FIRST NAME__________________________MIDDLE NAME___________________LAST NAME________________________

NICK NAME___________________________________ EMAIL____

DATE OF BIRTH______________________SSN (**REQUIRED** for insurance purposes) ________________________ GENDER: F / M

HOME PHONE_______________________ CELL PHONE_______________________ MARITAL STATUS S / M / D / W

PHYSICAL HOME ADDRESS____

CITY____STATE______________________ ZIP________________

BILLING ADDRESS____

CITY____STATE_______________________ZIP________________

EMERGENCY CONTACT____RELATIONSHIP ____________________________

EMERGENCY CONTACT NUMBER____

REFERRED BY________________________________ PRIMARY CARE PROVIDER_____________________________________

HOW DID YOU HEAR ABOUT US____

IS THIS A WORK INJURY? _______________ AUTO ACCIDENT? ___________ DATE OF INJURY _________________________

CASE MANAGER (IF APPLICABLE) __________________________CLAIM NUMBER___________________________________

ADJUSTER'S NAME ___________________________________ ADJUSTER'S PHONE NUMBER_________________________

ADDRESS: ____

PRIMARY INSURANCE COMPANY ____

SUBSCRIBER / EMPLOYER / RESPONSIBLE PARTY ____

INSURANCE ADDRESS ____

SUBSCRIBER/MEMBER ID # _____________________________________ GROUP #_________________________________

SUBSCRIBER/MEMBER DATE OF BIRTH: __________________ELIGIBILITY DATES: FROM______________TO_____________

SECONDARY INSURANCE COMPANY ____

SUBSCRIBER / EMPLOYER / RESPONSIBLE PARTY ____

INSURANCE ADDRESS ____

SUBSCRIBER/MEMBER# (ID #) ___________________________________ GROUP #_________________________________

SUBSCRIBER/MEMBER DATE OF BIRTH: __________________ELIGIBILITY DATES: FROM______________TO_____________

EMPLOYER ____ OCCUPATION________________________________

WORK ADDRESS______________________________________ CITY______________ STATE ______ ZIP CODE ____________

WORK PHONE__________________________________START DATE _________________ END DATE ___________________

Patients Signature: ____ **Date** ________________

ARCTIC SPINE FINANCIAL POLICY

- We are an out-of-network provider and because there is no in-network neurosurgeon in the state of Alaska, your plan can process your claims with us at an in-network benefit level. For most plans, this means you will be covered at 80/20 instead of 60/40, and your deductible, coinsurance and out-of-pocket maximum will all contribute to your in-network benefits. Please enquire with your plan's Customer Service department about this 'out-of-network exception' or 'benefit level exception'. Once this exception is approved, benefits for covered services will be provided at the in-network benefit level. You will still be responsible for amounts applied towards your calendar year deductible, copays, co-insurance and may be billed for amounts that exceed the benefit maximums, amounts above the allowable charges and charges for non-covered services. (______ initial)
- We bill your insurance company for services rendered as a courtesy to you. Payment of your claim is based on your eligibility and benefits at the time services are rendered. Insurance coverage is not a guarantee of payment. (_______initial)
- We ask that you become actively engaged in your plan's payment process. You are responsible for monitoring the processes of your insurance company to ensure your claim is processed in a timely manner. You are responsible for contacting them if you have questions regarding how your claim was processed. (_______initial)
- We bill you directly once your insurance company has responded to us. You will be billed for any balance that your health plan applies as 'patient responsibility'. We ask that payment be made in full immediately to our office. We accept cash, checks and all major credit cards for your convenience. Checks should be issued to 'Arctic Spine'. (_______initial)
- If you have a balance on your account, are under financial hardship and need to make payment arrangements, please contact our office immediately to do so. We require consistent monthly payments in order to participate. If your statement is more than 120 days overdue and you have not made any payment, your account will be considered delinquent and may be turned over to collections without warning. Please maintain a current address and telephone number with our office in order to avoid collection actions. Remember, we are willing to work with you to establish a payment plan. (_______initial)
- 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 (_______initial)
- **If you have Auto Insurance:** We will bill the FIRST PARTY coverage only. We do not accept THIRD PARTY coverage. Please provide us with the name of your auto insurance company, address, phone number, claim number and date of accident. If you have an attorney working on your case, this does not constitute us waiting for payment on your settlement. If the medical benefits of your policy have been exhausted, you will ultimately be responsible for the fees of all services rendered. (_______initial)
- **If you are under Worker's Compensation:** It is your responsibility to supply Arctic Spine with the name of the insurance company, the date of injury, the insurance company's mailing address, insurance company's phone number, your adjuster's name and your claim number. Without this information we will be unable to file your visit/claim with the insurance company. If your Worker's Compensation claim becomes controverted, you will ultimately be responsible for the fees of all services rendered. (_______initial)

I understand and agree to the above conditions. I understand that if my insurance does not cover my bill, I will ultimately be responsible and if I fail to make payments as arranged I will be subject to collection activity, in which I am responsible for any and all collection agency expenses/fees and/or full actual and reasonable attorney fees incurred, and any legal costs incurred. I understand that I am also subject to interest on delinquent amounts at a rate of the lower of 10.5% annually, or the highest rate permissible by law.

