



Dear Patient:

Thank you for choosing Advanced Pain Centers of Alaska for your pain management care. 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 before your appointment. Please bring with you **MRI and/or CT films** 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 completed.**

We will call you with a reminder the day before your appointment. Should you have any questions before this, please call our office at (907) 278-2741 Anch, (907)374-6602 Fairbanks, or (907)357-8330 Wasilla.

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 Center of Alaska

Initial _____



This form is to be completed by all patients before their first appointment. 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 Physician that is referring you to our Clinic, along with your Primary Care Physician'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 Physician

Primary Care Physician

Name: _____ Name: _____

Address: _____ Address: _____

Phone #: _____ Phone #: _____

Fax #: _____ Fax #: _____

PAIN DESCRIPTION

There are many ways to describe pain and the impact that pain has on your life. Pain description is very important in the development of a diagnosis and treatment plan. Please carefully consider your pain problem and describe your problem as accurately as possible.

1. How long have you had pain? _____ Years _____ Months

2. Did an injury cause your pain? Yes No If yes what was the date of injury? _____

Describe your injury or the history of your pain treatment: _____

3. Where is your pain located? 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. How much does your pain interfere with your daily activities? Not at all Mildly Moderately

Severely Completely dependent upon others

5. Describe your typical daily activities: _____

6. What causes your pain to increase? _____

7. Have you seen other doctors for your pain condition? Yes No If yes, **who** did you see and **where** did you see them? _____

8. How often do you see doctors for your pain: Never Very Rarely Occasionally A Lot

9. Have you had surgery for your pain? Yes No If yes, please list: _____

10. 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			
Other			

11. Do you receive Disability Compensation? Yes No

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

GENERAL MEDICAL HISTORY

13. What other medical problems do you have? _____

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

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

15. Are you allergic to:

Iodine? Yes No

Tape? Yes No

X-Ray Dye? Yes No

16. 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>

MEDICATIONS

What medications do you CURRENTLY take for your PAIN?

<i>Medication</i>	<i>Dosage</i>	<i>How Often?</i>

What medications have you taken in the past for your pain? _____

What other medication do you take?

<i>Medication</i>	<i>Dosage</i>	<i>How Often?</i>

Have you ever taken or been given the following?

	<i>Yes</i>	<i>No</i>	<i>When?</i>	<i>Any Problems?</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?				

Reason for visit: _____

Pain Detail

Timing of Pain:

- _____ Constantly (100% of the time)
- _____ Frequently (75% of the time)
- _____ Intermittently (50% of the time)
- _____ Occasionally (25% of the time)

Pain Quality (mark all that apply):

- _____ Burning
- _____ Throbbing
- _____ Dull, aching
- _____ Shooting
- _____ Sharp
- _____ Cramping
- _____ Pressure
- _____ Lightning like
- _____ Electric like
- _____ Cutting
- _____ Numbness
- _____ Tingling

Pain Intensity (scale 1-10, 0 being no pain - 10 being worst pain)

- _____ Current Pain
- _____ Average pain last 7 days
- _____ Best pain last 7 days
- _____ Worst pain last 7 days

Pain Modifiers

Moderates Pain	Relieves	Worsens	Unchanged
Lying down			
Standing			
Sitting			
Walking			
Exercise			
Medications			
Relaxation			
Think about something else			
Coughing/Sneezing			
Urination			
Bowel movement			

Function Limits

Activities avoided during past month due to pain:

- _____ Work
- _____ Yard work/shopping
- _____ Recreation
- _____ Exercise
- _____ House Work
- _____ Socializing
- _____ Having sexual relations
- _____ Driving
- _____ Self care

Activity Tolerance

- _____ Unable to walk for more than (feet)
- _____ Unable to sit for more than (minutes)
- _____ Unable to stand for more than (minutes)

Lie down during the day due to pain:

- _____ Never
- _____ Seldom
- _____ Sometimes
- _____ Often
- _____ Constantly

Functional Changes Start Date in Month or Years

Please provide the approximate date of functional changes below:

