ADVANCED PAIN CENTERS
OF ALASKA

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 prior to 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 30 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 #: _____

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.

	Worse	*Better*	*No Change*		*Worse*	*Better*	*No Change*
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.

HAVE YOU TRIED ANY OF THE FOLLOWING TO TREAT YOUR SYMPTOMS OR CONDITION?				*WAS IT HELPFUL?*	
	Yes	*No*	*Don't Know*	*Yes*	*No*
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?

Diagnostic Test	*When*	*Where*	*Results*
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:

Surgery	*Date of Surgery*	*Surgeon*

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?

Allergen	*Reaction*

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

DATE:_____

MEDICATIONS

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

Medication	*Dosage(mg, mcg)*	*How Often?*

28. What medications have you tried in the past to control your symptoms or condition? _____

_____

_____

29. What other medication do you take?

Medication	*Dosage (mg, mcg)*	*How Many times per day?*

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

	Yes	*No*	*When?*	*Please Explain*
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?				

31. 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; _____
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; _____

SOCIAL HISTORY

32. 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? _____

33. 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? _____

_____

34. Do you walk regularly? ☐ Yes ☐ No How many times per week? _____ How many blocks? _____

ADVANCED PAIN CENTERS OF ALASKA

Notice of Privacy 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 carefully.

PURPOSE OF THE NOTICE

Effective 4-14-2003
Updated 7-30-2013

Advanced Pain Centers of Alaska is required by law to preserve the privacy and confidentiality of your health information. We are also required to notify you of our legal duties and privacy practices regarding your health information, and abide by the practices of this Notice, unless more stringent laws or regulations apply. This 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 reserve the right to change this Notice and to make the revised and 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 and on our website at www.apcalaska.com. For more information contact **our business office at 907-278-2741**.

This Notice applies to: (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.

DISCLOSURES OF YOUR HEALTH INFORMATION THAT WE MAY MAKE WITHOUT YOUR AUTHORIZATION

Treatment: We may use your health information to provide you with health care treatment and services. We may disclose your health information to doctors, pharmacists, 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.

Payment: In order to get your healthcare services paid for, we may have to provide your healthcare information to the party responsible for paying. This may include Medicare, Medicaid (state health plan), or your insurance company. Your insurance company or health plan may need your information for activities such as determining your eligibility for coverage and reviewing the medical necessity of the healthcare services. 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.

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.

USES AND DISCLOSURES OF HEALTH INFORMATION IN SPECIAL SITUATIONS

Appointment Reminders. We may use or disclose your health information for purposes of contacting you to remind you of a health care appointment.

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.

Family Member 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: (1) we have your verbal agreement to do so; (2) we make such disclosures and you do not object; or (3) 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.

In addition, we 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, in our best professional judgment, it is in your best interest to make such disclosures and the disclosures relate to the family member or friend's involvement in your care.

OTHER DISCLOSURES THAT WE MAY MAKE WITHOUT YOUR AUTHORIZATION

There are certain instances in which we may be required or permitted by law to use or disclose your health information without your authorization.

As required by law. Your health information may be used and disclosed when required by federal, state, or local law to do so.

Public Health Activities. Your health information may be used for public health activities. Public health authorities are authorized to collect or receive the information for purposes such as controlling disease, injury or disability.

Victims of Abuse, Neglect or Domestic Violence. Your health information may be disclosed to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.

Health Oversight Activities. Your health information may be disclosed to health oversight agencies for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

Judicial and Administrative Proceedings. Your health information may be disclosed 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 (1) notify you of the request for disclosure or (2) obtain an order protecting your health information.

Law Enforcement Official. Your health information may be disclosed to a law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons, or similar process.

Worker's Compensation. Your health information may be used or disclosed to comply with worker's compensation laws and other similar legally established programs.

Coroners, Medical Examiners, or Funeral Directors. Your health information may be disclosed to a coroner or medical examiner for identification purposes, determining cause of death or other legally required duties. Your health information may also be released to a funeral director in order to permit him/her to perform their duties.

Cadaveric Organ, Eye, or Tissue Donation. Your health information may be used or disclosed to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue.

Research. Your health information may be disclosed to researchers, provided that the research has been approved by an Institutional Review Board and the research protocols have been approved to ensure your privacy. We may disclose your healthcare information to people preparing to conduct a research project; for example, to help the researcher identify patients with specific medical needs that would relate to the proposed research. Information used for this purpose will not leave our clinic. 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.

