

NEW PATIENT MEDICAL HISTORY

Disease:	Year	Disease:	Year
Achondroplasia	_____	Gastric-Ulcer	_____
Alcohol Abuse	_____	Gastro-Esophageal-Reflux	_____
Allergies, Environmental	_____	Glaucoma	_____
Anemia	_____	Gout	_____
Antiphospholipid Antibody	_____	Hemophilia	_____
Aortic Aneurysm Adominal	_____	Hepatitis A History	_____
Aortic Aneurysm Thoracic	_____	Hepatitis B History	_____
Appendicitis	_____	Hepatitis C History	_____
Arthritis:		Herpes Zoster	_____
➤ Osteo	_____	➤ Chickenpox	_____
➤ Rheumatoid	_____	➤ Shingles	_____
➤ Other	_____	Hital Hernia	_____
Asthma	_____	Hypothyroidism	_____
Bipolar Affective Disorder	_____	Hyperlipidemia	_____
Bladder Incontinence	_____	Hypertension (High Blood Pressure)	_____
Bowel Incontinence	_____	Hyponatremia (Low Sodium)	_____
Bronchitis, Acute	_____	Hypokalemia (Low Potassium)	_____
Bronchitis, Chronic	_____	Hypomagnesemia (Low Magnesium)	_____
Cancer:		Kidney:	
➤ Breast	_____	➤ Infection	_____
➤ Cervical	_____	➤ Transplant	_____
➤ Colon	_____	➤ Stones	_____
➤ Lung	_____	➤ Failure	_____
➤ Melanoma	_____	Liver Disease	_____
➤ Prostate	_____	Osteoporosis	_____
➤ Skin	_____	Otitis Externa	_____
➤ Testicular	_____	Otitis Media (Middle Ear Infection)	_____
Cardiac:		Ovarian Cyst	_____
➤ Angina	_____	Pain:	
➤ Aortic Insufficiency	_____	➤ Chronic Neck	_____
➤ Atrial Fibrillation	_____	➤ Chronic Low Back	_____
➤ Atrial Septal Defect	_____	➤ Chronic Muscle	_____
➤ Ventricular Septal Defect	_____	Panic Disorder	_____
➤ Tetralogy of Fallot	_____	Peptic Ulcer Disease	_____
➤ Congestive Heart Disease	_____	Peripheral Vascular Disease	_____
➤ Congestive Heart Failure	_____	Pneumonia	_____
➤ Mechanical Aortic Valve	_____	Prosthetic Eye	_____
➤ Mechanical Mitral Valve	_____	➤ Left	_____
➤ Myocardial Infarction	_____	➤ Right	_____
➤ Mitral Valve Prolapse	_____	Prosthetic Hip	_____
➤ Murmur	_____	➤ Left	_____
➤ Patent Foramen Ovale	_____	➤ Right	_____
➤ Pacemaker	_____	Protein C Mutation	_____
➤ Defibrillator	_____	Protein S Mutation	_____
➤ Other _____	_____	Psychosis	_____
Cataracts	_____	Pulmonary Embolism	_____
Cataracts – Congenital	_____	Renal Artery Stenosis	_____
Chronic-Obstructive-Pulmonary Disease	_____	Reynauld's Phenomenon	_____
Coronary-Artery-Disease	_____	Sarcoidosis	_____
Cushings Disease	_____	Schizophrenia	_____
Detached Retina	_____	Sinus Infections	_____
Deep Vein Thrombosis	_____	Systemic-Lupus-Erythematosis	_____
Depression	_____	Skin Disorder	_____
Diabetes:		Tuberculosis	_____
➤ Adult Onset	_____	Ulcer	_____
➤ Juvenile Onset	_____	Ulcerative Colitis	_____
Diabetic Neuropathy	_____	Other _____	_____
Diverticulosis	_____		_____