Months/Years	Functional Changes
	Reduced physical activity
	Physical activity tolerance
	Instrumental activities of
	Inability to cope with daily
	Intolerant to activities
	Leisure activities
	Temporary cessation of strenuous physical activity
	Drug use results in reduce in important activities
	General improvement-ability to resume activities
	Physical disability affecting ability to work
	Intolerant to household maintenance maintaining
	Unable to drive

History Present Illness

	Approximate Date of Treatment	Pain Relief		
		Excellent	Moderate	None
Bed Rest				
Traction				
Back Brace				
TENS Unit				
Physical Therapy				
Exercise				
Ice				
Heat				
Medication				
Muscle Relaxants				
Aspirin				
Corticosteroid Injection				
Cervical Facet Injection				
Epidural Injection				
Lumbar Facet Injection				
Nerve Block				
Surgery				
Previous Hospital				
Chiropractor				
Accupuncture				
Psychotherapy				
Biofeedback				
Hypnosis				
Other Therapy				

Past Medical History

Please mark all that apply:

Yes	No	History		Yes	No	History
		Medical history				Stroke Syndrome
		Renal Disorders				Cancer
		Hypertension (systemic)				Chronic Cough
		Angina Pectoris				Psychiatric Therapy
		Prior myocardial infarction				History of Suicidal ideation
		Hepatic disorders				Recent infection
		Hepatitis				Previous pain medication
		HIV Infection				Tuberculosis
		Diabetes Mellitus				CPAP Ventilation
		Arthritis				Long-Term Oxygen Therapy

Other: _____

Past Surgical History

Check all that apply:

Orthopedic Surgery History

- Back Surgery
- Hip replacement
- Knee replacement
- Rotator Cuff Repair
- Neck Surgery

Cardiovascular Surgery History

- Heart Valve Replacement
- Coronary Artery Bypass Graft
- Cardiac Catheterization
- Cardiac Pacemaker

General Surgery History

- Appendectomy
- Gallbladder Surgery
- Hernia Repair
- Upper EGD
- Colonoscopy
- Sigmoidoscopy
- Hemorrhoidectomy
- Lung Surgery
- Tonsillectomy/Adenoidectomy
- Nephrectomy
- Lithotipsy

Head Surgery History

- Temporal Artery Biopsy
- Carotid Endarterectomy
- Cataract Surgery

Reproductive Surgery History

- Tubal Ligation
- Cesarean Section
- Prostate Surgery

Thyroid History

- Radiation of the Thyroid
- Thyroid Surgery
- Hysterectomy
- Other

Social History

Please mark all that apply:

Living Situation

- Living with significant other
- Living with a friend
- Living with adult children
- Living independently with spouse
- Living with and caring for child
- Living independently alone

Educational Level

Highest level achieved

- _____ GED
- _____ High school diploma
- _____ Masters Degree
- _____ Doctorate

Social History

Yes	No	
_____	_____	Caffeine use
_____	_____	Drug Use
_____	_____	Drug and Alcohol Detoxification
_____	_____	Alcoholics Anonymous
_____	_____	Narcotics Anonymous (NA)
_____	_____	Physical Disability
_____	_____	Unable to perform ADL
_____	_____	Life Circumstance Event
_____	_____	Pending lawsuit
_____	_____	Alcohol Use
		_____ Beer Consumption
		_____ Wine Consumption
		_____ Hard Liquor Consumption
_____	_____	Previous Problem with Alcohol
_____	_____	Drinking does not cause any problems
_____	_____	Smoking
		_____ How many years
_____	_____	Previous history of Smoking

Family History

Yes	No	Family History Detail	Family member affected
_____	_____	Suicide	_____
_____	_____	Mental Illness (not retardation)	_____
_____	_____	Alcoholism	_____
_____	_____	Medication/Drug use Disorders	_____
_____	_____	Cancer	_____
_____	_____	Acute MI prior to age 50	_____
_____	_____	Heart Disease	_____
_____	_____	Hypertension	_____
_____	_____	Early Deaths	_____
_____	_____	Depression	_____

