AA Spine & Pain Clinic- PATIENT REGISTRATION

PATIENT INFORMATION: *(Please Print)* Date:_____

Last Name:_____ First Name:_____ Middle Initial:_____
Age:_____Birth date:_____ SS#:_____Sex: ☐Male ☐Female ☐Transgender
Physical Address:_____City:_____Apt No:_____
State:_____ Zip:_____

Mailing Address (if different from above):
Address:_____ City:_____Apt No:_____
State:_____ Zip:_____

Telephone: (Home)_____ (Work) _____ (Cell) _____
Employer:_____ Occupation:_____
Address: _____ Phone: _____

Email address:_____

Present Employer:_____Occupation:_____

Please complete the following three sections as per new governmental healthcare regulations:

1) Race *(Please check all that apply)*: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐More Than One Race ☐Native Hawaiian ☐Other Pacific Islander ☐White ☐Refused to Report/Unreported

2) Ethnicity *(Please check one)*: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Refused to Report/Unreported

3) Preferred Language: ☐English ☐Spanish ☐Other: _____

PHYSICIANS:
Referring Physician:_____ Telephone No:_____
Address:_____
Primary Care Physician: _____ Telephone No:_____
Address:_____

INSURANCE INFORMATION:
Primary Insurance:_____ID#_____Group#_____
Ins. Address:_____Ins. Phone#:_____
Subscribe'r Name:_____Subscriber's Birth date:_____
Subscriber's Employer:_____

Secondary Insurance:_____ID#_____Group#_____
Ins. Address:_____Ins. Phone#:_____
Subscriber's Name:_____Subscriber's Birth date:_____
Subscriber's Employer:_____

Is this visit related to an accident? ☐YES or ☐NO ☐Workers Compensation ☐Auto Accident
Date of injury:_____Adjuster Name:_____Claim#:_____
Adjuster Phone #:_____Adjuster Fax #:_____
Employer:_____

PHARMACY INFORMATION:

Preferred Local Pharmacy: _____

(Name/City/Phone #)

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐Newspaper ☐Internet ☐Friend ☐Referring doctor ☐Self ☐Movie theater

EMERGENCY CONTACT INFORMATION:

Name:_____Relationship to patient:_____

Contact Phone Number(s):_____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT ID REPONSIBILE FOR ALL FEES, REGARDLESS OF THE INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN):

I hereby authorize AA Spine & Pain Clinic to furnish information to insurance carriers concerning my illness and / or treatments, and I assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Patient Signature: _____ Date: _____

HOW DO YOU PLAN TO PAY? (Circle one) CASH CHECK CREDIT CARD

AA Spine & Pain Clinic

aapain.com

4100 Lake Otis Parkway Suite 216 & 208
Anchorage, AK 99508
(907) 563-2873 Fax: (907) 563-5852

RELEASE OF INFORMATION TO PERSON(S)

I, _____, give permission to AA Spine & Pain Clinic to provide the following information regarding my care to the following person:

_____	_____	_____
Name	DOB	Relationship to Patient

Please check the items below that you would like to be released to the above named person. Note that releasing the information to the above named person to pick up does not necessarily give them the right to open any sealed information or read any of the information labeled strictly for the patient.

- ☐ Prescription pick-up
- ☐ Receive Medical Information in person and/or over the phone
- ☐ Appointment information

_____	_____	_____
Patient Printed Name	Patient Signature	Date

_____	_____	_____
Printed Witness Name	Witness Signature	Date

AA Spine
& Pain Clinic

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Anchorage, AK 99508
Phone 907 563-2873 Fax 907 563-5852
aapain.com

Authorization for Use/Release of Health Information

Name:				Phone:	
Date of Birth:		Age:		S.S. #:	

I Hereby Authorize AASP to Release Information to:					
Person/Agency:					
Address:					
City:		State:		Zip:	
Phone #:		Fax #:			

