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NCSRA Medical Corporation
2801 K Street, Suite 410
Sacramento, CA 95816

(916) 389-7100 phone line
(916) 389-7140 fax line

Dear Patient,

You have been referred to NCSRA Medical Corporation for an evaluation. We would like to take this time to welcome you to our practice and look forward to assisting you in your health care needs.

Before your appointment:

Step 1: Create your Patient Portal account, log in and select "Update Medical History".

Step 2: Complete the appropriate paperwork below and hand carry it to your appointment.

You will need to bring: Current insurance card or complete Worker's Compensation information. You will also need to hand carry any diagnostic studies and the reports that are relating to your present condition, such as MRI, CT, Bone Scan, and EMG/NCV studies.

About our office

NCSRA is HIPAA compliant. You may review a copy of the Privacy Policy to read upon check in, if you choose a copy will be provided to you. If you have any questions we would be happy to answer them when you arrive.

Directions: For directions please call 916-389-7100 ext. 6.

Parking (cash only): Our building contains a parking garage, the entrance is on K street. The cost is $1.00 for 20 minutes.

Appointment cancellation policy: Please notify our office 24 hours prior to your appointment time. Failure to do so may result in a fee.

Prescription refill policy: Medication refills must be done at the time of your scheduled visit or by calling your pharmacy. For medical and legal reasons, we do not refill medications on Fridays, weekends, or by telephone.

Disabiltity and Insurance Forms: The fee for completion of most forms is $5.00 per page and payment is required in advance. Please complete your portion before mailing or bringing your form to the office.

Payment for services rendered: Co-pays, PPO deductibles and HSA deductibles are due at the time of service. We accept cash, checks, Visa or Mastercard and will bill your insurance plan whenever possible, however, please remember that the primary responsibility for payment is yours, not the insurance company. Not all physicians at NCSRA Medical Corporation are on all plans or the same plans.

Preferred provider with your insurance? Please check with your carrier to see if our physician is a member of your insurance plan, if not you may be required to pay in full for services.

Returned check: A $35.00 fee is due and payable by cash, money order or credit card and must be paid before the next visit.

NCSRA MEDICAL CORPORATION * PATIENT REGISTRATION

PATIENT DEMOGRAPHICS:

Full Name: _____

Address/City/St/Zip: _____

DOB: _____ **Age:** _____ **Gender:** M F **Marital Status:** S M W D DP **SSN:** _____--_____--_____

Home: _____ ☐Okay to leave a message? **Cell:** _____ ☐Okay to leave a message?

Email: _____ **Reminder preference:** ☐Phone call ☐Text message ☐Email

Emergency contact: _____ **Phone:** _____

Primary Language: ☐English ☐Spanish ☐_____ **Do you need an interpreter?** Yes No

Primary Care MD: _____

Referring MD: _____

INSURANCE COVERAGE: *Cards must be presented at time of service*

Primary: _____	Secondary: _____
Subscriber: _____	Subscriber: _____
DOB: _____ Relationship: Self Spouse Child	DOB: _____ Relationship: Self Spouse Child
Mem ID:	Mem ID:

WORKER'S COMPENSATION COVERAGE:

Date of injury: _____ Employer at the time of injury: _____ body part(s): _____

Insurance Carrier/Address: _____

Claims adjuster: _____ Claim number: _____

HIPAA (Health Insurance Portability and Accountability Act): You may IList a personal contact whom may request and/or pick up information on your behalf:

**List full name(s) only: _____ ☐ None

_____ (Initial) **Noticy of Privacy Practices:** I hereby acknowledge that I received a copy or have access to a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. Dyann Wolfe, Administrator (916) 389-7100-Privacy Officer

_____ (Initial) **Assignment of Benefits, Release of information:** I hereby assign all necessary medical and/or surgical benefits to which I am entitled, including private insurance and any other plan to NCSRA Medical Corporation for all services rendered by its medical providers and representatives. 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 understand that I am financially responsible for all charges not paid for by said insurance according to contract or regulations. I hereby authorize NCSRA or its representatives to release or obtain necessary medical records for treatment purposes and/or to secure payment.

Patient or Parent/Guardian Signature: _____ Date: _____

Parent/ Guardian full name (Please Print): _____

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2801 K Street #410 Sacramento, CA 95816

OSWESTRY QUESTIONNAIRE

This questionnaire has been designed to give us information regarding how your back and/or neck pain has affected your ability to manage everyday life.

- *Mark ONLY ONE answer for each section*
- *Answer every section.*

We realize you may consider that two or more statements in any one section relate to you. Please select only the one that most clearly describes your condition.

