Alaska Pain to Wellness Centre
2751 DeBarr Road, Bldg. B, Ste. 310 | Anchorage, AK 99508
(907) 277-9700 **[P]** | (907) 868-1215 **[F]**

Please complete the following questions to the best of your knowledge. If nothing applies, please initial N/A. Thorough completion of this information will help us to better assist you with your care. Thank you.

Patient Demographics

Patient Name (***First / MI / Last***): ______________________________ DOB: __________

SSN: ________________ Sex: ***Male / Female*** Method of contact: ☐ Mobile ☐ Home ☐ Work

Mailing Address: ____________________ City: ______________ State: _____ Zip: _______

Physical Address: ____________________ City: ______________ State: _____ Zip: _______

Email: ____________________ Mobile phone #: ______________ Home #: ______________

Employer: ______________________________ Work #: ______________

Race: ______________ Ethnicity: ______________ Language: ______________

Emergency Contact: ______________ Relationship: __________ Phone #: ______________

PCP: ______________ Referral source: ______________ Preferred Pharmacy: ______________

Responsible Party

☐ Check box if you are the responsible party, and do not fill out the information below.

Patient Name (***First / MI / Last***): ______________________________ DOB: __________

SSN: ________________ Sex: ***Male / Female*** Relationship to Patient: ______________

Mailing Address: ____________________ City: ______________ State: _____ Zip: _______

Physical Address: ____________________ City: ______________ State: _____ Zip: _______

Mobile phone #: ______________ Home #: ______________

Insurance Information

☐ Check box if you are a private-pay patient.

Primary Insurance Company: ____________________ Insured: ____________________

Policy ID: ____________________ Group #: ____________________

Insured' Relation to Patient: ______________ DOB: __________ SSN: __________

Secondary Insurance Company: ____________________ Insured: ____________________

Policy ID: ____________________ Group #: ____________________

Insured' Relation to Patient: ______________ DOB: __________ SSN: __________

______________________________ ______________________________

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

HIPAA Acknowledgement and Consent

I, ____ acknowledge that I have been provided the HIPAA Notice of Privacy Practices by ***Alaska Pain to Wellness Centre***. I acknowledge that the HIPAA Notice of Privacy Practices describes the use and disclosure of my protected health information (PHI), and identifies my rights and the duties of which ***Alaska Pain to Wellness Centre*** must uphold.

Please initial the following:

_____ Use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

_____ Call my home or other designated locations to speak in person or leave a voice message about any items that assist the practice in carrying out TPO. Including, but not limited to: appointment reminders, insurance items, my clinical care, and laboratory and diagnostic results.

_____ Send mail to my home or other designated location any items that assist the practice in carrying out TPO. Including, but not limited to: appointment reminders, patient statements, and insurance items.

_____ I have the right to request that ***Alaska Pain to Wellness Centre*** restrict how my PHI is used and/or disclosed to carry out TPO. However, the practice is not required to agree with my requested restriction, but if they do, they are bound to this agreement.

_____ I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ***Alaska Pain to Wellness Centre*** may decline to provide treatment to me.

_____ Patient can review a copy of the “Notice of Privacy Practices” posted in patient waiting room. Copy will be provided upon request.

- 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 operation with your health insurer.
  - We may say “yes” unless a law requires us to share that information.
- You can ask to see or receive an electronic or paper copy of your medical records and other health information we have about you within 30 days of you’re your request. **We may charge a reasonable, cost based fee.**
- You can ask us to correct health information about you that you think is incorrect ot incomplete, We may say “no” to your request, but we will tell you why in writing in 60 days.
- How we typically use or share your health information.
  - **Treat You**- We can use your health information and share it with other professionals who are treating you.
  - **Run Our Organization**- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  - **Bill for Your Service**- We can use and share your health information to bill and get payment from health plans or other entities.
- 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.
  - Information See:**www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html./index.html**

HIPAA Acknowledgement and Consent Continuation

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information to be released to the following:

Spouse: ____

Children: ____

Other Family or Friends: ____

[ ] *Information is not to be released to anyone*

I authorize ***Alaska Pain to Wellness Centre*** to leave voice messages if I am not available to take a phone call:

[ ] Home [ ] Cell [ ] Other ______________________

[ ] You may leave a detailed message

[ ] You may leave a message asking me to return your call

I authorize ***Alaska Pain to Wellness Centre*** to send appointment reminders in the following method(s):

[ ] Text message [ ] Voice message

[ ] Both Text & Voice message [ ] Email

____ __________________________

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

Financial Policies

I, ________________________________ am responsible for the payment of all charges associated with my visit. As a courtesy, and for my convenience, ***Alaska Pain to Wellness Centre*** will bill my insurance company when I have provided my insurance information. I am responsible for deductibles, co-payments, co-insurances, and uncovered services at the time services are rendered. I am responsible for contacting my insurance carrier if I am unsure of my coverage. If the insurance payment is not received within 60 days of billed charges, I am immediately responsible for the full account balance.

