



## A Multidisciplinary Pain Management Center

### ABOUT PAIN MANAGEMENT

Advanced Pain Centers of Alaska manages and treats all forms of chronic pain utilizing a unique multidisciplinary approach. Chronic pain management is a process that requires the patient to become an active participant, an approach that has been proven to be the most effective treatment for chronic pain conditions. We provide our patients with the skills and guidance necessary to optimize their outcome.

### OUR GOAL

The goal of the physicians and staff at Advanced Pain Centers of Alaska is to improve quality of life by helping patients restore function and manage chronic pain by addressing the medical, physical, and psychological aspects of their pain. Our multidisciplinary team of pain management physicians, nurse practitioners, physical therapists, and psychologists have specialty training to address the complexity of chronic pain conditions. With the advanced training and knowledge of the latest research in treatment and technology, our team works together to coordinate a treatment plan specifically designed for your pain.

### MAKING A DIAGNOSIS

There are times when other physicians may perform procedures without making a complete diagnosis. Advanced Pain Centers of Alaska believes that in order to treat chronic pain effectively, it is very important to make the appropriate evaluation and diagnosis before assessing treatment options. Individualized treatment is dependent upon this evaluation and diagnosis. Our multidisciplinary treatment team takes a comprehensive approach to find the right combination of techniques to effectively address your chronic pain condition. Diagnosis is a significant part of your treatment plan.

### WORKING TOGETHER

Chronic pain is a very complex problem, involving both physical and psychological components. It is important that the multidisciplinary treatment team (Pain Management Physicians, Physical Therapists, and Health Psychology Providers) work together to address your chronic pain problem. To effectively accomplish this goal, your care is coordinated with the physicians, the health psychology providers, and the physical therapists. This allows for significantly improved communication and treatment coordination between staff, and works to your advantage in addressing your chronic pain problem.

### PAIN SYNDROMES TREATED

*Back Pain	*Spinal Stenosis	*Postherpetic Neuralgia
*Discogenic Pain	*Radicular Pain	*Neuroma Pain
*Neuropathic Pain	*Facet Pain	*Causalgia
*Reflex Sympathetic Dystrophy	*Myofacial Pain	*Headaches
*Psychological Aspects of Pain	*Sacroiliac Joint Pain	*Pelvic Pain

### SPECIALTY PROCEDURES AND PROGRAMS

Depending on the diagnosis, IntraDiscal Electro Thermal Therapy (IDETT), DisTrode, Nucleoplasty, Radiofrequency Neuro-Ablation, Discography, Indwelling Drug Delivery Systems, and Spinal Cord Stimulation are available for the treatment of chronic pain. These procedures have significantly greater success utilizing the multidisciplinary approach of Advanced Pain Centers of Alaska. Psychological procedures include cognitive-behavioral pain management techniques including biofeedback training, and treatment of anxiety or depression. Psychiatric treatments include medication assessment, management, and consultation. The Functional Restoration Program at Advanced Pain Centers of Alaska takes a comprehensive treatment approach to helping you decrease pain, increase function, and ultimately improve your quality of life!



Dear Patient:

Thank you for choosing Advanced Pain Centers of Alaska. We are very happy to have you as a patient and are committed to giving you the best quality medical care possible. This sheet is meant to be a helpful source of information for you. **Please read it thoroughly and initial at the bottom!**

In consideration of your valued time we are mailing you the pain-patient questionnaire required by our providers prior to your appointment. PLEASE FILL OUT THE ATTACHED FORMS COMPLETELY and return them at the time of your appointment. We also remind you that your **MRI and/or CT films** are needed for your appointment. These are an integral part of your evaluation and **your appointment may be rescheduled if you do not bring the films with you, OR if the attached forms are not filled out.**

Please arrive 15 minutes prior to your scheduled appointment time.  
We will call you with a reminder the day before your appointment..

In order to provide you with the best possible care we encourage you to make arrangements for child care during your appointment. This will allow your healthcare provider to give you their undivided attention.

We will do our best to assist you in every way in complying with the particular guidelines of your insurance plan. However, it is ultimately your responsibility to make sure that you have the necessary coverage for any services rendered in our facility.

We are obligated to collect your insurance co-pay it at the time of your visit. Every time you see any of our providers you will need to make your co-pay. This includes all follow up visits, discussions regarding any medication you are taking, or medical counseling of any kind.

Some insurance plans ask that you go to a particular facility for tests. This may include laboratories, x-ray facilities and hospitals. We make every effort to send you to the appropriate facility; however, it is your responsibility to know if you are limited to a particular facility for these tests and to inform our staff of such.

