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NCSI  
2801 K Street, Suite 410

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

Phone: (916) 389-7100  
Fax: (916) 389-7140

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.

**CHECK-IN TIME: 30 min. prior to your appointment time**

**Before your appointment:**

1. Complete the patient history form online through your portal account and....
2. Print, complete and hand carry this paperwork with you to your appointment.

**You will need to bring:**

1. Current insurance card or complete worker's compensation information.
2. Hand carry any diagnostic studies 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.

**Patient Portal:** To sign up for access to the online Patient Portal please contact our office.

**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 allow 24 hours notice for appointment changes, failure to do so will result in the following fee which is due prior to rescheduling.

Fee: Follow up: \$25.00      Consultation/Evaluation: \$50.00      EMG/injection procedures: \$50.00

**Prescription refill policy:** Medication refills must be done at the time of your scheduled visit. We do not refill on Fridays, weekends, or by telephone.

**Disability/Insurance Forms:** There is a pre-paid fee due for most forms. Please contact the office before mailing or bringing your form into the office.

**Payment for services rendered: It is your responsibility to know your benefits prior to your appointment.** 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 your insurance companies. Not all physicians at NCSRA Medical Corporation are on all plans or the same plans. 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.

**Credit Card Fee:** There is a 3.5% service fee when payment is made using a credit card.

**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.

<b>PATIENT NAME/DOB:</b>			
<b>FULL ADDRESS:</b>			
<b>Marital Status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner		
<b>Primary Language:</b>	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other, please list:		
<b>Interpreter needed?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Home Phone:</b>		Okay to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Correct
<b>Cell Phone:</b>			<input type="checkbox"/> Correct
<b>Email Address:</b>			<input type="checkbox"/> Correct
<b>Appointment Reminder:</b>	<input type="checkbox"/> Phone call <input type="checkbox"/> Text message <input type="checkbox"/> Email message		
<b>Emergency Contact:</b>		Phone #:	
<b>Primary Care MD:</b>			
<b>Referring MD:</b>			

<b>HIPAA: Health Insurance Portability and Accountability Act</b>	
List any person by name whom may act on your behalf to discuss and/or request medical information, you may also choose "none".	
<b>**Full name only:</b>	<input type="checkbox"/> None

<b>INSURANCE COVERAGE</b>			
You must present your insurance card at the time of service			
	<b>COMPANY</b>	<b>ID#</b>	<b>SUBSCRIBER/DOB &amp; RELATIONSHIP</b>
Primary:			<input type="checkbox"/> Self <input type="checkbox"/> Spouse:
Secondary:			<input type="checkbox"/> Self <input type="checkbox"/> Spouse:
Other:			<input type="checkbox"/> Self <input type="checkbox"/> Spouse:

<b>WORKER'S COMPENSATION COVERAGE</b>	
<b>Insurance Carrier:</b>	
<b>Adjuster:</b>	<b>Claim Number:</b>
<b>Employer:</b>	<b>Date of Injury:</b>
<b>Body Part(s):</b>	
<b>Social Security Number:</b>	

<p><b>Noticy of Privacy Practices:</b> 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</p> <p><b>Assignment of Benefits, Release of information:</b> 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.</p>	
Patient or Parent/Guardian Signature: _____  Printed Name: _____	<b>DATE:</b>  _____

# NCSRA: OSWESTRY

## Patient Name/DOB:

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

• **Mark ONLY ONE answer for each section**

• **Answer every section.**

### 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 more 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 prevents 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. sports
- 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: \_\_\_\_\_