Patient's Signature: ____ **Date** ________________

ARCTIC SPINE GENERAL POLICIES

- We do not fill out disability forms that require an extensive capacity evaluation. If you require these to be filled out, please ask your Primary Care Provider or Pain Management Physician. Alternatively, we can refer you to a Physical Therapist who can perform a Functional Capacity Evaluation (FCE) and complete these forms for you (_______initial)

- If you are undergoing surgery, we can grant you an off-work note for up to 30 days after your surgery date. If you feel you need to be extended off-work after 30 days, we can grant you part-time work status within 30-45 days after your surgery date. Any further extended times off-work after 45 days of your surgery date will not be granted by our office. If you feel that you cannot work after 45 days post-surgery, we can refer you to a Physical Therapist to perform a Functional Capacity Evaluation (FCE) to assess your working ability. (_______initial)

- If you are undergoing surgery, we will require your MRI disc as it will be used intraoperatively. If you require a separate copy of any radiology discs after providing these to us, you can easily obtain them directly from your radiologist / Imaging Center. (_______initial)

ARCTIC SPINE HIPAA DISCLOSURE

Arctic Spine, LLC is committed to keep all information about you and your care private. We may use medical information about you to help with and coordinate your treatment with other doctors, nurses, therapists or other medical personnel.

If there are any health care professionals that you **DO NOT** allow us to release information to, please list:
____

To contact you with appointment, lab or test information we may need to call you by phone. If you are not available, please indicate whether we can leave appointment and lab or test results:

1. On your answering machine or voice mail? (circle one) YES NO
2. With a person who answers your phone? (circle one) YES NO

Please list anyone we are **ALLOWED** to release medical records to, please list name and relationship:
____

Is there anyone who might answer the phone that we **SHOULD NOT** leave this information with, please list:
____

We may be required to disclose medical information about you to insurance companies when required for payment or reimbursement for services. You have a right to inspect, read or obtain a copy or limit the distribution of your medical record.

If you have any questions about your medical record or privacy, you may read a more detailed description, available on request.

Please sign to show you understand the above:

Patient's Signature: ____ **Date** ________________

REVIEW OF SYPTOMS
(PLEASE CIRCLE ANY SYMPTOMS YOU HAVE HAD RECENTLY)

CONSTITUTIONAL
Fevers/chills/sweats
Fatigue
Weight Gain/Loss

EYES
Blurred/Double Vision
Vision Loss
Change in Vision

EARS/NOSE/MOUTH THROAT
Hearing Loss/Ringing in ears
Sore Throat/Congestion

PSYCHIATRIC
Anxiety
Depression
Insomnia

GASTROINTESTINAL
Nausea/vomiting/heartburn
Diarrhea/Constipation
Blood in Stool

GENITOURINARY
Frequent/Urgent Urination
Incontinence
Burning
Sexual Dysfunction

SKIN
Itch/Rash

NEUROLOGICAL
Headaches
Dizziness
Confusion/Memory Loss
Seizures
Weakness
Numbness/Tingling
Balance Problems
Difficulty Walking

MUSCULOSKELETAL
Neck/Back Pain
Joint Pain/Swelling
Use of Cane/Walker

CARDIOVASCULAR
Chest Pain
Palpitations
Swelling of Feet/Ankles

RESPIRATORY
Cough
Wheeze
Shortness of breath

ENDOCRINE
Change in Hat/Glove Size
Heat/Cold Intolerance
Excessive Hunger/Thirst

FAMILY HISTORY (state member of family)
X – SELF / F – FATHER / M – MOTHER / B – BROTHER / S – SISTER
GF – GRANDFATHER / GM – GRANDMOTHER

High Blood Pressure_________
Emphysema_______________
Ulcer______________________
Kidney Problems____________
Osteoporosis_______________
Heart Disease______________
Asthma___________________
Acid Reflux________________
Depression________________
Cancer____________________
Stroke____________________
Cirrhosis__________________