Serious Threat to Health or Safety. Your information may be disclosed when necessary to prevent a serious threat to health or safety of you or other individuals.

Military and Veterans. If you are a member of the armed forces, your health information may be used or disclosed as required by military command authorities.

National Security and Intelligence Activities. Your health information may be used or disclosed to authorized federal officials for purposes of intelligence, counterintelligence, and other national security activities, as authorized by law.

Inmates. Your health information may be used or disclosed by us if you are an inmate of a correctional facility and your physician created or received your medical information in the course of providing care to you.

Limited Data Set Information. We may disclose limited healthcare information to third parties for purposes of research, public health and healthcare operations. Before disclosing this information, we must enter into an agreement with the recipient of the information that limits who may use or receive the data and requires the recipient to agree not to re-identify the data or contact you. The recipient of your information is required to have appropriate safeguards to prevent inappropriate use or disclosure of your information.

AUTHORIZED USES AND DISCLOSURES

Other uses and disclosures of your health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke the authorization, at any time, in writing, except to the extent that we have already taken an action in reliance on the use or disclosure indicated in the authorization.

If you need for us to share your health information with someone for purposes other than those listed here, or for additional information regarding how to exercise your rights, and the associated costs, can be obtained from **our business office.**

Psychotherapy Notes. Your psychotherapy notes may not be used without obtaining your authorization except for the following exceptions: (1) When your psychotherapy notes originated with our clinic we may use them for treatment; and (2) We may use or disclose your psychotherapy notes for our own training and to defend our clinic in legal proceedings brought by you, for HHS to investigate or determine our compliance with the Privacy Rules, to avert a serious and imminent threat to public health and safety, to a health oversight agency for lawful oversight of the originator of the psychotherapy notes, for the lawful activities of a coroner or medical examiner or as required by law.

Marketing. We will not use your health information for marketing purposes nor will we sell your health information without your written authorization.

Fundraising. We intend to use your name and contact information to contact you when our clinic engages in fundraising activities. You have the right to opt out of any fundraising activities and direct us to not use your name or contact information for fundraising. If you wish to opt out of our fundraising activities simply mark the box on the attached "Acknowledgement of Receipt of Notice of Privacy Practices" that you are requesting to opt out of any fundraising activities or call 907-278-2741.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The following information describes your rights with respect to your medical information that we maintain.

Right to Access. You have the right to receive a copy of your health information, in paper or electronic form, that we maintain, with some limited exceptions. You may request access to those records in writing and provide us with information about the specific information you need so that we can fulfill your request. We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. For more information about the cost, you may contact **our business office.**

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: (1) was not created by use, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the information that is kept by or for our clinic; (3) is not part of the information which you are permitted to inspect and copy; or (4) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting, in writing, 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. If you would like to receive an accounting of your disclosures, you should contact **our business office.**

Notification following a Breach. If an improper disclosure of your unsecured health information (breach) occurs you will be notified of it in writing.

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.

In addition, you can request to restrict disclosure of a healthcare item or service you received by our clinic, for payment or healthcare operations, in which you make payment in full at the time of service. "Payment in full at the time of service" means that you will pay cash or with a credit card or debit card for full amount due at the time service is rendered.

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.

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 of this Notice.

QUESTIONS AND 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 907-278-2741. If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of Health and Human Services (HHS). To file a complaint with our clinic, contact our Privacy Officer at 1917 Abbott Road, Suite 100, Anchorage, AK 99507 or HHS at:

Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 98121-1831

All complaints must be in writing. You will not be penalized for filing a complaint.

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.)

Patient Registration Form: PLEASE PRINT

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

Address_____
(mailing address) (city) (state) (zip)

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

Race:_____ Ethnicity (circle one): Latino-Hispanic / Other 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 us? ☐Referring Provider ☐Friend/Family ☐Yellow Pages ☐Website ☐Facebook ☐Radio ☐TV ☐Other (list):_____

PRIMARY INSURANCE INFORMATION: Insurance Co. Name_____

Ins. Co. Address_____

Ins. Co. Phone #_____ Relationship to patient_____

Policy Holder Name_____ Policy Holder SS# _____Policy Holder 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# _____Policy Holder 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_____

ADVANCED PAIN CENTERS
OF ALASKA

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 Patient or Responsible Party Relationship to Patient

Patient Name:_____ **Date:**_____

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