I Hereby Authorize AASP to Obtain Information from:					
Person/Agency:					
Address:					
City:		State:		Zip:	
Phone #:		Fax #:			

HIPPA requires that only specificied records be released			**Required** *(please tick YES or NO for each line)*		
☐ Yes ☐ No	Office Notes		☐ Yes ☐ No	Procedures	
☐ Yes ☐ No	Medications		☐ Yes ☐ No	Hospital	
☐ Yes ☐ No	Labs		☐ Yes ☐ No	All Records	
☐ Yes ☐ No	Radiology		☐ Yes ☐ No	Other: _____	

_____I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar condition. This does not indicate that I have these conditions but allows the release of the records without review.

_____ I have been provided a copy of **AA Spine & Pain Clinic's** Notice of Privacy Practices and any changes that may be associated with this authorization. I have discussed any concerns. I may have about the use, release, and disclosure of my health information disclosed under this authorization. I release **AA Spine & Pain Clinic** from any legal liability that may arise from this authorization.

_____The patient or their representative may revoke this authorization by notifying in writing **AA Spine & Pain Clinic's** designated Privacy Officer. Federal Law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient.

Signature of Patient or Representative:		**Date:**	
Relationship to Patient:		**Witness:**	

Expiration date: 1 year from date signed

**AA Spine and Pain Clinic records will be provided on CD. The first copy each year will be provided at no charge. Additional copies are $25 each.*

AA Spine & Pain Clinic

4100 Lake Otis Pkwy. Suite 216 & 208
Anchorage, AK 99508
PH: 907-563-2873 FAX: 907-563-5852

aapain.com

New Patient Evaluation-Intake and History

Date: _____

Name: _____ Date of Birth: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Visit: _____
Timing/Onset: When did symptoms first occur? _____
Duration: Frequency of symptoms? _____
Characterized as/Severity: Describe the severity of the symptoms/pain.

☐Mild ☐Moderate ☐Severe ☐Extreme

The pain was generally WORSE by (check all that apply):

☐None ☐Lifting ☐Standing ☐Sitting ☐Climbing stairs
☐Sleeping ☐Walking ☐Straining ☐Driving ☐Bending

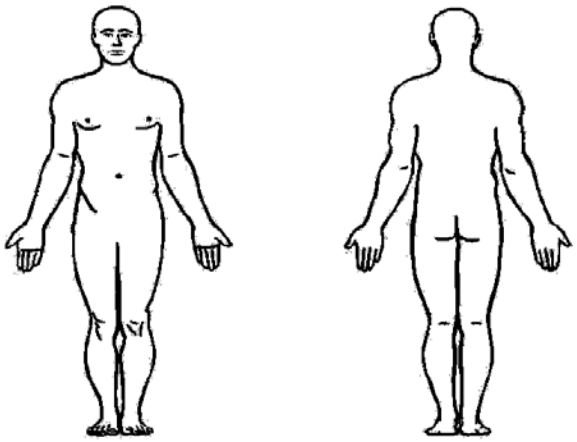
What makes your pain BETTER? (check all that apply):

☐Nothing ☐Exercise ☐Injections ☐ Medication ☐Rest
☐Sleeping ☐Lying down ☐Heat ☐Physical Therapy

What words would you use to best describe your pain (check all that apply):

☐Sharp ☐Shooting ☐Stabbing ☐Burning
☐Aching ☐Dull ☐Pinching ☐Throbbing

Please shade in the areas on the diagrams where your pain is located:



Right Left Left Right

REASON FOR VISIT (CONTINUED):

Have you previously been treated for your current pain? ☐Yes ☐No
If yes: Name of physician:_____

Is your pain the result of an illness? ☐Yes ☐No
If yes: When was your illness diagnosed, and by whom?_____
_____

Is your pain the result of an injury? ☐Yes ☐No
If yes: Describe your injury and how it occurred:_____
_____
_____
When did your injury occur?_____