NEW PATIENT FRACTURE AND SURGICAL HISTORY

Fracture Disease	(please circle)		Year
Ankle	Left	Right	_____
Carpals	Left	Right	_____
Cervical Vertebra			_____
Clavicle	Left	Right	_____
Femur (Thigh Bone)	Left	Right	_____
Fibula	Left	Right	_____
Humerus (Upper Arm)	Left	Right	_____
Knee ACL	Left	Right	_____
Knee MCL	Left	Right	_____
Lumbar Vertebra (Low Back)			_____
Mandible (Jaw)			_____
Maxialla			_____
Pelvis (Hips)	Left	Right	_____
Radius (Lower Arm)	Left	Right	_____
Ribs	Left	Right	_____
Rotator Cuff	Left	Right	_____
Sacral Vertabra (Tail bone)			_____
Skull			_____
Tarsals	Left	Right	_____
Tibia	Left	Right	_____
Ulna (Lower Arm)	Left	Right	_____
Wrist	Left	Right	_____
Other _____			_____
_____			_____
_____			_____

Surgical_History		Year
Adominal Surgery		_____
Adenoidectomy		_____
Aneurysm Clip		_____
Ankle Surgery		_____
➤ Left		_____
➤ Right		_____
Appendectomy		_____
Baclofen Pump Placement		_____
Brain Tumor Resection		_____
Breast Biopsy		_____
Cardiac Surgery:		_____
➤ Catheterization		_____
➤ Coronary Artery Bypass Graft		_____
➤ Valve		_____
➤ Transplant		_____
Carotid Endarterectomy		_____
Left	Right	_____
Carotid Stent		_____
Left	Right	_____
Carpal Tunnel Surgery		_____
➤ Left		_____
➤ Right		_____
Cataract Surgery		_____
➤ Left		_____
➤ Right		_____
Cervical Spine Surgery		_____
Cervical Spine Fusion C2-C3		_____
Cervical Spine Fusion C3-C4		_____
Cervical Spine Fusion C4-C5		_____
Cervical Spine Fusion C5-C6		_____
Cervical Spine Fusion C6-C7		_____

Surgical_History	Year
Cervical Spine Laminectomy C2-C3	_____
Cervical Spine Laminectomy C3-C4	_____
Cervical Spine Laminectomy C4-C5	_____
Cervical Spine Laminectomy C5-C6	_____
Cervical Spine Laminectomy C6-C7	_____
Cholecystectomy (Gallbladder)	_____
C-Section	_____
Colectomy	_____
Hip Arthroplasty (Replacement)	_____
➤ Left	_____
➤ Right	_____
Hysterectomy	_____
Knee Arthroplasty (Replacement)	_____
➤ Left	_____
➤ Right	_____
Knee Meniscus Repair	_____
➤ Left	_____
➤ Right	_____
Knee ACL Repair	_____
➤ Left	_____
➤ Right	_____
Laparoscopy (Exploratory)	_____
Lumbar Spine Surgery	_____
Lumbar Spine Surgery Fusion L2-L3	_____
Lumbar Spine Surgery Fusion L3-L4	_____
Lumbar Spine Surgery Fusion L4-L5	_____
Lumbar Spine Surgery Fusion L5-S1	_____
Lumbar Spine Laminectomy L2-L3	_____
Lumbar Spine Laminectomy L3-L4	_____
Lumbar Spine Laminectomy L4-L5	_____
Lumbar Spine Laminectomy L5-S1	_____
Mastectomy	_____
Prostatectomy	_____
Prostate TURP	_____
Radial Keratotomy	_____
Renal Transplant	_____
Rotator Cuff Repair	_____
Seizure Surgery	_____
Skin Lesion Removal	_____
Skin Melanoma Resection	_____
Stabismus Correction	_____
Temporal Lobectomy	_____
➤ Left	_____
➤ Right	_____
Thymectomy	_____
Thyroidectomy	_____
Tonsillectomy	_____
Tubal Ligation	_____
Tympanostomy Tubes	_____
Ventriculo-Peritoneal Shunt	_____
Other _____	_____
_____	_____
_____	_____

Alaska Brain Center, LLC Office Policies

SERVICES:

Alaska Brain Center, LLC is a specialty clinic. We do not treat primary care issues. We require our patients to have a primary care physician. If you do not have a primary care physician, we can provide you with a list of local physicians.