Review of Symptoms #1

Systemic Symptoms

Yes	No	
_____	_____	Weight Change
_____	_____	Chills
_____	_____	Fever
_____	_____	Night Sweats
_____	_____	Feeling tired or poorly (malaise)

Head Symptoms

Yes	No	
_____	_____	Headache
_____	_____	Facial Pain
_____	_____	Sinus Pain
_____	_____	Other Head related Symptoms

Otolaryngial Symptoms

Yes	No	
_____	_____	Mouth Sores
_____	_____	Difficulty Swallowing (dysphagia)
_____	_____	Difficulty Chewing
_____	_____	Dentures currently being worn
_____	_____	Dentures improperly fitting

Pulmonary Symptoms

Yes	No	
_____	_____	Shortness of breath
_____	_____	_____ Difficulty breathing at rest
_____	_____	_____ Difficulty breathing during exertion
_____	_____	Sleep Apnea
_____	_____	Wheezing responding to bronchodilators
_____	_____	Pulmonary Symptoms

Review of Systems #2

Cardiovascular Symptoms

Yes	No	
_____	_____	Chest pain or Discomfort
_____	_____	Fast Heart Rate
_____	_____	Palpitations
_____	_____	Cardiovascular Symptoms

Gastrointestinal Symptoms

Yes	No	
_____	_____	Appetite
_____	_____	Recent Weight loss (reported)
_____	_____	Difficulty Swallowing (dysphagia)
_____	_____	Heartburn
_____	_____	Nausea
_____	_____	Vomiting
_____	_____	Bowel Movement Frequency

Genitourinary Symptoms

Yes	No	
_____	_____	Dysuria
_____	_____	Increased urinary frequency
_____	_____	Urinary loss of control
_____	_____	Using incontinence devices
_____	_____	_____ Urinary frequency ___ times during the night
_____	_____	Hematuria
_____	_____	Genital lesion
_____	_____	Genitourinary symptoms

Neurological Symptoms

Yes	No	
_____	_____	Dizziness
_____	_____	Vertigo
_____	_____	Fainting (syncope)
_____	_____	Motor disturbances
_____	_____	Sensory disturbances
_____	_____	Decreased concentrating ability
_____	_____	Memory lapses or loss
_____	_____	Neurological Symptoms

Review of Symptoms #3

Endocrine Symptoms

Yes	No		
_____	_____	Excessive sweating	_____
_____	_____	Excessive thirst (polydipsia)	_____
_____	_____	Libido has changed	_____
_____	_____	Endocrine symptoms	_____

Hematologic Symptoms

Yes	No		
_____	_____	Easy Bleeding	_____
_____	_____	Easy Bruising Tendency	_____

Musculoskeletal Symptoms

Yes	No		
_____	_____	Joint pain. Localized	_____
_____	_____	Joint stiffness, localized	_____
_____	_____	Muscle aches	_____
_____	_____	Musculoskeletal Symptoms	_____

Skin Symptoms

Yes	No		
_____	_____	Pruritus	_____
_____	_____	Skin lesions	_____
_____	_____	Rashes	_____
_____	_____	Skin Symptoms	_____

Psychological Symptoms

Yes	No		
_____	_____	Sleep disturbances (Sleep quality 11-15)	
_____	_____	Anxiety	_____
_____	_____	Depression	_____
_____	_____	Previous Psychiatric treatment	_____
_____	_____	Syncope (passing out) with needles/procedures	_____
_____	_____	Psychological Symptoms	_____

Implanted Devices

Yes	No		
_____	_____	Intravenous Catheter	_____
_____	_____	AICD	_____
_____	_____	Previous Pacemaker Placement	_____
_____	_____	Surgical Screws, pins, plates, clips, device	_____

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

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.				

Patient Registration Form: PLEASE PRINT

Patient Name _____ SS# _____ Birth date: _____
(last) (first) (Middle Int.)

