ALGONE
ANCHORAGE
4001 Dale Street Ste 105
Anchorage, AK 99508
P|907.770.1152 F|907.770.1153

- ***Completed New Patient Packet***
- ***Current Picture ID***
- ***Current Insurance Card(s)***
- ***Current Medicaid Card*** and $3 ***copayment*** (if applicable)
- ***Medication Bottles*** that you are currently taking or a detailed ***medication list*** with the exact names, milligrams and dosing instructions
- ***Imaging*** such as MRI, X-Rays, CT scans ect. Please bring them on a CD with the report.
- ***Medical records*** related to your condition from previous facilities where you have been seen- We make every attempt to obtain records from your referring physician, however, it is ultimately ***your responsibility*** to provide these to Algone
- Come prepared to give a ***urine sample*** as this may be required before you are seen

We try our best to stay on schedule so it is ***very important that you arrive at your check in time***, so we can complete the registration process in time for your appointment time. Patients who are ***late patients or that do not have the information listed above will be rescheduled per Algone Policy***. Again, we would like to welcome you to Algone Interventional Pain Clinic. We realize that you have a choice as to where you go for your care and want to thank you for choosing Algone!

Appointment Date_____ Check in Time_____ Appt Time _____

Provider_____ Location_____

.

PATIENT DEMOGRAPHICS

Last Name:	First Name:	Middle Initial:	Date of Birth:

Previous name(s) used:	Biological Gender: ○ Male ○ Female	SSN#:

Mailing Address:	City	State/ ZIP

Residence/ Street Address	City	State/ ZIP

Primary Phone:	Secondary Phone:	Race:	Ethnicity:

Language	Marital Status	Employer	Can we call you at work? If yes, work phone #

May we e-mail you information relevant to your condition, clinic announcements, etc.?

☐ Yes

☐ No

If yes, please provide e-mail _____

RESPONSIBLE PARTY (MINORS ONLY)

Last Name:	First Name:	MI:	Date of Birth:

Mailing Address	City	State/ ZIP

Phone:	SSN #:	Relation to Patient:

ALGONE ANCHORAGE

Patient Demographics Continued

INSURANCE INFORMATION

PRIMARY Insurance: | Policy #: | Group #:

Policy Holder: | DOB:

Relationship: | Social Security #:

SECONDARY Insurance: | Policy #: | Group #:

Insured: | DOB: | Social Security #:

GENERAL INFORMATION

Person to contact if unable to reach patient

Name: | Phone/Cell: | Relationship:

How did you hear about us? | Preferred Pharmacy:

Primary Care Provider to send office note to: | Who do you authorize to pick up your prescriptions?

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans, Medicaid, RR Medicare, and all other health plans to Algone Anchorage. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance (including Medicaid). I hereby authorize said assignee to release all information needed to secure the payment.

Signature Date

New Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (907) 770-1152 if you have any question on how to complete any section of this form.

Patient Information

Name: Date of Birth:

Height: Weight:

Referring Physician: Primary Care Physician:

Pain History:

Chief Complaint (Reason for your visit today)?

Does this pain radiate?