You will need to notify us if your plan requires any pre-certification or prior authorization for any service we provide. This includes office visits, procedures, surgery and physical therapy. Again, you are responsible for getting any pre-certification or prior authorization if needed. We will assist you with any information you need.

For patients from out of town: you may be referred for additional treatment that requires you to stay in Anchorage overnight. It is your responsibility to arrange for your own accommodations and travel, including taxicabs. If you have Medicaid **you must obtain your travel vouchers from your referring physician.** APCA will **not** arrange for travel.

Thank you,

The Staff and Physicians at  
Advanced Pain Centers of Alaska

Initial \_\_\_\_\_



**PATIENT INFORMATION**

This form is to be completed by all patients before their first appointment with Advanced Pain Centers of Alaska. Your careful answers will help us to understand your pain problem and begin the best treatment program for you.

It is understandable that you might be concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential and no one outside of your health care team is permitted to see your case record without your written permission.

**BACKGROUND INFORMATION**

Today's Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Age in Years: \_\_\_\_\_

If you are employed, please describe your job. Occupation: \_\_\_\_\_

Full-time    Part-time    Unemployed    Disability (list disability): \_\_\_\_\_

Are you here for a work-related injury?    Yes    No   If yes, how did your injury occur? \_\_\_\_\_

Worker's Comp Carrier: \_\_\_\_\_ Case Manager: \_\_\_\_\_

Address for Claims: \_\_\_\_\_ Case #: \_\_\_\_\_

Please complete the following information about the Provider that is referring you to our Clinic, along with your Primary Care Provider's Name, Address, Telephone number, and if possible fax number.

**\*\*Important to complete thoroughly so that we can update your referring physician(s) with your treatment plan\*\***

**Referring Provider (MD,DO,ANP,PA)**

**Primary Care Provider (MD, DO,ANP,PA)**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Fax #: \_\_\_\_\_

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**SYMPTOM DESCRIPTION**

There are many ways to describe your symptoms and the impact they have on your life. Descriptions of your symptoms are very important in the development of a diagnosis and treatment plan. Please carefully consider your pain and/or neurological symptoms then describe them as accurately as possible. (eg. Seizure or epilepsy, numbness, tingling, weakness, balance or walking problems, head pain, dizziness, changes in vision, difficulty swallowing or with speech, stiffness, pain)

1. When did you first notice these symptoms? \_\_\_\_\_ Years \_\_\_\_\_ Months
2. Did these symptoms begin after an injury?  Yes  No If yes what was the date of injury? \_\_\_\_\_

Describe your injury: \_\_\_\_\_  
\_\_\_\_\_

3. Where are the symptoms?  Primarily Left Side  Primarily Right Side  Both Right and Left Side
- Face  Head  Neck  Shoulder  Arm(s)  Wrist(s)  Hand(s)  Finger(s)  Upper back
- Middle Back  Lower Back  Chest  Abdomen  Leg(s)  Feet  Other: \_\_\_\_\_

4. If you have pain, what does your pain feel like?  Ache  Pressure  Pulsating  Stabbing  Numbness
- Other: \_\_\_\_\_

5. How often do you have these symptoms? #\_\_\_\_daily, #\_\_\_\_per week, #\_\_\_\_per month, #\_\_\_\_per year?

6. If you have pain, the intensity can be described on a scale of 0 to 10. "0" is no pain at all, "10" is the worst pain imaginable, like surgery without anesthesia. Circle the appropriate number to describe your pain level:

Now:	0	1	2	3	4	5	6	7	8	9	10
At its Worst:	0	1	2	3	4	5	6	7	8	9	10
At its Best:	0	1	2	3	4	5	6	7	8	9	10
On Average:	0	1	2	3	4	5	6	7	8	9	10

7. What word best describes your pain or symptoms?  No Pain  Mild  Moderate  Horrible  Excruciating

8. How much do these symptoms interfere with your daily activities?  
 Not at all  Mildly  Moderately  Severely  Completely dependent upon others

9. Describe your typical daily activities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. What causes your symptoms to become worse? \_\_\_\_\_  
\_\_\_\_\_

11. What causes your symptoms to become better? \_\_\_\_\_  
\_\_\_\_\_

10. Does any of the following make your symptoms better or worse? Please place a check mark in the appropriate box.

	<i>Worse</i>	<i>Better</i>	<i>No Change</i>		<i>Worse</i>	<i>Better</i>	<i>No Change</i>
Heat				Sex			
Cold/Ice				Bending			
Standing				Lifting			
Sitting				Pushing			
Lying Down				Tension			
Walking				Stress			
Staying Busy				Rest/Sleep			
Moving Around				Pain Pills			
Bowel Movement				Alcohol			
Coughing				Other: (list below)			
Exercise							

### SLEEP QUALITY

Your symptoms can often lead to problems with your sleep quality. It is important to assess these potential problems because this is often treatable with behavioral and/or appropriate medication.