Was your injury work-related? ☐Yes ☐No

Are you currently involved in litigation or a lawsuit because of this accident? ☐Yes ☐No

Please check any of the following treatments you have had for <u>this pain problem</u>:
☐No previous Intervention

Tens Unit:	☐Not Effective	☐Effective	☐Somewhat effective
Physical Therapy:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Acupuncture:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Chiropractor:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Psychiatrist:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Hypnosis:	☐ Not Effective	☐ Effective	☐ Somewhat effective
NSAIDs:	☐ Not Effective	☐ Effective	☐Somewhat effective
Biofeedback:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Pain Medication:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Bedrest:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Traction:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Epidural Steroids:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Facet Blocks:	☐ NotEffective	☐ Effective	☐ Somewhat effective
Medial Branch Block:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Radio Frequency:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Selective Nerve Root Block:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Sympathetic Blocks:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Spinal Cord Stim:	☐ Not Effective	☐ Effective	☐ Somewhat effective
Intrathecal Pain Pump:	☐ Not Effective	☐ Effective	☐ Somewhat effective

PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

AIDS or HIV ☐	Diverticulitis ☐	Kidney Disease ☐
Anemia or low blood count ☐	Fatigue ☐	Kidney Failure ☐
Anxiety ☐	Fibromyalgia ☐	Dialysis ☐
Arthritis ☐	Fractures or broken bones ☐	Kidney stones ☐
Asthma/wheezing ☐	Glaucoma ☐	Liver disease ☐
Atrial fibrillation ☐	Headaches ☐	Lupus ☐
Blood disorder ☐	*More than 2 times/week* ☐	Mental disorder ☐
Brain aneurysm/hemorrhage ☐	Hearing Aid ☐	Multiple Sclerosis ☐
Cancer ☐	Hearing Problems ☐	Muscular Dystrophy ☐
Chemotherapy ☐	Heart disease ☐	Myasthenia gravis ☐
Radiation ☐	*Heart Pacemaker* ☐	Palpitations or rapid pulse ☐
Collapsed lung ☐	Heart murmur ☐	Peripheral vascular disease ☐
Congestive Heart Failure ☐	Hepatitis A, B, or C ☐	Scoliosis ☐
COPD ☐	Hernia ☐	Seizures ☐
Coughing up blood ☐	*Area:*_____	Shingles ☐
Depression ☐	High blood pressure ☐	Sleep disorder ☐
Diabetes ☐	History of blood clots ☐	Stroke ☐
Insulin Use ☐	History of chest pain ☐	Thyroid disease ☐
Difficulty hearing ☐	Irregular heartbeat ☐	Ulcers ☐
Difficulty walking ☐	Irritable bowel syndrome ☐	Weakness/Numbness of arms/legs ☐

MEDICATION HISTORY:

☐ I am **not** currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Strength/Dosage	Who Prescribed them

Are you currently taking any Anticoagulants (blood thinners): ☐Yes ☐No

If yes, please specify: ☐Coumadin ☐Heparin ☐Plavix ☐Innohep ☐Other ☐Have taken in the past

Have you ever taken or are you currently taking Cortisone or Steroids: ☐Yes ☐No

If yes, please specify:_____

ALLERGY HISTORY:

☐**NKDA (No Known Drug Allergies)** ☐**Bad reaction to local anesthetic**

PAST SURGICAL HISTORY: ☐None

List significant surgeries or injuries:

Surgeries/Injuries:	Date(s)/Age of patient	Surgeon

Recent Hospitalization(s)	Date(s)	Reason

Recent Pain Procedure(s)	Date(s)	Reason

DIAGNOSTIC STUDIES HISTORY: ☐ None

☐EKG	Date(s) performed:_____	☐MRI-Brain	Date(s) performed:_____
☐EMG/NCV	Date(s) performed:_____	☐MRI-Cervical	Date(s) performed:_____
☐ CT Scan-Cervical	Date(s) performed:_____	☐MRI-Thoracic	Date(s) performed:_____
☐ CT Scan-Thoracic	Date(s) performed:_____	☐MRI-Lumbar	Date(s) performed:_____
☐ CT Scan-Lumbar	Date(s) performed:_____	☐Myelogram-Cervical	Date(s) performed:_____
☐Discogram	Date(s) performed:_____	☐Myelogram-Thoracic	Date(s) performed:_____
☐ X-Ray	Date(s) performed:_____	☐Myelogram- Lumbar	Date(s) performed:_____
Body location:_____		☐Other:_____	

FAMILY HISTORY: ☐ Unknown; adopted

Has any member in your family been diagnosed with any of the following conditions (include deceased family members)? Place a ☑ under the correct family member with the condition.

	Father	Mother	Father's Parents	Mother's Parents	Son	Daughter	Uncle	Aunt
Anxiety								
Asthma								
Bleeding Disorder								
Cancer								
Type:								
Congestive Heart Failure								
Coronary Artery Disease								
Depression								
Diabetes								
Gallbaldder Disease								
Hepatitis								
High Blood Pressure								
High Cholesterol								
Inflammatory Bowel Diease								
Kidney Disease								
Osteoarthritis								
Osteoporosis								
Seizure Disorder								
Substance Abuse								
Thyroid Disease								
Tumors								

SOCIAL HISTORY:

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

Do you have children? ☐Yes ☐No

If yes: What are their ages?_____

Please describe your current/past tobacco use:

☐Smoker, current status unknown ☐Light tobacco smoker ☐Heavy tobacco smoker
☐Current every day smoker ☐Current some day smoker ☐Former smoker
☐Never smoker ☐Unknown if ever smoked ☐Chewing tobacco

If current smoker: Packs per day:_____ Packs per week:_____
If former smoker: Packs per day:_____ Packs per week:_____ Year that you quit:_____

Do you drink alcoholic beverages? ☐Yes ☐No
If yes: Please indicate how many serving- per day:_____ per week:_____

Any legal issues with alcohol, past or present? ☐Yes ☐No
If yes: ☐DUI ☐DWI ☐Other:_____
If yes: When?_____

Have you ever used illegal drugs? ☐Yes ☐No
If yes: ☐Marijuana ☐Cocaine ☐IV Drugs ☐Heroin ☐Methamphetamines ☐Other
If yes: When?_____ Date last used:_____

Any legal issues with illegal drugs, past or present? ☐Yes ☐No
If yes: Please explain:_____

How many caffeinated beverages (coffee, cola, etc.) do you drink- per day:_____ per week:_____

What is your current Military Status? ☐N/A ☐Active ☐Retired ☐Discharged

Are you currently working? ☐Yes ☐No
If yes: ☐Full-time ☐Part-time What is your occupation?_____
If no: ☐Unemployed ☐Disabled

Did your pain cause you to quit work? ☐Yes ☐No
Did your pain cause you to change occupations? ☐Yes ☐No
If yes: What is your new occupation?_____

Activities of daily living: ☐Care for yourself ☐Need assistance

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CANCELLATIONS: As of **September 1, 2008**; we require a 24 hour notice to cancel or reschedule your appointment. Appointments missed, rescheduled due to tardiness, or rescheduled without a 24 hour notice will result in a **$50.00** fee to the patient.