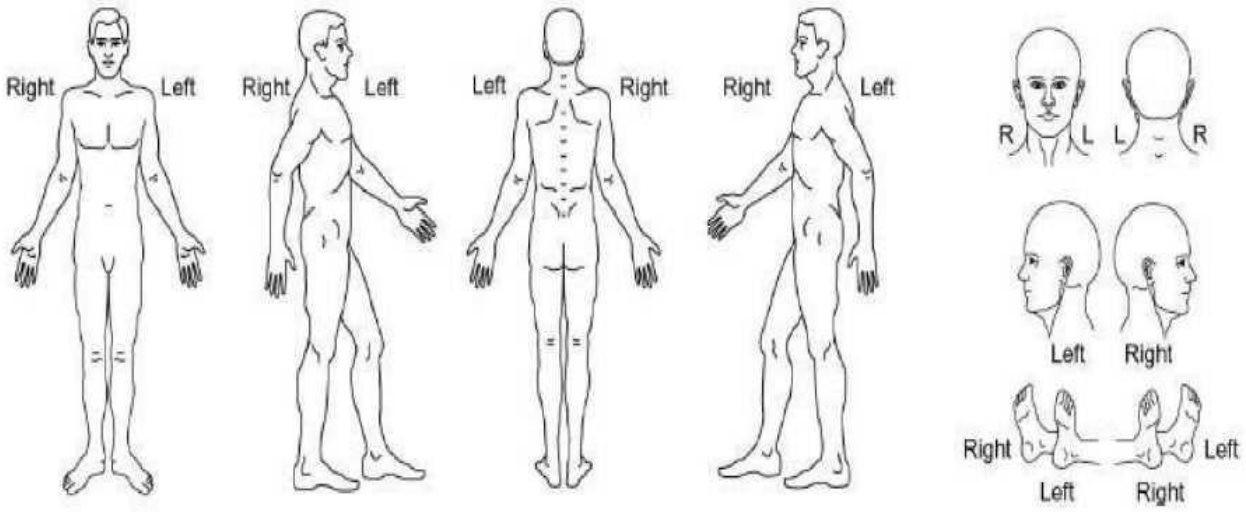
☐ Yes

☐ No

If yes, where?

Please list any additional areas of pain:

Use this diagram to indicate the area of your pain. Mark the location with an"X"



Onset of Symptoms:

Approximately when did this pain begin?

What caused your current pain episode?

How did your current pain episode begin?

☐ Gradually ☐ Suddenly

Since your pain began, how has it changed?

☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description:

Check all of the following that describe your pain

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp ☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness ☐ N/A

When is your pain at its worst?

☐ Morning ☐ Daytime ☐ Evening ☐ Middle of the night ☐ Always the same

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

If "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now: _____

The Best It Gets: _____

The Worst It Gets: _____

Mark the effect each of the following have on your pain level.

	Increases	Decreases	No Change
Bending Backward			
Bending Forward			
Changes in Weather			
Climbing Stairs			
Coughing/Sneezing			

Driving			
Lifting Objects			
Looking upward			
Looking downward			
Rising from seated position			
Sitting			
Standing			
Walking			

What other factors worsen or affect your pain which is not mentioned above?

Associated Symptoms:

	No	Yes	Comments (Where?)
Numbness/Tingling			
Weakness in the arm/leg			
Balance Problems			
Bladder Incontinence			
Bowel Incontinence			
Joint Swelling/Stiffness			
Fevers/chills			

Please mark all of the following treatments you have used for pain relief:

	No Change	Worsened Pain	Helped Pain
Spine Surgery			
Physical Therapy			
Chiropractic Care			
Psychological Therapy			
Brace Support			
Acupuncture			
Hot/Cold Packs			
Massage Therapy			
Medications			
TENS Unit			
Other			

If other, specify:

_____

_____

Interventional Pain Treatment History

☐ Epidural Steroid Injection

Check all levels that apply:

☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Joint Injection(s)

Joint(s):

☐ MILD (Minimally Invasive Lumbar Decompression)

Comments _____

☐ Nerve Blocks

Check all levels that apply:

☐ Cervical ☐ Thoracic ☐ Lumbar

Area(s)/Nerve(s) _____

☐ Radiofrequency Nerve Ablation

Check all levels that apply:

☐ Cervical ☐ Thoracic ☐ Lumbar

Spinal Cord Stimulator:

☐ Trial ☐ Implant

Trigger Point Injection(s): What area(s):

_____

Vertebroplasty/Kyphoplasty

Level(s):

_____

Other, please specify:

_____

Which of these procedures listed above have helped with your pain?