11. How many hours of sleep do you get per night? \_\_\_\_
12. Your symptoms interfere with your sleep:  Never  Rarely  Sometimes  Every Night
13. If your sleep is interrupted, do you have more problems:  Falling asleep  Staying asleep  Both
14. How would you rate the quality of your sleep?  Poor  Fair  Good
15. How do you generally feel upon awakening?  Refreshed  Fatigued

### PREVIOUS TREATMENTS

Often people have sought treatment for their pain condition or neurological symptoms prior to being seen at the Advanced Pain Centers of Alaska. It is important to consider your previous treatments and if these relieved or lessened your symptoms.

<i>HAVE YOU TRIED ANY OF THE FOLLOWING TO TREAT YOUR SYMPTOMS OR CONDITION?</i>				<i>WAS IT HELPFUL?</i>	
	<i>Yes</i>	<i>No</i>	<i>Don't Know</i>	<i>Yes</i>	<i>No</i>
Specialty Clinic, Pain Clinic, Anesthesiologist, or Neurologist. If yes, Who did you see?					
Anti-inflammatory (Aspirin, Motrin, Ibuprofen, etc.)					
Prescription Pain Medication					
Anti-depressant Medications					
Trigger Point Injections					
Epidural Steroids					
Biofeedback or Relaxation Training					
Group Therapy					
Individual Counseling					
Physical Therapy					
Home Exercises					
TENS Unit					
Naturopathic provider					
Acupuncture					
Chiropractor					
Other					

16. Have you seen other health providers ( MD,DO,NP,PA, therapist) for your condition?  Yes  No If yes, **WHO** did you see and **WHERE** did you see them? \_\_\_\_\_

17. How often do you see doctors (or other providers) for your symptoms or condition:  
 Never  Very Rarely  Occasionally  A Lot

18. Have you had surgery for your symptoms or condition?  Yes  No If yes, please list: \_\_\_\_\_

19. Have you had any of the following diagnostic tests?

<i>Diagnostic Test</i>	<i>When</i>	<i>Where</i>	<i>Results</i>
X-rays			
CAT Scan			
MRI Scan			
Bone Scan			
Myelogram			
EMG Nerve Test			
EEG			
Other			

20. Do you receive Disability Compensation?  Yes  No

21. Is a lawyer involved for disability or injury?  Yes  No

**GENERAL MEDICAL HISTORY**

22. What other medical problems do you have? \_\_\_\_\_

23. Have you had any other surgeries?  Yes  No If yes, please list below:

<i>Surgery</i>	<i>Date of Surgery</i>	<i>Surgeon</i>

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24. Are you allergic to:

Iodine?  Yes  No

Tape?  Yes  No

X-Ray Dye?  Yes  No

25. Do you have any other allergies?  Yes  No If Yes, what are you allergic to and what is your reaction?

<i>Allergen</i>	<i>Reaction</i>

26. Do you have any medical problems that run in your family?  Yes  No If yes, list the medical problems:

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27. Please describe how you have felt during the PAST WEEK by making a check mark in the appropriate box. Please answer all questions. Do not think too long before answering.

	Not at all	A little	A great deal	Extremely
1. Heart rate increase				
2. Feeling hot all over				
3. Sweating all over				
4. Sweating in particular body part				
5. Pulse in neck				
6. Pounding in head				
7. Dizziness				
8. Blurring of vision				
9. Feeling faint				
10. Everything appearing unreal				
11. Nausea				
12. Butterflies in stomach				
13. Pain or ache in stomach				
14. Stomach churning				
15. Desire to urinate				
16. Mouth becoming dry				
17. Difficulty swallowing				
18. Muscles in neck aching				
19. Legs feeling weak				
20. Muscles twitching or jumping				
21. Tense feeling across forehead				
22. Tense feeling in jaw muscles				