MEDICATION POLICY:

Please be aware that the providers in this office do not prescribe pain medications classified as controlled substances. Examples include: codeine, hydrocodone, oxycodone, morphine, Demerol, methodone, cannabis, and Marinol. Requests for controlled substance medications may be grounds for discharge from our clinic. We will make a referral to a pain management specialist if appropriate.

PROFESSIONALISM:

The providers and staff of Alaska Brain Center, LLC strive to maintain the upmost professionalism with our patients and colleagues in other medical offices. Complaints regarding other providers are not clinically useful. Our providers and staff will not make adverse statements against other offices.

FINANCIAL POLICY:

It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered. All coinsurance, co-pays and deductibles are due at the time of service. It is the patient's responsibility to know their co-pay amount, and if they have met their deductible and out-of-pocket for the year.

- Patients with Medicaid are expected to make their \$3.00 co-pay at each visit.
- Patients who do not have insurance are required to pay 80% at the time of service.
- Patients with Medicare are not required to make a payment at the time of service.
- Patients with multiple insurances are not required to make a payment at the time of service.

All account balances must be paid within 90 days. Accounts with outstanding balances will be sent to collections after 90 days. A service charge may be assessed on all accounts sent to collections. Patients, whose accounts are in collections, may not schedule an appointment until the balance is paid in full.

MEDICAL RECORDS REQUESTS:

Requests for a copy of a patient's records must be made in writing. Records will be placed on a CD unless otherwise specified. There is a \$20.00 service charge for records on CD. The charge for paper records is \$30.00 for the first 25 pages and \$35.00 for any amount over 25 pages. Pre-payment is required. There is no charge for records being sent to another provider's office for coordination of care or further treatment. We will make every effort to process your request within 48 hours.

MISSED APPOINTMENTS:

We reserve your scheduled appointment time specifically for you. When you cancel or miss your appointment, this takes valuable time away from another patient waiting to be seen in our clinic. Patients who cancel or miss appointments without a valid reason may be discharged from our clinic.

PRESCRIPTION REFILLS:

Please allow 24-48 hours for prescription refill requests. You may contact your pharmacy and ask them to fax us a refill request form.

I have read, understand, and agree to comply with the above policies.

Patient signature: _____ **Date:** _____

Parent/Guardian signature: _____ **Date:** _____

Authorization to Release Medical Information

1. I AUTHORIZE:

Name of sending person/organization

Street Address

City State Zip Code

2. TO RELEASE TO:

JEFFREY L. SPONSLER, MD
ALASKA BRAIN CENTER, LLC
4551 E. BOGARD ROAD
WASILLA, AK 99654
phone: 907-373-6500
fax: 888-456-0663

3. **INFORMATION TO BE RELEASED:** (Check all applicable)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> All Information | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Imaging Reports |
| <input type="checkbox"/> EEG Reports | <input type="checkbox"/> EMG Reports | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Other: _____ | | | |

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below.

By signing below, I am authorizing the office to release any and all information regarding:

- Alcohol Drugs Mental Health Sexually Transmitted Diseases HIV AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

4. **RECORDS FROM THE TIME PERIOD:** _____ / _____ / _____ through _____ / _____ / _____

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Continued Medical Care | <input type="checkbox"/> Payment of Insurance Claim | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Personal | <input type="checkbox"/> Workers' Compensation Claim | <input type="checkbox"/> Other: _____ |

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

Patient's Signature: _____ **Date:** _____

Patient's Name (Please Print): _____

Date of Birth: _____ **Home Phone:** _____ **Work Phone:** _____

Alaska Brain Center, LLC

Acknowledgment of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by mail, fax, or in person.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient: _____
(Print)

(Signature)

Date: _____

Witness: _____