Arthritis____________
Anxiety____________
Diabetes___________
Hepatitis___________
HIV/AIDS___________
Blood Clots_________
High Cholesterol_____
Hypothyroidism______
Bleeding Disorder____
Enlarged Prostate____
Other______________

Drug Allergies & Reaction(s)

____
____
____
____

Current Medication(s)

____
____
____
____

PREFERRED PHARMACY:

____

Have you ever had one of the following conditions? Yes / No

Myocardial Infraction (heart attack) / Pulmonary Embolism / Deep Vein Thrombosis / Other Strokes

If yes, please state when: ____

SOCIAL HISTORY Highest Level of Education ________________________________Occupation ________________________________

Tobacco Use: Y / N Packs per day __________ How many years ________________Date quit ___________________________________

Alcohol Use: Y / N Drinks per week _________ Drug or Substance use? Y / N

Patient's Signature: ____ **Date** _________________

Marius Maxwell, MD, PhD, FACS, FAANS
Board Certified Neurosurgeon
1335 Gambell Street Anchorage, AK 99501 Phone: 907-222-6500 Fax: 907-222-6550

PATIENT'S NAME:______________________________________ **DATE**:____________________

DOB:____________________ **AGE**:_________ **REASON FOR TODAY'S VISIT**:______________________________

REFERRING PROVIDER:________________________________

Please draw on the human figures where and what your symptoms are, according to the following key below:

Burning	Numbness/Tingling	Stabbing	Pins & Needles	Ache	Weakness
XXXXXXX	OOOOOOO	///////	*******	########	+++++++

Date of first occurrence/onset of symptoms:
____

Previous surgeries pertaining to body part:
____
____
____

Have you had conservative therapy?

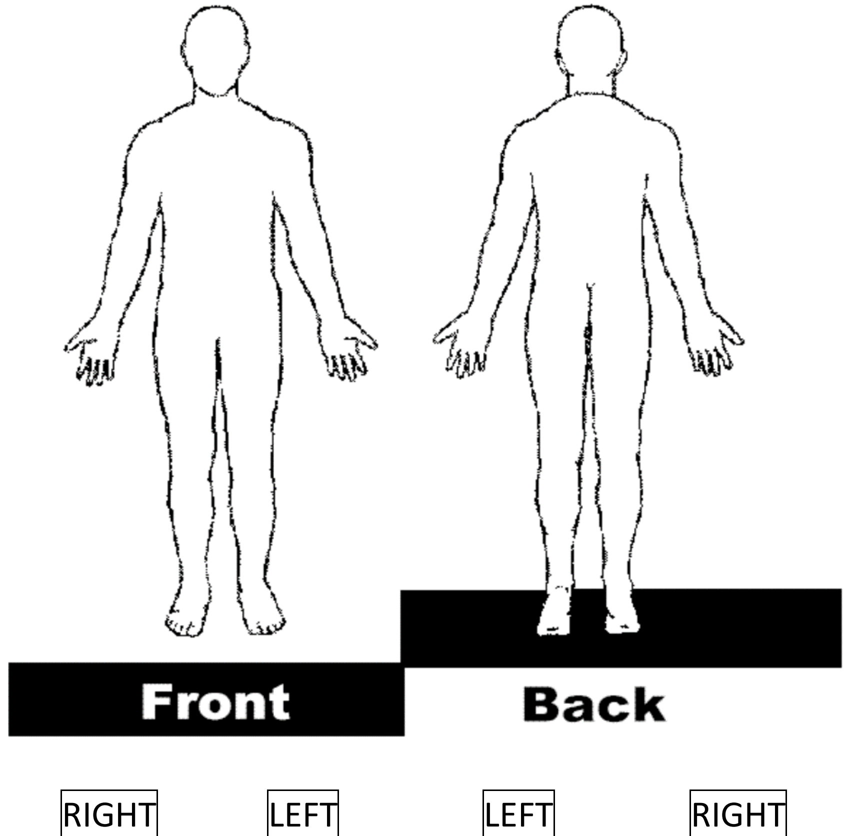
Y/N Injections
- If yes, when? ______________________
- Which clinic? ______________________

Y/N Chiropractic
- If yes, when? ______________________
- Which clinic? ______________________

Y/N Physical Therapy
- If yes, when? ______________________
- Which clinic? ______________________

Y/N Massage therapy
- If yes, when? ______________________
- Which clinic? ______________________

Y/N Acupuncture
- If yes, when? ______________________
- Which clinic? ______________________



RIGHT LEFT LEFT RIGHT

FOR OFFICE USE ONLY:

VITAL SIGNS:

Height:__________ Weight:_____________ Blood Pressure: _____________ Pulse:_________ Temperature: ___________

Physician(s) Signature: ____ Date:__________________