From Main, C.J., Psychosom Res 27 (503-514), 1983

28. Please indicate for each of these questions which answer best describes how you have been feeling recently.

	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1-2 days per week)	A moderate amount of time (3-4 days per week)	Most of the time (5-7 days per week)
1. I feel downhearted and sad.				
2. Morning is when I feel best.				
3. I have crying spells or feel like it.				
4. I have trouble getting to sleep at night.				
5. I feel that nobody cares.				
6. I eat as much as I used to.				
7. I still enjoy sex.				
8. I notice that I am losing weight.				
9. I have trouble with constipation.				
10. My heart beats faster than usual.				
11. I get tired for no reason.				
12. My mind is as clear as it used to be.				
13. I tend to wake up too early.				
14. I find it easy to do things I used to.				
15. I am restless and can't keep still.				
16. I feel hopeful about the future.				
17. I am more irritable than usual.				
18. I find it easy to make a decision.				
19. I feel quite guilty.				
20. I feel that I am useful and needed.				
21. My life is pretty full.				
22. I feel that others would be better off if I were dead.				
23. I am still able to enjoy the things I used to.				

**MEDICATIONS**

29. What medications are you CURRENTLY taking to control pain and/or symptoms (including herbal or naturopathic)?

<i>Medication</i>	<i>Dosage(mg, mcg)</i>	<i>How Often?</i>

30. What medications have you tried in the past to control your symptoms or condition? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

31. What other medication do you take?

<i>Medication</i>	<i>Dosage (mg, mcg)</i>	<i>How Many times per day?</i>

32. Have you ever taken or been given the following?

	<i>Yes</i>	<i>No</i>	<i>When?</i>	<i>Please Explain</i>
Anticoagulants (blood thinners such as coumadin or Heparin)?				
Cortisone or Steroids?				
Local anesthetic (given by your doctor or dentist)?				
Antidepressants, anti-anxiety, or other psychiatric meds?				

33. Please complete the following medical history:

**Constitutional**

Have you had recent weight loss?  Yes  No; \_\_\_\_\_  
Have you had recent weight gain?  Yes  No; \_\_\_\_\_

**Neurologic**

Have you ever had a stroke?  Yes  No; \_\_\_\_\_  
Have you ever had a brain infection?  Yes  No; \_\_\_\_\_  
Do you have frequent headaches?  Yes  No; \_\_\_\_\_  
Have you ever had syncope (passed out)?  Yes  No; \_\_\_\_\_  
Do you have numbness or weakness anywhere?  Yes  No; \_\_\_\_\_  
Have you ever had seizures?  Yes  No; \_\_\_\_\_  
Have you ever had neurological disease?  Yes  No; \_\_\_\_\_  
Have you had any recent changes in vision?  Yes  No; \_\_\_\_\_  
Have you had any recent changes in hearing?  Yes  No; \_\_\_\_\_  
Have you had any recent changes in smell or taste?  Yes  No; \_\_\_\_\_

**Pulmonary**

Do you have asthma?  Yes  No; \_\_\_\_\_  
Do you have emphysema?  Yes  No; \_\_\_\_\_  
Do you have a chronic cough?  Yes  No; \_\_\_\_\_  
Do you have bronchitis?  Yes  No; \_\_\_\_\_  
Have you ever coughed up blood?  Yes  No; \_\_\_\_\_  
Do you awaken at night short of breath?  Yes  No; \_\_\_\_\_  
Do you get short of breath when you exert yourself?  Yes  No; \_\_\_\_\_

**Cardiovascular**

Have you ever had a heart attack?  Yes  No; \_\_\_\_\_  
Have you ever had a fast or slow heartbeat that required medical treatment?  Yes  No; \_\_\_\_\_  
Do you have high blood pressure?  Yes  No; \_\_\_\_\_  
Do you have chest pain?  Yes  No; \_\_\_\_\_  
Do you have heart failure?  Yes  No; \_\_\_\_\_  
Do you have heart valve problems?  Yes  No; \_\_\_\_\_

**Genitourinary**

Have you ever had blood in your urine?  Yes  No; \_\_\_\_\_  
Have you ever had urinary tract infections?  Yes  No; \_\_\_\_\_  
Do you have a history of kidney disease?  Yes  No; \_\_\_\_\_  
Have you had a recent change in bladder function? (such as passing your urine or stools without control)  Yes  No; \_\_\_\_\_

**Gastrointestinal**

Do you have a history of ulcers?  Yes  No; \_\_\_\_\_  
Do you have a history of abdominal pain which required medical treatment?  Yes  No; \_\_\_\_\_  
Do you have nausea and vomiting now?  Yes  No; \_\_\_\_\_  
Have you ever vomited blood?  Yes  No; \_\_\_\_\_  
Have you had blood in your stool?  Yes  No; \_\_\_\_\_  
Have you had liver problems?  Yes  No; \_\_\_\_\_  
Have you had a recent change in bowel habits?  Yes  No; \_\_\_\_\_

