ARCTIC MEDICAL CENTER

3901 Old Seward Hwy. Ste 11. Anchorage, AK. 99503.

Patient Name_____ Date: _____ Email: _____

SS #/SIN_____ DOB_____ ☐ Male ☐Female Cell Phone _____

Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Address _____City _____ State_____ Zip_____

Employer Name: _____

Spouse or Patient's Guardian name_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Arctic Medical Center** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____ (SEAL)
(patient signature)

X_____
(signature of Guardian if applicable)

X_____
(please print patient name)

Primary Care Physician:_____

Other Providers involved with your care_____

HEALTH HISTORY

Where is your primary area of pain?_____

When did this pain begin?_____

Describe the pain: □ sharp □ dull/achy □ burning □ shooting □ tingling

How often is the pain present? □ constantly □ frequently □ intermittently

What makes the pain worse? _____

What makes the pain better? _____

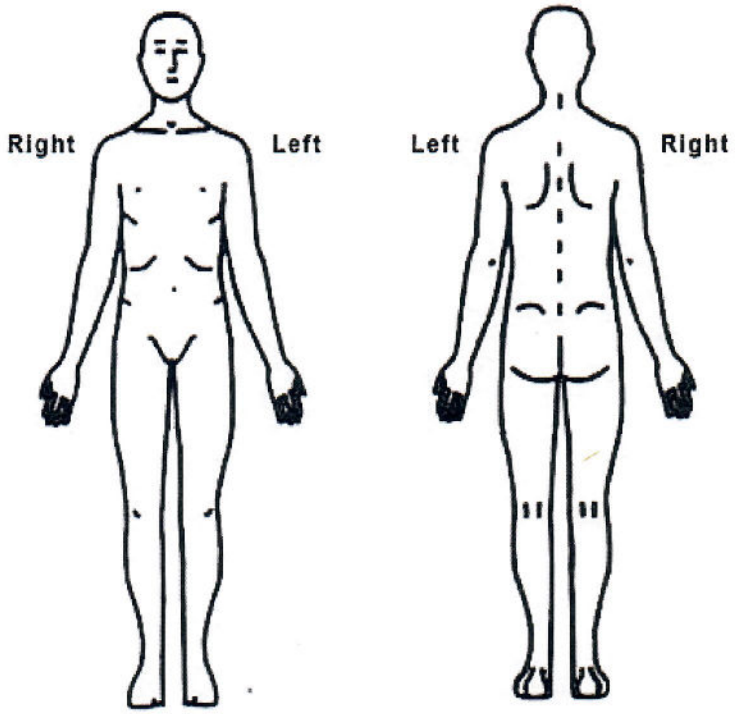
Rate the severity of the pain: with 10 being the worst possible pain imaginable, and 0 being no pain: _____/10

Does the pain radiate/travel? □ No □ Yes. Where to? _____

Any numbness? □ No □ Yes. Where? _____
Any pins-and-needles? □ No □ Yes. Where? _____

How does your pain interfere with you daily life? _____
_____

With an "X", please mark on the diagram below where your main pain is located.



PAST MEDICAL and SURGICAL HISTORY

Have you been diagnosed with, or are you currently being treated for (check all that apply):

- □ Previous heart attack
- □ Depression
- □ Heart arrhythmia
- □ High blood pressure
- □ High cholesterol
- □ COPD or lung disease
- □ Stroke or mini-stroke (TIA)
- □ Asthma
- □ Diabetes
- □ Cancer (type:_____)
- □ Liver disease
- □ Hepatitis
- □ Anxiety
- □ Peripheral Neuropathy
- □ Schizophrenia
- □ Bleeding disorder
- □ Anemia or blood disease
- □ Slow thyroid (hypothyroidism)
- □ Fast thyroid (hyperthyroidism)
- □ Kidney disease (renal failure)
- □ Gastroesophageal reflux disease
- □ Ulcer disease
- □ Intestinal bleeding
- □ Dizziness, unsteadiness or poor balance
- □ Heart surgery or stenting
- □ Prior joint problems
- □ Seizures
- □ Multiple sclerosis
- □ HIV infection
- □ Rheumatoid arthritis
- □ Fibromyalgia
- □ Prior back problems
- □ Prior neck problems
- □ Osteoarthritis (degenerative arthritis)

Are you pregnant, or possibly pregnant? □ Yes □ No

Do you have a pacemaker or defibrillator? □ Yes □ No

List any surgeries you have had—When and Where

_____

_____

_____

_____

Current Medications (prescriptions, over the counter, vitamins, etc)

Name of Medication	Dose of medication?	How often taken?	Why you take it?

Allergies and Reaction:_____

_____

_____

SOCIAL HISTORY

What is your current work status?

□ employed full time □ employed part time □ unemployed □ retired

Occupation_____

Employer_____

Brief description of daily physical activity _____

_____

Marital Status? □ Married/Partnered □ Single □ Divorced □Widowed

Do you smoke or chew tobacco? □ never □ in the past, but quit_____ □ current cigarettes per day ___

Do you drink alcohol? □ never □ in the past, but quit_____ □ current drinks per day _____

Do you use illicit drugs (including marijuana)? □ never □ in the past, but quit_____□ current

CURRENT SYMPTOMS. Circle Yes or No if you are currently experiencing any of these:

Symptom	Yes/No	Symptom	Yes/No	Symptom	Yes/No
Weight loss	Yes/No	Weight gain	Yes/No	Seasonal Allergies	Yes/No
Runny nose	Yes/No	Watery Eyes	Yes/No	Earache	Yes/No
Ear Infections	Yes/No	Hearing loss	Yes/No	Rash	Yes/No
Hair Loss	Yes/No	Itchy skin	Yes/No	Sore throat	Yes/No
Wheezing	Yes/No	Chronic Cough	Yes/No	Shortness of Breath	Yes/No
Cough	Yes/No	Edema	Yes/No	Irregular Heart Rate	Yes/No
Chest Pain	Yes/No	Palpitations	Yes/No		
Dizziness	Yes/No	Fatigue	Yes/No	Weakness/Tiredness	Yes/No
Irritability	Yes/No	Poor Balance	Yes/No	Lightheadedness	Yes/No
Headaches	Yes/No	Migraines	Yes/No	Visual Changes	Yes/No
Forgetfulness	Yes/No	Tremors	Yes/No		
Muscle Aches	Yes/No	Arthritis	Yes/No	Joint Pain	Yes/No
Neck Pain	Yes/No	Shoulder Pain	Yes/No	Elbow Pain	Yes/No
Wrist Pain	Yes/No	Hand Pain	Yes/No	Finger Pain	Yes/No
Midback Pain	Yes/No	Low Back Pain	Yes/No	Hip Pain	Yes/No
Knee Pain	Yes/No	Ankle Pain	Yes/No	Foot Pain	Yes/No
Toe Pain	Yes/No	Other Body Pain	Yes/No		

Patient Name: _____ Date_____

Patient Signature: _____

Signature of Parent/Guardian Responsible: _____

"Life's good when you're pain free!"

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances.

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public Health and Safety - to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government Agencies or Law Enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name	DOB	HR#
Patient's Signature	Date	
Witness	Date	