_____

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

	Body Part	YES	Date
MRI of the:			
X-Ray of the:			
CT Scan of the:			
EMG/NCV study of the:			

- ○ Other Diagnostic Testing
- ○ I have not had ANY diagnostic tests for my current pain complaint

If Other, specify:

_____

_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Chiropractic ☐ Massage Therapy ☐ Neurosurgeon

☐ Orthopedic Surgeon ☐ Physical Therapy ☐ Psychiatrist/Psychologist ☐ Other

If other, specify:

_____

Past Medical History

Please list the names of other Pain Physicians you have seen in the past

_____

_____

_____

_____

Mark the following conditions/diseases that you have been treated for in the past:

General Medical:

☐ Cancer (Type): _____ ☐ Diabetes (Type): _____ ☐ N/A _____

Cardiovascular/Hematologic:

☐ Anemia ☐ High Blood Pressure ☐ Peripheral Vascular Disease
☐ Stroke/TIA Heart Vavle Disorders ☐ N/A

Gastrointestinal:

☐ GERD (Acid Reflux) ☐ Constipation ☐ N/A

Urological:

☐ Chronic Kidney Disease ☐ Dialyisis ☐ Kidney Stones
☐ Urinary Incontinence ☐ N/A

Neuropsychological:

☐ Depression ☐ Bipolar Disorder ☐ Multiple Sclerosis

Head/Ears/Eyes/Nose/Throat:

☐ Headaches ☐ Head Injury ☐ Hypothyroidism ☐ Hyperthyroidism
☐ Glaucoma ☐ Migraines ☐ N/A

Respiratory:

☐ Asthma ☐ Bursitis ☐ Bronchitis/Pneumonia ☐ COPD
☐ Emphysema ☐ N/A

Musculoskeletal/Rheumatologic:

☐ Carpal Tunnel Syndrome ☐ Fibromyalgia ☐ Chronic Joint Pain(s)
☐ Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ N/A

Other Diagnosed Conditions:

_____

_____

_____

Pain Level:

☐ 0 – No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 - Worst Possible Pain

Comments:

_____

_____

Past Surgical History

Please list any surgical procedures you have had done in the past including approximate date:

	Surgical Procedure	Date
1		
2		
3		

☐ I have NEVER had any surgical procedures performed

Current Medications

Are you currently taking any blood thinners or anti-coagulants?

☐ Yes
☐ No

If YES, which ones?

☐ Aspirin ☐ Eliquis ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other

If other, specify: _____

_____

Please list all medications you are currently taking including vitamins.

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Please list all past pain medications that you have been on at any point for your current pain complaints?

	Medication Name	Dosage	Frequency
1			
2			
3			
4			
5			

Allergies

Do you have any drug/medication allergies?

☐ Yes

☐ No

If so, please list all medications you are allergic to:

	Medication Name	Allergic Reaction
1		
2		
3		
4		
5		

Topical Allergies:

☐ Iodine ☐ IV Contrast ☐ Latex ☐ Tape

Family History

Mark all appropriate diagnoses as they pertain to your first-degree relatives:

☐ Arthritis ☐ Diabetes ☐ Seizures
☐ Other Medical Problems ☐ I have no significant family medical history

If other medical problems please specify below:

_____

_____

Social History

Which best describes you?

☐ Temporary Disability Permanent Disability

☐ Retired Unemployed

☐ Employed

Occupation: When was the last time you worked?

_____ _____

Who is in your current household?

_____

Are there any stairs in your current home?

☐ Yes

☐ No

If Yes, how many? _____

Are you currently under worker's compensation? ☐ Yes ☐ No

Is there an ongoing lawsuit related to your visit today? ☐ Yes ☐ No

Alcohol Use:

☐ Current alcoholism ☐ Daily use of alcohol ☐ History of alcoholism

☐ Social Use ☐ Never

Tobacco Use:

☐ Current use ☐ Former user ☐ Never used

Packs per day? How many years? Quit Date:

_____ _____ _____

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently using illegal drugs

☐ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications?