Address _____
(street) (city) (state) (zip)

Home Phone _____ Cell Phone # _____ Marital Status: Married Single Other Gender _____
(circle one) M - F

Race: _____ Language Spoken: _____ (Race and language information used anonymously for public health statistics)

Employer _____ Business phone # _____

Employer Address _____ Occupation _____

Spouse _____ Spouse's Employer _____ Work # _____

Emergency Contact Name _____ Relationship _____
(other than spouse)

Emergency Contact home phone _____ Work phone _____

How did you hear about Advanced Pain Centers of Alaska: (circle one) Referring Physician Yellow Pages Radio TV Other

PRIMARY INSURANCE INFORMATION: Insurance Co. Name _____

Ins. Co. Address _____

Ins. Co. Phone # _____ Relationship to patient _____

Policy Holder Name _____ Policy Holder SS# _____ Birth Date _____

Group # _____ Identification # _____

WORKER'S COMP INFORMATION: Worker's Comp Insurance Co. Name _____

W/C Co. Address _____

W/C Claim# _____ Date of Injury _____ Employer at time _____

Name of Adjustor _____ Adjustor Phone # _____ Site of Injury: _____

SECONDARY INSURANCE INFORMATION: Insurance Co. Name _____

Ins. Co. Address _____

Ins. Co. Phone # _____ Relationship to patient _____

Policy Holder Name _____ Policy Holder SS# _____ Birth Date _____

Group # _____ Identification # _____

I understand that I am fully responsible for any and all charges for services rendered by the Advanced Pain Centers of Alaska. 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 Advanced Pain Centers of Alaska providers and I further authorize release of any information necessary to my insurance company for payment of claims. I understand a finance charge of 1.5% will be applied to any outstanding balance due after insurance payment or denial after a 90-day grace period.

Date _____ Patient Signature _____

I, the undersigned, hereby authorize Advanced Pain Centers of Alaska providers to examine me, to administer such treatment as is necessary and to perform such procedures as are considered therapeutically or diagnostically necessary.

Date _____ Patient Signature _____



FINANCIAL POLICY

Thank you for choosing us as your Pain Management Specialists. We are committed to your treatment being successful. 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.

- PAYMENT IS DUE AT THE TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD.
- WE OFFER A PAYMENT PLAN WITH PRIOR BUSINESS OFFICE APPROVAL.
- 10.5% APR ASSESSES ON ALL ACCOUNTS OVER 60 DAYS.
- THERE WILL BE A \$25.00 SERVICE CHARGE ON ALL NSF CHECKS.

Regarding Insurance:

It is our goal to provide fast and efficient billing 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 in a timely manner. If you fail to inform us within 60 days of the change, the Advanced Pain Centers of Alaska will not be responsible for filing 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 responsible). 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: _____



ABOUT THIS NOTICE

APCA (Advanced Pain Centers of Alaska) is dedicated to maintaining the privacy of your Protected Health Information (PHI). APCA provides health care items and services through its schools of medicine, nursing, pharmacy and allied health sciences. APCA provides services at its main community hospitals, primary care specialty clinics, pharmacies, research units and several community service outreach centers throughout Alaska. APCA is required by law to maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices. This notice of privacy practices describes how APCA may use or disclose your PHI. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; (3) the past, present, or future payment for your healthcare. This notice also tells you about your privacy rights and APCA's legal duties with respect to your PHI. The terms of this notice shall apply to APCA's privacy practices until it is changed by APCA.

CHANGE IN NOTICE OF PRIVACY PRACTICES

APCA reserves the right to change this notice of privacy practices at anytime. Any changes will apply to all PHI that APCA created or maintained for you. If this notice is changed, it will be posted at our clinics and on our website (www.apcalaska.com) and you can request a copy of this notice.

APCA PERMITTED USES AND DISCLOSURES OF PHI FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION

APCA may use or disclose your PHI without your written authorization the following:

TREATMENT

Your PHI may be used and disclosed to provide, coordinate or manage your healthcare and related services. This may include talking with other health care providers about your treatment or coordinating and managing your healthcare with others. For example, when your family physician refers you to another doctor your family physician may tell the other doctor about any drug allergies you may have so the other doctor can diagnose or treat you.

