You have been referred to Cascade Surgeons, the office of Dr. Whitman and Dr. Wolff.

You have an appointment with

DATE: TIME:

Please bring your insurance card and the enclosed paperwork completed.

Cascade Surgeons bills most insurance companies. Please contact your insurance company prior to your appointment to verify coverage and benefits.

The summary from your visit will be available to you in 3 business days.

If you have any questions or need to reschedule this appointment, please give our office a call as soon as possible at 360.435.6097.

Thank you,

Cascade Surgeons

INITIAL PATIENT INFORMATION FORM

Welcome to our office. In order to make your visit as efficient as possible, we would like you to fill out some details about your medical history. Our goal is to make sure we do not miss a portion of your medical condition that could impact your surgical care. Please bring this completed form with you to your scheduled appointment.

Name:_____ DOB:_____ Date: _____
Pharmacy:_____ Email: _____

Drug allergies □ No □ Yes? (Please list with reaction)

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Strength?**	**How many times per day?**	**How many pills each time?**
Example: Tylenol	325 mg	3	2
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please attach a list if more medications are taken

PAST MEDICAL HISTORY (Do you now or have you ever had)			
□ Atrial fibrillation	□ Deep Vein Thrombosis	□ Diverticulosis	□ Fibromyalgia
□ Heart murmur	□ Taking blood thinners	□ Colon polyps	□ Stroke
□ Prior MI	□ Hiatal hernia	□ High cholesterol	□ Epilepsy (seizures)
□ High blood pressure	□ Stomach ulcer	□ Thyroid disorder	□ Migraines
□ Artificial heart valve	□ Gastric reflux	□ Liver disease	□ Glaucoma
□ COPD	□ Crohn's disease	□ Kidney disease	□ Cataracts
□ Asthma	□ Colitis	□ Diabetes	□ Cancer (type)_____
□ Emphysema	□ Irritable bowel syndrome	□ Arthritis	□ Other _____
□ Pulmonary embolism	□ Diverticulitis	□ Gout	**Attach list if more or not listed here**

Name:_____ Date of Birth:_____ Date:_____

Please list **all surgeries you have ever had** and the year of your surgery:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY				
	IF LIVING		**IF DECEASED**	
	Age	Health	Age At death	Cause
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
Children	_____	_____	_____	_____

□ yes □ no Do you work outside the home? Occupation?_____

What is your marital status? □ married □ single □ widowed □ divorced

Do you have children? □ yes □ no Sons or daughters? _____

Are you a smoker? Yes ☐ No ☐ How much did you smoke per day?_____

Are you a former smoker? Yes ☐ No ☐

□ yes □ no Do you drink alcohol? How much per day?_____

□ yes □ no Caffeine use? How much per day? _____

□ yes □ no Recreational drug use? What do you use?_____

Date of last pap smear (women only):

_____

Date of last mammogram (women only):

_____

Have you ever had a colonoscopy? ☐ Yes ☐ No

What year was it done?_____

Where was it done?_____

What was found?_____

Name:_____ Date of Birth:_____ Date:_____

Please check any symptoms below that you are currently experiencing:

Systemic

□ Yes □No Weight change – how much? _____
Loss or Gain? _____
□ Yes □No Chills
□ Yes □No Fever
□ Yes □No Night sweats
□ Yes □No Feeling tired/poorly

Head

□ Yes □No Headache
□ Yes □No Facial pain
□ Yes □No Sinus pain

Eyes

□ Yes □No Eyesight problems
□ Yes □No Sensitivity to light
□ Yes □No Eye pain
□ Yes □No Itching of eyes

Ears, Nose, Throat

□ Yes □No Earache
□ Yes □No Hearing loss
□ Yes □No Ringing in ears
□ Yes □No Nosebleeds
□ Yes □No Runny nose
If yes, what color? _____
□ Yes □No Mouth sores
□ Yes □No Bleeding gums
□ Yes □No Hoarseness
□ Yes □No Throat pain

Neck

□ Yes □No Neck pain
□ Yes □No Neck stiffness
□ Yes □No Lumps or swelling in neck

Breasts

□ Yes □No Breast pain
□ Yes □No Nipple discharge
If yes, what color? _____
□ Yes □No Breast lumps