☐ Yes

☐ No

Review of Systems

Mark the following symptoms that you currently suffer from:

1. General:
   ☐ Chills ☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Weight Gain ☐ Low Sex Drive
   ☐ N/A

2. ENT:
   ☐ Dental Problems ☐ Ear Pain ☐ Hearing Loss ☐ Nose Bleeds ☐ Sinus Congestion ☐ N/A

3. Genitourinary:
   ☐ Blood in Urine ☐ Pain with Urination ☐ Bladder Habit Change
   ☐ Flank Pain ☐ Kidney Stones ☐ N/A

4. Eyes:
   ☐ Vision Changes ☐ N/A

5. Cardiovascular:
   ☐ Chest Pain ☐ Palpitations ☐ Swelling (Edema) ☐ Shortness of Breath with Exertion ☐ N/A

6. Respiratory:
   ☐ Cough ☐ Wheezing ☐ Shortness of Breath at Rest ☐ N/A

7. Gastrointestinal:
   ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn
   ☐ Nausea ☐ Vomitting ☐ N/A

8. Muscles and Joints:
   ☐ Cramps ☐ Neck Pain ☐ Joint Swelling ☐ Stiffness ☐ Joint Pain ☐ Back Pain ☐ N/A

9. Neurologic:
   ☐ Dizziness ☐ Fainting ☐ Headaches ☐ Numbness/Tingling
   ☐ Weakness ☐ Tremors ☐ Seizures ☐ N/A

10. Hematologic:
    ☐ Easy Bruising ☐ Bleeding ☐ Blood Clots ☐ N/A

11. Psychiatric:
    ☐ Anxiety ☐ Depression ☐ Sleep Problems ☐ Suicidal Thoughts
    ☐ Thoughts of Harming Others ☐ N/A

Pain Level:

☐ 0 – No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 - Worst Possible Pain

ALGONE ANCHORAGE

AUTHORIZATION FORM

I _____ authorize Algone Anchorage to verbally discuss my medical records with:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

By signing this authorization form, I understand that:

- This is not an authorization to release printed medical records.
- Some records may contain extremely confidential information. This may include alcohol/substance abuse/testing, mental health conditions/psychotherapy notes and psychological evaluations, HIV testing, status or care and treatment for AIDS, sexually transmitted disease/testing, and genetic records.
- Once the office discloses health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.
- I may revoke this authorization in writing. If revoked, it would not affect any actions already taken by Algone Anchorage based upon this authorization. Two ways to revoke this authorization are: Fill out a revocation form (available from the office) or write a letter to the office.

Print Patient Name: _____ Date of Birth: _____

_____ _____

Patient or Parent/Guardian Signature Date

CONSENT TO TREAT

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any necessary anesthetics
- Performance of such procedures as may be deemed medically necessary or advisable as part of my treatment use of prescribed medication(s)
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable
- based on the judgment of the attending physician or their assigned designees I fully understand that this is document

was given to me and executed in advance to any specific diagnosis or treatment.

My intent is for this consent to be continual in nature, even after a specific diagnosis has been made and treatment recommended. The consent will remain in full effect until revoked in writing.

I understand that Algone Interventional Pain Clinic may include this consent to apply to services, procedures and tests at satellite offices under common ownership if applicable.

I, the undersigned, acknowledge that Algone Interventional Pain Clinic will use and disclose my information for the purposes of treatment, collection of payment, and healthcare operations as described in the Notice of Privacy Practices that I have been given.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize Algone Interventional Pain Clinic to release my medical information to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Algone Interventional Pain Clinic.