**Endocrine**

Do you have diabetes?  Yes  No; \_\_\_\_\_  
Do you have thyroid problems?  Yes  No; \_\_\_\_\_

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Have you been diagnosed with an Autoimmune problem ?  Yes  No; \_\_\_\_\_

***Musculoskeletal***

Do you have a history of swelling, redness, or pain in your joints?  Yes  No; \_\_\_\_\_

Do you have a history of swelling, redness, or pain in your muscles?  Yes  No; \_\_\_\_\_

Do you have skin rashes?  Yes  No; \_\_\_\_\_

***Psychiatric***

Have you had a psychiatric illness?  Yes  No; \_\_\_\_\_

Have you had a history of depression?  Yes  No; \_\_\_\_\_

Have you ever been treated by a psychiatrist, psychologist, nurse practitioner, or counselor?  Yes  No; \_\_\_\_\_

***Hematologic***

Have you had a history of bleeding disorders?  Yes  No; \_\_\_\_\_

Have you had a history of anemia?  Yes  No; \_\_\_\_\_

Do you take blood thinners (anticoagulants)?  Yes  No; \_\_\_\_\_

Have you ever had slow blood clotting when the skin is cut?  Yes  No; \_\_\_\_\_

***Other***

Have you ever had cancer?  Yes  No; \_\_\_\_\_

Have you had recent fever, chills, or night sweats?  Yes  No; \_\_\_\_\_

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**SOCIAL HISTORY**

34. Are you married?  Yes  No Who lives with you? \_\_\_\_\_

Do you smoke?  Yes  No How many packs per day? \_\_\_\_\_ How long? \_\_\_\_\_ years

Do you drink alcohol?  Yes  No How many days per week? \_\_\_\_\_

How much per day? \_\_\_\_\_

What do you drink? \_\_\_\_\_

35. How often do you exercise?  Never  1 to 4 times per week  4 to 6 times per week  Everyday

If yes, what type(s) of exercise do you participate in? \_\_\_\_\_

36. Do you walk regularly?  Yes  No How many times per week? \_\_\_\_\_ How many blocks? \_\_\_\_\_



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# ADVANCED PAIN CENTERS OF ALASKA

## NOTICE OF PRIVACY INFORMATION 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.**

### **A. PURPOSE OF THE NOTICE.**

EFFECTIVE 04-14-2003

ADVANCED PAIN CENTERS OF ALASKA is committed to preserving the privacy and confidentiality of your health information which is created and/or maintained at our clinic. State and federal laws and regulations require us to implement policies and procedures to safeguard the privacy of your health information. This Notice will provide you with information regarding our privacy practices and applies to all of your health information created and/or maintained at our clinic, including any information that we receive from other health care providers or facilities. The Notice describes the ways in which we may use or disclose your health information and also describes your rights and our obligations concerning such uses or disclosures.

We will abide by the terms of this Notice, including any future revisions that we may make to the Notice as required or authorized by law. We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice which will identify its effective date in our clinic.

The privacy practices described in this Notice will be followed by:

1. Any health care professional authorized to enter information into your medical record created and/or maintained at our clinic;
2. All employees, students, residents, and other service providers who have access to your health information at our clinic; and
3. Any member of a volunteer group which is allowed to help you while receiving services at our clinic.

The individuals identified above will share your health information with each other for purposes of treatment, payment and health care operations, as further described in the Notice.

### **B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.**

1) **Treatment, Payment and Health Care Operations.** The following section describes different ways that we may use and disclose your health information for purposes of treatment, payment, and health care operations. We explain each of these purposes below and include examples of the types of uses or disclosures that may be made for each purpose. We have not listed every type of use or disclosure, but the ways in which we use or disclose your information will fall under one of these purposes.

- a. **Treatment.** We may use your health information to provide you with health care treatment and services. We may disclose your health information to doctors, nurses, nursing assistants, medication aides, technicians, medical and nursing students, rehabilitation therapy specialists, or other personnel who are involved in your health care to include but not limited to urine analysis results.

For example, we may order physical therapy services to improve your strength and walking abilities. We will need to talk with the physical therapist so that we can coordinate services and develop a plan of care. We also may need to refer you to another health care provider to receive certain services. We will share information with that health care provider in order to coordinate your care and services.