Section 1: Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment
☐ The pain is moderate at the moment
☐ The pain is fairly severe at the moment
☐ The pain is very severe at the moment
☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. Washing, dressing)

☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but can manage most of my personal care
☐ I need help every day in most aspects of self care
☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives me extra pain
☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. On table
☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
☐ I can lift very light weights
☐ I cannot lift or carry anything

Section 4: Walking

☐ Pain does not prevent me from walking any distance
☐ Pain prevents me from walking more than 1 mile
☐ Pain prevents me from walking more than 1/4 mile
☐ Pain prevents me from walking more than 100 yards
☐ I can only walk using a stick or crutches
☐ I am in bed most of the time

Section 5: Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than 1 hour
☐ Pain prevents me from sitting more than 30 minutes
☐ Pain prevents me from sitting more than 10 minutes
☐ Pain prevents me from sitting at all

Section 6: Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives me extra pain
☐ Pain prevents me from standing more than 1 hour
☐ Pain prevents me from standing mor than 30 minutes
☐ Pain prevents me from standing more than 10 minutes
☐ Pain prevents me from standing at all

Section 7: Sleeping

☐ My sleep is never disturbed by pain.
☐ My sleep is occasionally disturbed by pain.
☐ Because of pain I have less than 6 hours of sleep
☐ Because of pain I have less than 4 hours of sleep
☐ Because of pain I have less than 2 hours of sleep
☐ Pain iprevents me from sleeping at all

Section 8: Sex Life (if applicable)

☐ My sex life is normal and causes no extra pain
☐ My sex life is normal but causes some extra pain
☐ My sex life is nearly normal but is very painful
☐ My sex life is severely restricted by pain
☐ My sex life is nearly absent because of pain
☐ Pain prevents any sex life at all

Section 9: Social Life

☐ My social life is normal and gives me no extra pain
☐ My social life is normal but increases the degree of pain
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg. sport
☐ Pain has restricted my social life and I do not go out as often
☐ Pain has restricted my social life to home
☐ I have no social life because of pain

Section 10: Travelling

☐ I can travel anywhere without pain
☐ I can travel anywhere but it gives me extra pain
☐ Pain is bad but I manage journeys over two hours
☐ Pain is bad but I manage journeys over one hour
☐ Pain restricts me to short necessary journeys under 30 minutes
☐ Pain prevents me from travelling except to receive treatment

Patient signature:_____ Date:_____

WORK COMP QUESTIONAIRE

Name:_____ **DOB:**_____ **Date:**_____

Date of Injury: ____/____/_____ **Time of Injury**_____:_____ am/pm

Current work status (Circle one): Regular duty Modified duty (since)_____ Off work (since)_____

Name of Employer at the time of injury: _____

Employer Address:_____

City:_____ State_____ Zip_____ Phone ( ) _____

Occupation_____ Length of employment_____ years/months/weeks

Job Description: _____

1. In terms of an 8 hour workday: (Circle number of hours for each activity)

Sit: 1 2 3 4 5 6 7 8 hrs. **Stand:** 1 2 3 4 5 6 7 8 hrs. **Walk:** 1 2 3 4 5 6 7 8 hrs.

2. On the job, I perform the following activities: (Circle as many as apply)

a) Bend/Stoop **b)** Squat **c)** Crawl **d)** Climb **e)** Reach above shoulders

f) Crouch **g)** Kneel **h)** Push/Pull **i)** Maintain awkward positions

3. Do you use your hands for repetitive movements such as: (Circle as many as apply)

a. Simple grasping: Left hand / Right hand
b. Firm Grasping: Left hand / Right hand
c. Fine Manipulating: Left hand / Right hand

4. On the job, I regularly lift between:

1-10 lbs. 11-24 lbs. 25-34 lbs. 35-50 lbs. 51-74 lbs. 74-100 lbs.

5. Are you required to bend over while lifting? Yes No

6. Prior to this accident were you experiencing any similar physical complaints? (Yes No)
If yes, please explain:_____

_____

_____

7. In your own words, please describe how you were injured:

_____

_____

_____

8. Do you have any prior Workers' Compensation injuries or claims?(circle one) Yes No
If yes, please explain:_____

_____

_____

Important: This form may be used in the determination of your Workers Compensation eligibility and the amount of compensation you are entitled. To protect your rights please fill out this form correctly and completely.

Patient Signature_____ **Date**_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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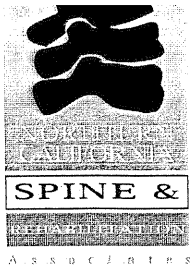

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We are excited to invite you to sign up for our Patient Portal

STEP 1: Provide the office with your home email address and obtain your account number.

STEP 2: Check your email inbox for an invitation to create your online account. (This can take up to 24 hours).

STEP 3: Create your online account by following the directions in the email.

STEP 4: Send a secure message to the office to verify that your account has been created and is working.

a. Select "Message Center" icon.
b. Select "Inbox".
c. Select "Account verification" and follow the instructions.

Enjoy access to online features that allow you to send and receive information to and from the office such as:

- Receive office notes, orders, work status, and/or summaries of visits.
- Update address, phone numbers and/or provide new insurance information.
- Request a copy of your medical records.
- Send secure messages to the medical records staff.
- Request your doctor to complete a new or supplement State Disability Insurance Form.
- Fill out a patient history questionnaire.
- Many more new features will be added in the future.....

After you create your account you can gain access by going to the following website:

https://www.exscribepatientportal.com/NCSRA/

Thank you for your patience during this transition period.

NCSRA Medical Corporation