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General: ☐Normal

- ❑ Weight gain
- ❑ Weight loss
- ❑ Fever
- ❑ Night sweats
- ❑ Fatigue
- ❑ Change in appetite
- ❑ Sleeping problems
- ❑ Chills
- ❑ Body aches
- ❑ Loss of appetite
- ❑ Sinus allergy symptoms
- ❑ Allergic dermatitis
- ❑ Frequent illnesses
- ❑ Frequent sneezing
- ❑ Food allergies
- ❑ Medication allergies
- ❑ Severe reaction to insect bites
- ❑ Post nasal drip
- ❑ Hives

Skin: ☐Normal

- ❑ Skin dryness
- ❑ Hair growth change
- ❑ Nail changes
- ❑ New skin lesions
- ❑ Acne
- ❑ Skin rash or sores
- ❑ Itching
- ❑ Skin color change
- ❑ Nodules
- ❑ Pressure ulcers
- ❑ Shingles

HEENT: ☐Normal

- ❑ Double vision
- ❑ Impaired vision
- ❑ Changes in vision
- ❑ Eye pain
- ❑ Floaters
- ❑ Sudden visual loss
- ❑ Eye glasses
- ❑ Glaucoma
- ❑ Eye lens implant
- ❑ Eye prosthesis
- ❑ Contact lenses
- ❑ Headaches
- ❑ Recent head injury
- ❑ Nose bleed
- ❑ Hearing loss
- ❑ Neck lumps or masses
- ❑ Ear fullness
- ❑ Snoring
- ❑ Dry mouth
- ❑ Frequent nosebleeds
- ❑ Sinus problems
- ❑ Hay fever allergies
- ❑ Difficulty hearing
- ❑ Ear infections
- ❑ Hearing aid
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Dentures or partial plates
- ❑ Capped teeth
- ❑ Loose teeth

Respiratory: ☐Normal

- ❑ Shortness of breath
- ❑ Asthma
- ❑ Wheezing
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Chronic cough
- ❑ Coughing up blood
- ❑ Collapsed lung
- ❑ Tuberculosis exposure
- ❑ Blueness of fingernails

Breast: ☐Normal

- ❑ Lumps
- ❑ Tenderness
- ❑ Swelling
- ❑ Nipple discharge

Cardiovascular: ☐Normal

- ❑ Chest pain
- ❑ Lightheadedness
- ❑ Heart murmur
- ❑ Heart pacemaker
- ❑ Irregular heartbeat
- ❑ Fainting spells
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ Blood clots
- ❑ Pulmonary embolism
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Varicose veins

Gastrointestinal: ☐Normal

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Loss of appetite
- ❑ Heartburn
- ❑ Excessive belching
- ❑ Abdominal pain
- ❑ Blood in stools
- ❑ Hemorrhoids
- ❑ Narrow stools
- ❑ Reflux
- ❑ Ulcers

Genitourinary: ☐Normal

- ❑ Urgency
- ❑ Change in urine color
- ❑ Urinary hesitancy
- ❑ Possible pregnancy
- ❑ Kidney dialysis
- ❑ Kidney stones
- ❑ Kidney infections
- ❑ Kidney failure
- ❑ Prostate problems
- ❑ Bladder infections
- ❑ Blood in urine
- ❑ Difficulty urinating
- ❑ Loss of urine at times
- ❑ Sexual problems

Musculoskeletal: ☐Normal

- ❑ Joint pain
- ❑ Joint swelling
- ❑ Muscle pain
- ❑ Limitation of motion
- ❑ Muscle cramps
- ❑ Back pain
- ❑ Back spasms
- ❑ Painful joints
- ❑ Stiffness
- ❑ Leg cramps
- ❑ Neck pain
- ❑ Shoulder(s) pain
- ❑ Hip(s) pain
- ❑ Leg(s) pain
- ❑ Wrist pain
- ❑ Knee pain
- ❑ Ankle pain
- ❑ Elbow pain
- ❑ Fractures/broken bones
- ❑ Arthritis
- ❑ Scoliosis

Neurological: ☐Normal

- ❑ Muscular weakness
- ❑ Difficulty concentrating
- ❑ Memory difficulties
- ❑ Tremors
- ❑ Loss of balance
- ❑ Tingling in feet
- ❑ Falls
- ❑ Head injuries
- ❑ Black out spells
- ❑ Change in alertness
- ❑ Seizures or convulsions
- ❑ Epilepsy
- ❑ Stroke
- ❑ Brain aneurysm
- ❑ Multiple sclerosis