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- b. **Payment.** We may use or disclose your health information so that we may bill and receive payment from you, an insurance company, or another third party for the health care services you receive from us. We also may disclose health information about you to your health plan in order to obtain prior approval for the services we provide to you, or to determine that your health plan will pay for the treatment.

For example, we may need to give health information to your health plan in order to obtain prior approval to refer you to a health care specialist, such as a neurologist or orthopedic surgeon, or to perform a diagnostic test such as a magnetic resonance imaging scan (“MRI”) or a CT scan.

- c. **Health Care Operations.** We may use or disclose your health information in order to perform the necessary administrative, educational, quality assurance and business functions of our clinic.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We also may use your health information to evaluate whether certain treatment or services offered by our clinic are effective. We also may disclose your health information to other physicians, nurses, technicians, or health profession students for teaching and learning purposes.

### C. **USES AND DISCLOSURES OF HEALTH INFORMATION IN SPECIAL SITUATIONS**

We may use or disclose your health information in certain special situations as described below. For these situations, you have the right to limit these uses and disclosures as provided for in Section \_\_\_\_\_ of this Notice.

1. **Appointment Reminders.** We may use or disclose your health information for purposes of contacting you to remind you of a health care appointment.
2. **Treatment Alternatives & Health-Related Products and Services.** We may use or disclose your health information for purposes of contacting you to inform you of treatment alternatives or health-related products or services that may be of interest to you. For example, if you are diagnosed with a specific condition, we may contact you to inform you of an instruction class that is offered for your condition.
3. **Family Members and Friends.** We may disclose your health information to individuals, such as family members and friends, who are involved in your care or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object to such disclosures. For example, if your spouse comes into the exam room with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room.

We also may disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interests to make such disclosures and the disclosures relate to that family member or friend’s involvement in your care. For example, if you present our clinic with an emergency medical condition, we may share information with the family member or friend that comes with you to our clinic. We will need written permission to share your health information with your family and friends regarding your prescription(s).

### D. **OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES OF HEALTH INFORMATION.**

There are certain instances in which we may be required or permitted by law to use or disclose your health information without your permission. These instances are as follows:

1. **As required by law.** We may disclose your health information when required by federal, state, or local law to do so. For example, we are required by the Department of Health and Human Services (HHS) to disclose your health information in order to allow HHS to evaluate whether we are in compliance with the federal privacy regulations.
2. **Public Health Activities.** We disclose your health information to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling disease, injury, or disability; to report births, deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recalls.

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3. **Health Oversight Activities.** We may disclose your health information to a health oversight agency that is authorized by law to conduct health oversight information to health oversight investigations, inspections, or licensure and certification surveys. These activities are necessary for the government to monitor the persons or organizations that provide health care to individuals and the government to monitor the persons or organizations that provide health care to individuals and to ensure compliance with applicable state and federal laws and regulations.
  4. **Judicial or Administrative Proceedings.** We may disclose your health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. We may disclose your health information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, but only if efforts have been made to (i) notify you of the request for disclosure or (ii) obtain an order protecting your health information.
  5. **Worker's Compensation.** We may disclose your health information to worker's compensation programs when your health condition arises out of a work-related illness or injury.
  6. **Law Enforcement Official.** We may disclose your health information to a request received from a law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons, or similar process.
  7. **Coroners, Medical Examiners, or Funeral Directors.** We may disclose your health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We also may disclose your health information to a funeral director for the purpose of carrying out his/her necessary activities.
  8. **Organ Procurement Organizations or Tissue Banks.** If you are an organ donor, we may disclose your health information to organizations that handle organ procurement, transplantation, or tissue banking for the purpose of facilitating organ or tissue donation or transplantation.
  9. **Research.** We may use or disclose your health information for research purposes under certain limited circumstances. Because all research projects are subject to a special approval process, we will not use or disclose your health information for research purposes until the particular research project for which your health information may be used or disclosed has been approved through this special approval process. However, we may use or disclose your health information to individuals preparing to conduct the research project in order to assist them in identifying patients with specific health care needs who may qualify to participate in the research project. Any use or disclosure of our health information which is done for the purpose of identifying qualified participants will be conducted onsite at our facility. In most instances, we will ask for your specific permission to use or disclose your health information if the researcher will have access to your name, address, or other identifying information.
  10. **To Avert a Serious Threat to Health or Safety.** We may use or disclose your health information when necessary to prevent a serious threat to the health or safety of you or other individuals.
  11. **Military and Veterans.** If you are a member of the armed forces, we may use or disclose your health information as required by military command authorities.
  12. **National Security and Intelligence Activities.** We may use or disclose your health information to authorized federal officials for purposes of intelligence, counterintelligence, and other national security activities, as authorized by law.
  13. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose your health information to the correctional institution or to the law enforcement official as may be necessary (i) for the institution to provide you with health care; (ii) to protect the health or safety of you or another person; or (iii) for the safety and security of the correctional institution.