Review and initial the following:

_____ All co-payments, deductibles, and/or co-insurance are due at the time of service.

_____ If proof of insurance cannot be provided, patient will be deemed "self-pay", and payment will be due in full at the time of service.

_____ Private insurance is a contract between you and your insurance company. ***Alaska Pain to Wellness Centre*** will not be involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, etc. ***Alaska Pain to Wellness Centre*** will supply factual information as necessary.

_____ If the patient is a minor, in the case of separation or divorce, the parent bringing the minor in for their appointment is responsible to pay for services and must stay with them at all times.

_____ Any balances on your account must be paid in full before you will be seen again, unless payment arrangements have been made with the billing department.

_____ If you are here for a wellness visit/physical and have other health problems you wish to discuss with your provider during this time, additional charges may be applied. Please note that these charges may or may not be covered by your insurance. If you would like to update the reason for your visit, please see the front desk.

_____ Accounts with a balance of $10 or less will not generate a statement. Please refer to your insurance explanation of benefits (EOB) to see if you owe a balance.

_____ A fee of $35 will be charged to the patient for any returned checks marked for NSF. The patients account will be flagged until the debt has been paid. Payment must be made by cash, credit card, or money order.

_____ Methods of payment accepted: cash, personal checks, Visa, and MasterCard.

_____ If you cancel your appointment with less that 24 hour notice, or you no show for you appointment you will be charged $75.00 and this will need to be paid before you are seen at your next appointment. If you are 15 minutes late or more without notifying us, this will be considered a no-show. You will get one (1) free miss or no-show appointment.

____ ______________________

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

Medical History Questionnaire

Patient Name: ____ DOB: _____________ Today's Date: ______________

Height________________ Weight_________________

CHIEF COMPLAINT

Main reason for today's visit: ____

Date of injury/ onset of symptoms: ____

Explain how the injury occurred: ____

Is this injury work related? ☐ YES ☐ NO

Pain is: ☐ OCCASIONAL ☐ FREQUENT ☐ CONSTANT

Pain feels like: ☐ SHARP ☐ DULL ☐ ACHING

What makes the pain worse or better? ____

Do you have pain at night or while resting? ☐ YES ☐ NO

Do you have numbness or tingling? ☐ YES ☐ NO Where? ____

Do you have radiating pain? ☐ YES ☐ NO Where? ____

Back, Hip & Knee Complaints Only:

Where does it hurt when you walk? ____

Does your knee lock or catch? ☐ YES ☐ NO

On a scale of 1 to 10 (10 being the most pain), circle your pain level: **0 1 2 3 4 5 6 7 8 9 10**

CURRENT TREATMENT

Treatment for chief complaint:

☐ SPLINTING / BRACING ☐ PHYSICAL THERAPY ☐ INJECTIONS ☐ MEDICATIONS

Diagnostic Studies:

☐ MRI ☐ X-RAYS ☐ EMG / NCV STUDY ☐ CT SCAN

PAIN CONTRACT

☐ YES ☐ NO ☐ IN THE PAST

MEDICATIONS

If you are you currently taking any prescription and/or non-prescription medications including aspirin, steroids, vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal remedies, and cold medications please list them below. Be sure to include the frequency and dosage.

- ☐ Check box if you do not take any prescription or over the counter medications.
- ☐ Check box if you brought a list of your medications (please give it to the Medical Assistant to make a copy).

____

____

____

____

ALLERGIES

Including medications, please indicate any allergies and reaction below.

- ☐ Check box if you do not have any allergies

____

____

____

IMMUNIZATIONS

- ☐ Check box if you are unaware of immunization history.

	Yes	No	Year
Hepatitus A	☐	☐	
Hepatitus B	☐	☐	
HPV	☐	☐	
Influenza (flu shot)	☐	☐	
Meningitis	☐	☐	
MMR (measles, mumps, rubella)	☐	☐	
Pneumovax (pneumonia)	☐	☐	

	Yes	No	Year
Polio	☐	☐	
Tetanus (TD)	☐	☐	
Tetanus [w/Pertussis] (TDAP)	☐	☐	
Tuberculin (TB)	☐	☐	
Varicella (Chicken Pox)	☐	☐	
Zostavax (Shingles)	☐	☐	

SOCIAL HISTORY

Current Employment Status
- ☐ Employed
- ☐ Retired
- ☐ Unemployed
- ☐ Homemaker

Current Living Arrangement
- ☐ Alone
- ☐ Family
- ☐ Friends
- ☐ Roommate

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

Exercise
- ☐ Regularly
- ☐ Sometimes
- ☐ Never

Current occupation(s): ______________________________

Hobbies & Recreational Activities: ______________________________

HABITS

	Yes	No	Type	Frequency
Caffeine	☐	☐		
Cigarettes / Tobacco	☐	☐		
Alcohol	☐	☐		
Recreational / Street Drugs	☐	☐		

REVIEW OF SYSTEMS

Check all that currently apply.