Psychiatric: ☐Normal

- ❑ Delusions
- ❑ Impulsive behaviors
- ❑ Suicidal ideation
- ❑ Excessive anger
- ❑ Depression
- ❑ Anxiety/Panic attacks
- ❑ Mental disorder

Endocrine: ☐Normal

- ❑ Loss of hair
- ❑ Heat intolerance
- ❑ Central obesity
- ❑ Diabetes
- ❑ Insulin use
- ❑ Low blood sugar
- ❑ Thyroid problems
- ❑ Steroid use

Hematology: ☐Normal

- ❑ Lightheadedness
- ❑ Easy bleeding
- ❑ Easy bruising
- ❑ Lymph node enlargement/tenderness
- ❑ Swollen glands or masses in neck axilae
- ❑ Groin lyphedema

AA Spine & Pain Clinic

PAYMENT FOR SERVICES

Please read, initial where indicated, and sign below.

PATIENT RESPONSIBILITY

- Insurance coverage is not a guarantee of payment. (_____ initial)
- We will bill your insurance if you present your insurance card(s) at the time of your appointment. You are responsible for monitoring the processes of your insurance company to make certain your claim is processed in a timely manner, for contacting them if you have questions as to how your claim was processed, and that you are ultimately responsible for payment of services rendered. (_____ initial)
- Any co-payments or "patient responsibility" percentages must be paid at the time of service. (_____initial)
- **If we do not receive a response from your insurance company within forty-five days from the date we bill them, the balance will become your responsibility**. (_____ initial)
- You will receive a statement for any remaining balance after all applicable insurances have been applied. That balance is due in full at that time. (_____ initial)
- If we do not receive your payment in full within 90 days from the date of the first statement, your account may be turned over to a third-party collection agency. (_____ initial)

We also recommend that you research your insurance benefits prior to your office visit, as there could be reasons why your insurance may not pay for your visit. These reasons might include the following:

- Your deductible has not been met. Many policies have separate, higher deductibles for surgical procedures. All of the procedures performed in this office, including certain types of injections, are considered to be surgical procedures.
- You have not received the proper referral or preauthorization for the visit or procedure. If your insurance company requires preauthorization, it is your responsibility to obtain it before the procedure is performed. Remember, preauthorization is not a guarantee of payment.
- The services or procedures are not covered by your insurance. *We will inform you when we know a treatment/procedure will not be covered, but many times it is not possible for us to know with certainty, as this varies greatly among insurance companies, and because they will not make a final determination until they have received the claim. If there is any uncertainty about coverage, we will be happy to provide you with an estimate of your fees before treatment is given. You are responsible to pay for the non-covered services at the time of the visit.*

We accept cash, checks, and all major credit cards. If a payment in check form is returned to us because of insufficient funds, you will be charged a $30.00 fee. Payment ***in full*** at the time of service is required in the following circumstances:

- You do not have insurance coverage.
- You have not brought your insurance card(s) with you.
- You have not met your deductible.
- A contract is required by your policy and we are not contracted with your insurance carrier.
- A referral or preauthorization is required by your policy you have not obtained one.
- Any procedures or treatments we believe are not covered by insurance.

By my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them. This authorization is not limited in time.

_____ _____

Patient Signature (or Responsible Party) Date

AA Spine & Pain Clinic
Pain Management Agreement
aapain.com

I, _____ understand that in order to receive care for the treatment of pain at AA Spine & Pain Clinic, I agree to comply with the following:

A. **USE OF MEDICATIONS**: I will take all medications as prescribed. I will speak with a provider at AA Spine & Pain Clinic before making any change in either the dose or frequency of taking my medications. There will be no early refills of pain medications due to self escalation of medications. Narcotic pain medications must all be obtained from the same pharmacy (any exceptions must be approved by AA Spine & Pain Clinic).
B. **SEEKING PRESCRIPTIONS**: I will neither seek nor fill prescriptions for any medications related to pain relief from any other health care provider unless authorized by AA Spine & Pain Clinic
C. **MEDICAL RECORDS RELEASE:** I will inform all of my health care providers that I receive pain management through A.A. Spine & Pain Clinic and will maintain an unrestricted and current medical records release on file with AA Spine & Pain Clinic. I authorize AA Spine & Pain Clinic to provide a copy of the Pain Contract to release medical information to necessary pharmacies.
D. **MENTAL HEALTH**: A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with the healthcare providers of AA Spine & Pain Clinic
E. **DRUG SCREENING**: I will participate in drug screening as a part of my treatment plan. I understand that drug screening will be conducted quarterly and may be required more frequently at the discretion of AA Spine & Pain Clinic Screening may include urinalysis, blood testing and/or pill counts. I agree to pay any and all costs associated with drug testing not covered by my insurance. Refusal to submit to screening at the time specified may result in termination of service.
F. **ALCOHOL USE:** Any use of alcohol with prescriptions is against clinic policy. Testing for alcohol use may be added to random and routine urine drug screens at the discretion of the physician. Any use of alcohol deemed inappropriate by the physician will be grounds for termination from AA Spine & Pain Clinic.
G. **ILLEGAL AND NON-PRESCRIBED DRUG USE**: I understand that the use of any controlled medication, not prescribed by AA Spine & Pain Clinic, may result in termination of care. I authorize AA Spine & Pain Clinic to cooperate fully with any city, state, or federal law enforcement agency. I agree to waive any applicable privileged, right of privacy, or confidentiality with respect to these authorities. I also understand that the use of any illegal substance including marijuana will result in termination of care by AA Spine & Pain Clinic.
H. **LOST OR STOLEN MEDICATION**: I agree to safeguard all medication prescribed by AA Spine & Pain Clinic and understand that **lost, stolen, or damaged medications will not be replaced.**
I. **PRESCRIPTIONS WHILE TRAVELING**: AA Spine & Pain Clinic may choose to provide prescriptions for up to 60 days when I am traveling out of state. I will only be eligible for early medication when proof of travel can be obtained. Identification includes paper ticket and electronic confirmation sheet that shows how much I paid. I will have to arrange for shipment of controlled substances by my pharmacy at my own expense. If I will be out of state longer than 60 days, I need to arrange for my health care at my travel destination. On return to Anchorage, I need to advise AA Spine & Pain Clinic of the name and address of my provider out of state. I also authorize AA Spine & Pain Clinic to contact my provider to obtain any detailed information deemed necessary in my medical care.

J. **DRIVING AND OPERATING EQUIPMENT**: Many pain medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and whenever I feel drowsy.

K. **MISSED APPOINTMENTS**: I will contact the clinic if I will be 5 to 10 minutes late. If I arrive more than 15 minutes late, I will be rescheduled. Three missed appointments per year are grounds for termination from AA Spine & Pain Clinic.

L. **CANCELLATIONS:** As of **September 1, 2008**; we require a 24 hour notice to cancel or reschedule your appointment. Appointments missed, rescheduled due to tardiness, or rescheduled without a 24 hour notice will result in a **$50.00** fee to the patient.

M. **CHARGES:** All fees from patients are due at the time of visit. Non-payment of fees may result in the account being sent to collections and patient termination from AA Spine & Pain Clinic.

N. **TERMINATION**: I will no longer be eligible for care at AA Spine & Pain Clinic if I am in possession of illicit drugs or substances, trafficking of controlled or illegal substances, intoxicated or convicted for DUI. If I forge or alter the prescriptions in any way, sell or share medications, or fail to comply with this contract, I will no longer be eligible for care at AA Spine & Pain Clinic.