Heart

□ Yes □No Chest pain/discomfort
□ Yes □No Fast heart rate
□ Yes □No Feel heartbeat in chest (palpitations)

Lungs

□ Yes □No Shortness of breath
□ Yes □No Cough
□ Yes □No Producing any phlegm/mucus in cough?
If yes, what color? _____
□ Yes □No Coughing up blood
□ Yes □No Wheezing

Gastrointestinal

□ Yes □No Changes in appetite
□ Yes □No Difficulty swallowing
□ Yes □No Heartburn
□ Yes □No Nausea
□ Yes □No Vomiting
□ Yes □No Abdominal pain
□ Yes □No Diarrhea
□ Yes □No Black stool
□ Yes □No Red stool

Urinary

□ Yes □No Difficulty urinating
□ Yes □No Urinating more often
□ Yes □No Change in urine color
If yes, what color? _____

Skin

□ Yes □No Itching
□ Yes □No Moles, bruising, discoloration
□ Yes □No Rashes

Endocrine

□ Yes □No Excessive sweating
□ Yes □No Excessive thirst

Name:_____ Date of Birth:_____ Date:_____

Musculoskeletal

□ Yes □No Joint pain
If yes, where? _____
□ Yes □No Joint stiffness
If yes, where? _____
□ Yes □No Muscle ache

Psychological

□ Yes □No Sleep problems
□ Yes □No Anxiety
□ Yes □No Depression

Neurological

□ Yes □No Dizziness
□ Yes □No Vertigo (feel that the room is spinning)
□ Yes □No Fainting
□ Yes □No Movement disturbances (weakness, paralysis)
□ Yes □No Tingling, numbness

Height:_____Weight:_____

Do you have any family history of colon cancer, colon polyps, or colon disease?

_____

Have you had any rectal bleeding, diarrhea, constipation or abdominal pain in the last 3 months? If so, what?

_____

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To Whom It May Concern:

The following is _____ statement regarding the effects Varicose Veins has on his/her instrumental activities of daily living. (Defined as feeding, bathing, dressing, grooming, meal preparation, household chores and occupational tasks that are required as daily part of job functioning).

I am most symptomatic when I am: (describe the activity you are performing)
_____
_____
_____
_____

These symptoms cause (limit) me to: (describe what you do to alleviate your pain/discomfort)_____
_____
_____
_____

I wear my (strength/type) _____ compression stockings _____ hours per day _____times per week.

_____
Patient Signature

Cascade Surgeons

Patient Full Name _____

Address_____ **City**_____**State** _____ **Zip**_____

Home Phone _____**Cell Phone** _____

Email address_____

SS# _____ **Male / Female** **Birth-Date** _____

Language_____ **Race**_____ **Ethnicity**_____

Circle appropriate status: Minor Single Married Divorced Widowed Separated

Primary Care Physician_____ **Clinic**_____

Patient's or parent/guardian's employer_____**Work Phone**_____

Person to contact in case of emergency _____**Phone**_____

Primary Insurance Information:

Insurance Company _____ ID #_____
Group # _____Name of Insured _____Birth-Date _____
Ins. Co. Address_____ City _____ Zip_____
Insurance Company Phone #_____

Secondary Insurance Information:

Insurance Company_____ ID #_____
Group #_____Name of Insured _____Birth-Date_____
Ins. Co. address_____City_____Zip_____
Insurance Company Phone #_____

For a patient under the age of 18 please complete the following:

Name of responsible person_____Relationship_____
Home Address _____ City_____ State _____Zip_____
Phone _____ Cell Phone_____
Employer _____ Work Phone_____

Release of information:

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Names(s):_____ Relationship to patient:_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ Date_____
Signature of Patient or Parent/Guardian if Minor

Cascade Surgeons
875 Wesley Street Suite 230
Arlington, WA 98223

Acknowledge of Receipt Of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of the Notice of Privacy Practice, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of _____20_____

Printed Patient Name:

Relationship to Patient:_____

Signature_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, however, acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)_____

Cascade Surgeons Payment Policy

Thank you for choosing Cascade Surgeons for your surgical care. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any question you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at the time of visit.

3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collections agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary change for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date