PAYMENT

Your PHI may be used and disclosed to obtain payment for your health care services. For example, APCA may share your PHI with your health insurance plan for payment of health care items or services provide to you.

HEALTH CARE OPERATIONS

Your PHI may be used and disclosed to support our business activities. These include, but are not limited to, quality evaluation, work force reviews, education and training of students and physicians in training, licensing, and conducting or arranging for other business activities. For example, APCA may use your PHI to evaluate the performance of our staff in caring for you.

OTHER USES AND DISCLOSURES OPPORTUNITY FOR YOU TO AGREE OR OBJECT APCA MAY USE OR DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION FOR THE FOLLOWING PURPOSE UNLESS YOU OBJECT:

- **INVOLVEMENT IN PATIENT CARE AND NOTIFICATION PURPOSE** - To a family member, other relative, close personal friend or other person you have identified as involved with your treatment or payment for healthcare services. We may also use your PHI to notify or assist in notifying such persons of your location or health.
- **DISASTER RELIEF EFFORTS** - To public or private relief agencies to assist in disaster relief efforts.
- **APPOINTMENT REMINDERS** - We may contact you to remind you of your healthcare appointments or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

USES AND DISCLOSURES OF PHI WITHOUT YOUR WRITTEN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT. APCA MAY BE ALLOWED OR REQUIRED TO USE OR DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY FOR YOU TO AGREE OR OBJECT FOR THE FOLLOWING REASONS:

- **REQUIRED OR AUTHORIZED BY LAW** - As required by federal, state, or local law. Any disclosure must comply with the law and is limited to the requirements of the law.
- **PUBLIC HEALTH ACTIVITIES** - To public health authorities or other authorized persons to carry out certain public health activities, including the following:
 - To report, prevent, or control disease, injury or disability;
 - To report vital statistics, such as birth or death;
 - To report child abuse or neglect;
 - To report bad reactions to medications or problems with products or devices regulated by the food and drug administration;
 - To locate and notify you of recalls or products you may be using;
 - To notify a person who may have been exposed to a contagious disease in order to control who may be at risk of contracting or spreading the disease; or
 - To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.
- **ABUSE, NEGLECT, OR DOMESTIC VIOLENCE** - In certain cases to proper government authorities if we have reason to believe that you have been the victim of domestic violence, abuse, or neglect.
- **HEALTH OVERSIGHT ACTIVITIES** - To a health oversight agency for oversight activities authorized by law such as audits, investigations, inspections, and licensure activities or as necessary for certain government agencies to monitor the Healthcare system, government programs, and compliance with civil rights laws.
- **JUDICIAL, ADMINISTRATIVE AND LAW ENFORCEMENT PURPOSES** - Where requested by law enforcement, and as authorized or required by law, we may disclose your PHI;
 - In response to a court order, subpoena, warrant, summons or similar process;
 - In response to requests for limited information necessary to identify or locate a suspect, fugitive, material witness, or missing person;
 - If we suspect that you are a victim of a crime and if you agree to the disclosure, or under certain circumstances, where we are unable to obtain your permission;
 - About your death if we suspect it is the result of criminal conduct;
 - About criminal conduct that occurs at APCA; and

- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

OTHER USES AND DISCLOSURES CONTINUED

- **DECEDENTS** - To a coroner or a medical examiner to identify you and determine the cause of your death in addition, we may disclose your PHI to funeral directors, as authorized by law, so that they may do their jobs.
- **ORGANIZATIONS THAT OBTAIN ORGANS** - If you are an organ donor, after your death we may use or disclose your PHI to organizations that help get, locate, store, and transplant organs to help with organ, eye, or tissue donation and transplantation.
- **RESEARCH** - For research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA privacy rule.
- **TO STOP A SERIOUS THREAT TO HEALTH OR SAFETY** - In limited circumstances when necessary to help stop a threat to the health or safety of a person or to the public. This disclosure can be made only to a person who is able to help stop the threat.
- **NATIONAL SECURITY; INTELLIGENCE ACTIVITIES; AND PROTECTIVE SERVICES** - To federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.
- **CORRECTIONAL INSTITUTIONS** - Of inmates or other individuals under lawful custody to a correctional institution or law enforcement officer for the provision of healthcare, health and safety matters, law enforcement purposes or security of the correctional institution.
- **WORKER'S COMPENSATION** - To comply with workers' compensation programs or other similar programs that provide benefits for work-related injuries or illness without regard to fault.
- **LIMITED DATA SET** - We may use and disclose limited PHI that does not fully identify you only for purposes of research, public health, or health care operations.
- **PARENTAL ACCESS** - To your parents or legal guardian if you are under the age of 18, unless it is prohibited by Alaska law. Other than the categories mentioned above, APCA will not disclose your PHI without your written authorization. You may revoke your written authorization at any time in writing; however, your written revocation will only apply to PHI that has not already been used or disclosed by APCA under your written authorization.

YOUR PRIVACY RIGHTS• RIGHT TO INSPECT AND COPY - You have the right to inspect and request a copy of your PHI that is in a designated record set. This includes your insurance and billing records but not counseling notes of a mental health professional, information prepared by or for our attorneys to defend APCA, or where prohibited by

law. You may be charged a reasonable fee to obtain a copy of your PHI. APCA reserves the right to deny your request to access or receive a copy of your PHI as provided by law. All requests must be in writing using the APCA authorization for release of patient information form.

• **RIGHT TO REQUEST RESTRICTIONS** - You have the right to request APCA limit its use or disclosure of your PHI for treatment, payment, or healthcare operations. You may also request that APCA limit its disclosure of your PHI to family members, relatives, close personal friends or others you have identified as being involved in your care. We are not required to agree to your request. If we agree to your request, we will limit use or disclosure of your PHI except in certain cases, including where the information is needed to treat you or to verify coverage in the case of an emergency. To request restrictions, you must make your written request to an APCA privacy official. Your request must include: 1) The information that you want to limit, 2) How you want to limit the information, and 3) To whom you want those limitations to apply.

• **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION** - You have the right to request other means or locations to receive communications about your PHI. All requests must be in writing using a APCA confidential communication request form. APCA will agree to readable requests for other means or locations to receive communications about your PHI.

• **RIGHT TO REQUEST A CHANGE IN YOUR PHI** - You have the right to request APCA change information in your PHI for as long as APCA keeps your PHI. APCA can deny your request to change your PHI as provided by law. All requests must be in writing using a APCA amendment request form.

• **RIGHT TO AN ACCOUNTING OF DISCLOSURES** - You have the right to request an accounting of certain uses and disclosures of your PHI by APCA. This is a use of disclosures made by APCA during the past six years; except for uses or disclosures made:

- For treatment, payment, and health care operations;
- To family members or friends involved in your care;
- To you directly;
- Pursuant to a written authorization;
- For certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes); or
- Before April 14, 2003

If you wish to make a request for an accounting contact the privacy official to obtain a APCA accounting request form. The first list of accounting that you request in a 12-month period will be free, but we may charge you for any additional ones requested during the same 12-month period. We will tell you about these costs, and you may cancel your request at any time before costs are incurred.

• **RIGHT TO A PAPER COPY OF THIS NOTICE** - You have the right to receive a paper copy of this notice of privacy practices upon request. Even if you have agreed to receive this notice electronically, you can still receive a paper copy of this notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint in one of the following ways:

- The APCA privacy official at the address indicated below;
- Call our confidential Toll Free Number at 1-800-278-2741.
- Advanced Pain Centers of Alaska
1917 Abbott Road Suite 100
Anchorage, AK 99507

We will not retaliate or take action against you for filing a complaint

QUESTIONS -If you have any questions about this notice or would like additional information, please contact the privacy official at the address and telephone number listed above or you may visit our web site at www.apcalaska.com.

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

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.)

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. Home Telephone/Voicemail _____ | _____ | _____ | _____ |
| 2. Work Telephone/Voicemail _____ | _____ | _____ | _____ |
| 3. Cellular Phone/Voicemail _____ | _____ | _____ | _____ |

Personal Health Information

I, _____, hereby authorize Advanced Pain Centers of Alaska to speak to the person(s) listed below regarding my personal health information.