O. **TREATMENT OF STAFF**: Our clinic has a zero tolerance policy for verbal abuse towards our staff. Swearing, yelling at, or threatening our staff will result in termination from our clinic.

P. **EMERGENCY ROOM VISITS:** I am allowed to receive pain medication in the emergency room, but it is a violation of the AA Spine & Pain Clinic contract to receive narcotic medication to take home and it must be discussed with the on-call doctor prior to receiving medication. A violation includes any prescription and/or samples.

Have you ever had any medical or legal problems with alcoholism, drug abuse (including marijuana), addiction or drug trafficking? If yes, please explain:

_____
_____
_____

Have you used any illegal drugs (including marijuana) within the past six months? If yes, list the drugs you have used and when:

_____
_____
_____

Have you used any prescription drugs for which you did not have a personal prescription within the past six months? If yes, please explain:

_____
_____
_____

I HAVE THOROUGHLY READ THIS AGREEMENT BEFORE RECEIVING TREATMENT AT A.A. SPINE & PAIN CLINIC I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED. I KNOW THAT FAILURE TO COMLPY WITH ANY OF THESE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATIONS OF SERVICE.

Reviewed contract and answered all patient's questions (MA): _____ Date: _____

Patient's Signature: _____Date: _____

Practitioner Signature: _____Date: _____

AA Spine & Pain Clinic
aapain.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (name of patient) _____, acknowledge and agree that I have received a copy of AA Spine & Pain Clinic'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:

AA Spine & Pain Clinic 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.]

AA Spine & Pain Clinic
4100 Lake Otis Pkwy Suite 216 & 208
Anchorage, AK 99508

PATIENT RIGHTS

Your Information. Your Rights. Our Responsibilities.

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.**

LAYERED SUMMARY TEXT –

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Request corrections to your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services

- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for three years prior to the date you ask, who we shared it with, and why. Requests for this accounting must be submitted to the Privacy Officer in writing.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before

we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

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Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

.Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice September 23, 2013
- Privacy Official Ashley Kinney
- We never market or sell personal information.
- We will never share any psycho-therapy records without your written permission.

AA Spine & Pain Clinic
4100 Lake Otis Pkwy Suite 216 & 208
Anchorage, AK 99508

Effective Date April 1, 2003

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 CAREFULLY.

A. PURPOSE OF THE NOTICE.

AA Spine & Pain Clinic 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 received 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.

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 purpose 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 purpose 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 you 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.

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.

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 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, 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.

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 diabetic condition, we may contact you to inform you of a diabetic instruction class that we offer at our clinic.

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 you pay for your care. We make such disclosures when (a) we have your verbal agreement to do so; (b) we make 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 instance 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 health care. For example, if you present to 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 also may share your health information with a family member or friend who calls us to request a prescription refill for you.

D. OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES OR 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 may 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.

3. **Health Oversight Activities.** We may disclose your health information to a health oversight agency that is authorized by law to conduct health oversight activities, including audits, 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 to ensure compliance with applicable state and federal laws and regulations.

4. **Judicial or Administrative Procedures.** 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, 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 in response to a request received from a law enforcement official to report criminal activity or 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, transplantations, 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 your 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. **Phone Calls.** We may record your phone calls with our office for use in internal training by our staff.

11. **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 and safety of you or other individuals.

12. **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.

13. **National Security and Intelligence Activities.** We may use or disclose your health information to authorized federal officials for the purpose of intelligence, counter-intelligence, and other national security activities, as authorized by law.

14. **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 institutional 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 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 taken 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 complete form that you can obtain from our clinic. In some instances, we may charge you for the cost(s) associated with providing you with the requested information.

1. **Right to Inspect and Copy.** You have the right to inspect and copy 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 properly submitted 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 the 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 the 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.

G. QUESTIONS OR COMPLANTS

Any questions or complaints please contact our office at 907-563-2873 or 4100 Lake Otis Pkwy Suite 216, Anchorage, AK 99508 or visit our website at aapain.com