By signing below, I certify that I have read and fully understand the above statements and consent entirely and voluntarily to its contents. I also acknowledge that I have been offered a complete copy of Algone Anchorage's Interventional Pain Clinic's "Notice of Privacy Practices". I understand that if I have questions or complaints that I should contact Algone Anchorage's Patient Privacy Officer

Legal guardian if patient is a minor

Patient Signature _____ Date _____

ALGONE ANCHORAGE

FINANCIAL POLICIES

Print Patient Name: Date of Birth:

Please review:

- If proof of insurance/eligibility cannot be provided, payment will be due in full.
- Algone Anchorage will collect any deductibles, copay, or coinsurance on the date of service. Medical insurance is a
- contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, etc.
- Please be advised if you are here for a preventative visit/physical and have health problems you want to discuss with your provider during your well visit, this could result in an additional charge, which may or may not be covered by your insurance. For clarification or to update the reason for your visit, please see the front desk.
- Balances on your account must be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel. If you are in need of an arrangement, please contact the billing department in a timely manner as any claim over 90 days will be due in full.
- Statements are not generated for an amount due of less than $10.00; please watch your insurance explanations to see if you owe a balance.
- Please be aware you may receive a separate charge from an outside lab (i.e. Quest Diagnostics) for specialized lab tests
- Algone Anchorage is in network with the following insurances: Medicare, Medicaid, Blue Cross, Tricare, Cigna, Aetna, Moda, and United Healthcare. If your insurance is not one of these, please be aware your claim(s) will be processed as "out of network"
- Deliquent account (> 90 days) are subject to the collections processes which may include the account being tranferred to Cornerstone Credit Services (CCS). You will be responsible for any fees and/or commission charged to Algone Anchorage by CCS; patients whose accounts have been sent to CCS will be reviewed for possible discharge from the clinic.
- Algone Anchorage will charge a fee of $30.00 for any checks returned as NSF. The patient's account will be flagged until the debt has been paid
- Any appointments cancelled less than 24 hours prior to the scheduled appointment time will incur a $25.00 cancellation fee. After five missed appointments, an account may be reviewed for discharge from the practice.
- It is important to clarify the reason for your visit(s). Please do this at the time of your visit as it is Algone Anchorage's policy to not change a diagnosis code after the visit; feel free to clarify/confirm what diagnosis will be used with your provider before you leave the office.

Patient or Parent/Guardian Signature Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Algone Anchorage to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Algone Anchorage describes such uses and disclosures more completely.)
I have the right to review the Notice of Privacy Practices prior to signing this consent. Algone Anchorage reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Algone Anchorage Interventional Pain Clinic
4001 Dale Street Ste 105
Anchorage, AK 99508

With this consent, Algone Anchorage may call my home or other alternative location and leave a message on voice mail if needed (unless a Refusal to Voicemail form is completed) or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Algone Anchorage may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Algone Anchorage may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Algone Anchorage restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

By signing this form, I am consenting to allow Algone Anchorage to use and disclose my PHI to carry out TPO.

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, or later revoke it Algone Anchorage may decline to provide treatment to me.

Print Patient Name:

_____

Legal Guardian's Name (if applicable):

_____

_____ _____

Patient or Parent/Guardian Signature Date

RESCHEDULING POLICY

Algone Anchorage Interventional Pain Clinic strives to maintain an efficient schedule that limits the patient's wait time. In order to accomplish this, we ask our patients to take the following steps and provide the following documents:

- Current insurance card; the policy information will not be enough. For verification purposes, the Insurance card must be on file. This includes Medicaid.
- Valid photo ID
- Must have copayment if required by your insurance company
- Payment for service must be paid in full prior to your appointment time.
- Paperwork Requirements
- New Patients must have all paperwork completed before they arrive and must arrive 30 minutes prior to their scheduled appointment time to complete the registration process.
- Any forms that need to be filled out by the doctor must be completed to the extent possible by the patient prior to their appointment.
- Late Arrivals – the scheduled appointment time is the time that the patient should be in the exam room not the time the patient should be walking in the door. To avoid having your appointment rescheduled please arrive 10-15 min prior to your scheduled appointment time at all times.

Please keep in mind that your appointment will be rescheduled if you do not follow the guidelines outlined above:

Signing this form indicates that you have read and understand the policy stated above.

Patient Name Date

_____ _____

_____ _____

Patient or Parent/Guardian Signature Date