## E. USES AND DISCLOSURES PURSUANT TO YOUR WRITTEN AUTHORIZATION.

Except for the purposes identified above in Sections B through D, we will not use or disclose your health information for any other purposes unless we have your specific written authorization. You have the right to revoke a written authorization at any time as long as you do so in writing. If you revoke your authorization, we will no longer use or disclose your health information for the purposes identified in the authorization, except to the extent that we have already take some action in reliance upon your authorization.

## F. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have the following rights regarding your health information. You may exercise each of these rights, in writing, by providing us with a completed form that you can obtain from the Advanced Pain Centers of Alaska business office. In some instances, we may charge you for the cost(s) associated with providing you with the requested information. Additional information regarding how to exercise your rights, and the associated costs, can be obtained from **our business office**.

1. **Right to Inspect and Copy**. You have the right to inspect and receive copies of health information that may be used to make decisions about your care. We may deny your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
2. **Right to Amend**. You have the right to request an amendment of your health information that is maintained by or for our clinic and is used to make health care decisions about you. We may deny your request if it is not submitted in writing or does not include a reason to support your request. We may also deny your request if the information sought to be amended: (a) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (b) is not part of the information that is kept by or for our clinic; (c) is not part of the information which you are permitted to inspect and copy; or (d) is accurate and complete.
3. **Right to an Accounting of Disclosures**. You have the right to request an accounting of the disclosures of your health information made by us. This accounting will not include disclosures of health information that we made for purposes of treatment, payment or health care operations or pursuant to a written authorization that you have signed.
4. **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone, such as a family member or friend, who is involved in your care or in the payment of your care. For example, you could ask that we not use or disclose information regarding a particular treatment that you received. We are not required to agree to your request. If we do agree, that agreement must be in writing and signed by you and us.
5. **Right to Request Confidential Communications**. You have the right to request that we communicate with you about your health care in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
6. **Right to a Paper Copy of this Notice**. You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy or this Notice.

## G. QUESTIONS OR COMPLAINTS.

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our Privacy Officer at 278-2741. If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with our clinic, contact our Privacy Office at **1917 Abbott Road, Suite 100, Anchorage, AK. 99507**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (name of patient) \_\_\_\_\_, acknowledge and agree that I have received a copy of **ADVANCED PAIN CENTERS OF ALASKA'S** Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Legal Representative (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name Of Legal Representative

\_\_\_\_\_  
Relationship to patient

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**FOR CLINIC USE ONLY**

**ADVANCED PAIN CENTERS OF ALASKA** made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

**(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.)**



PATIENT REGISTRATION FORM (please print)

Patient Name \_\_\_\_\_ SS # \_\_\_\_\_ Birth Date \_\_\_\_\_

Is patient minor yes \_\_\_ no \_\_\_ If so, name of **RESPONSIBLE PARTY/GUARANTOR** \_\_\_\_\_

Mailing Address \_\_\_\_\_  
(city \_\_\_\_\_ (state) \_\_\_\_\_ zip \_\_\_\_\_)

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Marital Status: Married Single Other Gender: M – F

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ Occupation \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Who Referred you to us? \_\_\_\_\_

Spouse \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**Emergency Contact Name** \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**#1 PRIMARY INSURANCE INFORMATION:**

Insurance Company Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

GROUP NO \_\_\_\_\_ IDENTIFICATION # \_\_\_\_\_

**# 2 SECONDARY INSURANCE INFORMATION:**

Insurance Company Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

GROUP NO \_\_\_\_\_ IDENTIFICATION # \_\_\_\_\_

**WORKERS COMP INFORMATION**

Insurance Company Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Claim # \_\_\_\_\_ Date of Injury \_\_\_\_\_ Body Part Injured \_\_\_\_\_

Adjustor Name \_\_\_\_\_ Phone \_\_\_\_\_

\*\*\*\*\*

I understand that I am fully responsible for any and all charges for services rendered by the Advanced Pain Centers of Alaska (APCA). If insurance information is provided, my insurance company will be billed as a courtesy to me. I am responsible for my portion of the bill at the time that services are rendered. I hereby authorize payment under my insurance to be paid directly to APCA and I further authorize release of any information necessary to my insurance company for payment of claims. I understand a finance charge of 0.875% will be applied to any outstanding balance due after insurance payment or denial after a 60-day grace period.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

I, the undersigned hereby authorize Advanced Pain Centers of Alaska (APCA) providers to examine me, to administer such treatment as is necessary and to perform such procedures as are considered therapeutically or diagnostically necessary. I hereby authorize the medical providers of APCA to give my minor son/daughter treatment that he/she may need.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_



**FINANCIAL POLICY**

Thank you for choosing us for your health care needs. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment in our office.