☐ Check box if nothing below applies to you.

CARDIOVASCULAR

- ☐ Chest Pain or Discomfort
- ☐ Chest Tightness
- ☐ Heart Palpitations
- ☐ Shortness of Breath
- ☐ Swelling

CONSTITUTIONAL

- ☐ Fatigue
- ☐ Fever or Chills
- ☐ Trouble Sleeping
- ☐ Weakness
- ☐ Weight Loss or Gain

EARS

- ☐ Decreased Hearing
- ☐ Drainage
- ☐ Earache
- ☐ Ringing

ENDOCRINE

- ☐ Cold Intolerance
- ☐ Sweating
- ☐ Thirst

EYES

- ☐ Cataracts
- ☐ Contacts or Glasses
- ☐ Blurry or Double Vision
- ☐ Flashes of Light
- ☐ Floating Specks
- ☐ Glaucoma
- ☐ Pain
- ☐ Redness or Irritation

GASTROINTESTINAL

- ☐ Change in Appetite
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Nausea or Vomiting
- ☐ Rectal Bleeding

HEAD & NECK

- ☐ Headache
- ☐ Head Injury
- ☐ Migraine
- ☐ Neck Pain or Stiffness
- ☐ Lumps
- ☐ Swollen Glands

HEMATOLOGIC

- ☐ Ease of Bleeding
- ☐ Ease of Bruising

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Muscle or Joint Pain
- ☐ Redness of Joint Area
- ☐ Stiffness
- ☐ Swelling of Joint Area
- ☐ Trauma

NOSE

- ☐ Discharge
- ☐ Itching
- ☐ Nosebleeds
- ☐ Sinus Pain
- ☐ Stuffiness

NEUROLOGICAL

- ☐ Dizziness
- ☐ Fainting
- ☐ Numbness
- ☐ Seizures
- ☐ Tingling
- ☐ Tremors

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Nervousness

RESPIRATORY

- ☐ Cough
- ☐ Coughing up Blood
- ☐ Painful Breathing
- ☐ Shortness of Breath
- ☐ Sputum
- ☐ Wheezing

SKIN

- ☐ Color Changes
- ☐ Dryness
- ☐ Itching
- ☐ Lumps
- ☐ Rashes

THROAT

- ☐ Bleeding
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Non-healing Sores
- ☐ Sore Throat
- ☐ Sore Tongue
- ☐ Thrush

URINARY

- ☐ Blood in Urine
- ☐ Burning or Pain
- ☐ Frequency
- ☐ Incontinence
- ☐ Urgency

VASCULAR

- ☐ Leg Cramping
- ☐ Calf Pain

Please list any medical conditions below

____

____

____

SURGERIES & PROCEDURES

List all previous broken bones/fractures, injuries, and procedures/surgeries. Please include dates of each incident.

- ☐ Check box if nothing applies to you.

____

____

____

FAMILY HISTORY

If the following applies to one or more of your family members, please indicate:

- ☐ Check box if you are adopted and/or do **not** know your family history. Skip this section.
- ☐ Check box if nothing below applies.

Diseases & Conditions	Mother	Father	Sister(s)	Brother(s)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Daughter(s)	Son(s)
Alcoholism / Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety / Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma / Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (Specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes (Type 1 or 2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

List any other health issues that run in your family below:

____

____

____

______________________________ ______________

Patient Signature (***Parent/Legal Guardian if patient is a minor***) Date

______________________________ ______________

Reviewed for Completion By Date

Release of Information

Patient: ____ **DOB**: ____________

I hereby authorize:

______________________ NAME ______________________ PHONE ______________________ FAX

______________________ ADDRESS ______________________ CITY / STATE / ZIP

To release my medical and health information to:

______________________ NAME ______________________ PHONE ______________________ FAX

______________________ ADDRESS ______________________ CITY / STATE / ZIP

Please include the following records:

____ Entire Medical Record
____ Operative Reports
____ Pathology Reports
____ ER and Urgent Care Record
____ All Hospital Records
____ Other: ______________________
____ Office Chart Notes
____ Laboratory Reports
____ Imaging/X-ray Reports

The following items MUST be initialed to be included in the use or disclosure of other health information:

_____ HIV/AIDS related health information and/or records
_____ Mental health information and/or records
_____ Genetic testing information and/or records
_____ Drug/alcohol diagnosis, treatment and/or referral information

_____ **Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

____ Patient Signature (Legal Representative's Signature if applicable)

______________________ Date

____ Print Name of Legal Representative (if applicable)

______________________ Relationship to Patient

**I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.*