1. _____ relationship to patient _____
2. _____ relationship to patient _____

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

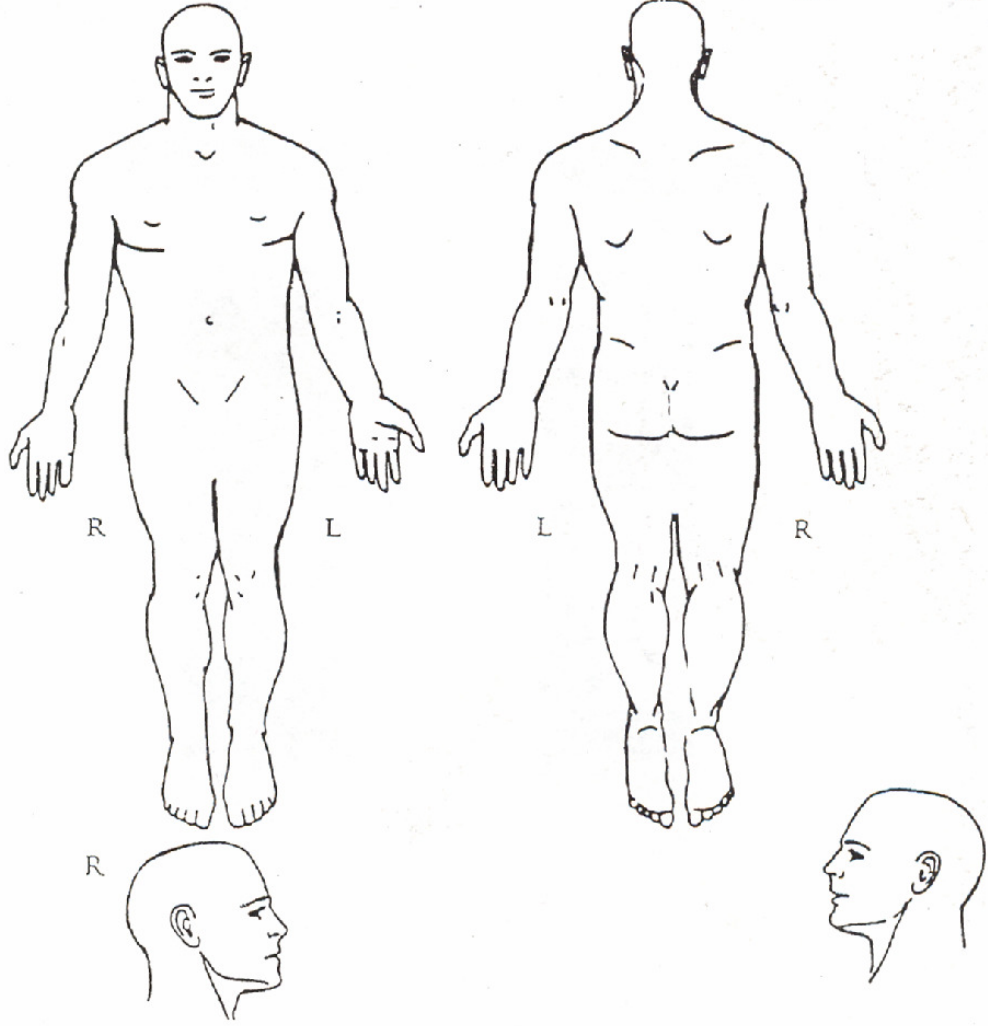
Date

Witness/ Staff Signature

Date

Mark the areas on your body where you feel the described sensations.
 Use the appropriate symbol. Include all affected areas.

Numbness ■	Pins & Needles ○○○○	Aching ✓✓✓✓	Cramping ●●●●	Burning xxx	Stabbing ///
■	○○○○	✓✓✓✓	●●●●	xxx	///
■	○○○○	✓✓✓✓	●●●●	xxx	///



Name: _____ Date: _____