All patients (parents or guardians) must complete our Patient Information and Financial Policy before seeing the Provider.

- YOUR PAYMENT PORTION IS DUE AT THE TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD.
- WE REQUIRE A PAYMENT PLAN FOR ALL OUTSTANDING BALANCES.
- THERE WILL BE A **\$35.00** SERVICE CHARGE ON ALL NSF CHECKS.

**Regarding Insurance:**

APCA bills insurance carriers as a courtesy to you. We need your help to accomplish this goal by providing complete and accurate insurance information. Knowledge of your deductible and co-pays is your responsibility. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. If for any reason your insurance coverage changes, it is your responsibility to inform Advanced Pain Centers of Alaska in a timely manner. If you fail to inform us within 60 days of the change, Advanced Pain Centers of Alaska will not file your insurance. Please be aware that some, and perhaps all of the services provided may be non-covered services. Some insurance companies reduce or deny benefits saying they are not considered UCR (usual, customary or reasonable). Please be advised that our fees are based on a national geographic standard and are , in fact, UCR for Alaska.

**All deductibles and co-pays are due and payable at the time of treatment:**

The balance is your responsibility whether your insurance company pays or not. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

**Usual and Customary Rates:**

Our Practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s determination of usual and customary rates.

**Minor Patients:**

The adult accompanying a minor, the parents (or legal guardians) of the minor, are responsible for payment.

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

**I have read, understand, and agree to this Financial Policy:**

X \_\_\_\_\_  
Signature of Parent or Responsible Party

\_\_\_\_\_  
Relationship to Patient

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

*Valley*  
3035 E. Palmer-Wasilla Hwy, Unit 501  
Wasilla, AK 99654  
(907) 357-8330 telephone  
(907) 357-8377 facsimile

*Anchorage*  
1917 Abbott Road, Suite 100  
Anchorage, AK 99507  
(907) 278-2741 telephone  
(907) 743-8284 facsimile

*Fairbanks*  
506 Gaffney Road, Suite 200  
Fairbanks, AK 99701  
(907) 374-6602 telephone  
(907) 374-6604 facsimile

## CONSENT FOR INVOLVEMENT IN CARE

Advanced Pain Centers of Alaska

In order to comply with specific rules regarding HIPAA, we ask that our patients complete and sign this privacy and security of health information. **Unless this form is completed, we cannot talk to anyone but you.**

### BILLING AND PAYMENT INFORMATION

I, \_\_\_\_\_, hereby authorize Advanced Pain Centers of Alaska's billing department to speak to the person(s) listed below regarding my billing and payment information.

1. \_\_\_\_\_ relationship to patient \_\_\_\_\_
2. \_\_\_\_\_ relationship to patient \_\_\_\_\_

### MEDICATION INFORMATION

I, \_\_\_\_\_, hereby authorize Advanced Pain Centers of Alaska to release prescriptions that need to be picked up on my behalf to the person(s) listed.

1. \_\_\_\_\_ relationship to patient \_\_\_\_\_
2. \_\_\_\_\_ relationship to patient \_\_\_\_\_

### APPOINTMENT REMINDERS

I, \_\_\_\_\_, hereby authorize Advanced Pain Centers of Alaska and staff to leave appointment reminders by the following methods.

- |                                | Yes   | No    | N/A   |
|--------------------------------|-------|-------|-------|
| 1. <b>Home Telephone</b> _____ | _____ | _____ | _____ |
| 2. <b>Work Telephone</b> _____ | _____ | _____ | _____ |
| 3. <b>Cellular Phone</b> _____ | _____ | _____ | _____ |
| 4. <b>Home Fax</b> _____       | _____ | _____ | _____ |
| 5. <b>Voice Mail</b> _____     | _____ | _____ | _____ |

I understand and assume responsibility of notifying APCA whenever the listed information changes. I understand this release **excludes**; insurance companies, attorneys and other health care providers.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness / Staff Signature

\_\_\_\_\_  
Date