Arctic Surgical Group

Arctic Laser Spine *Marius Maxwell, MD, PhD*
Arctic Pain *James Price, DO*
Arctic Orthopedics *William Oh, MD J. Michael Gruenwald, MD*
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:_____

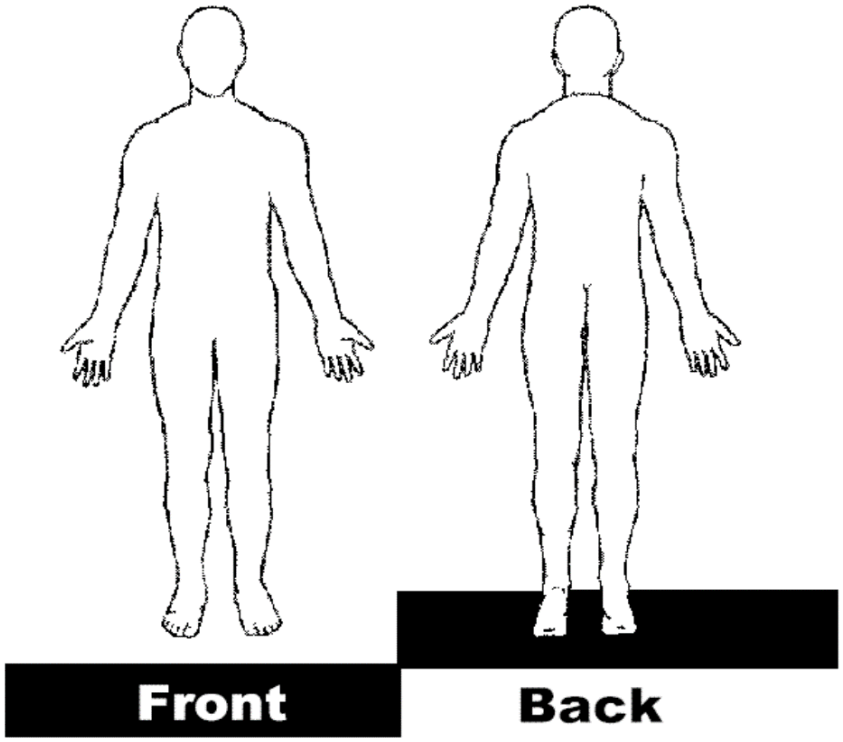
Please draw on the human figures where and what your symptoms are, according to the following key below:

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? _____



FOR OFFICE USE ONLY:

VITAL SIGNS: **BMI**: _____

Height:_____ Weight:_____ Blood Pressure: _____ Pulse:_____ Temperature: _____

Physician(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 / Kidney Disease or Injury

Sexual Dysfunction

SKIN

Itch/Rash

NEUROLOGICAL

Headaches

Dizziness

Confusion/Memory Loss

Seizures / Stroke

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 **Sleep Apnea**

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_____ Arthritis_____

Emphysema_____ Anxiety_____

Ulcer_____ Diabetes_____

Kidney Problems_____ Hepatitis_____

Osteoporosis_____ HIV/AIDS_____

Heart Disease_____ Blood Clots_____

Asthma_____ High Cholesterol_____

Acid Reflux_____ Hypothyroidism_____

Depression_____ Bleeding Disorder____

Cancer_____ Enlarged Prostate____

Stroke_____ Other_____

Cirrhosis_____

Drug Allergies & Reaction(s)

_____

_____

_____

_____

Current Medication(s)

_____

_____

_____

_____

_____

_____

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 _____

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Please mark whether you have pain in any of the following areas:	If yes, please rate your pain scale (1/10 – 10/10) and list any known diagnoses of the area
☐ Right Shoulder	
☐ Left Shoulder	
☐ Right Elbow	
☐ Left Elbow	
☐ Right Wrist	
☐ Left Wrist	
☐ Right Hand	
☐ Left Hand	
☐ Right Hip	
☐ Left Hip	
☐ Right Knee	
☐ Left Knee	
☐ Right Ankle	
☐ Left Ankle	
☐ Right Foot	
☐ Left Foot	

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First Name:	**Middle:**	**Last:**	**Suffix:**	**Nickname:**	**DOB:**

Address:	Zip:	City:	State:
Billing Address:	Zip:	City:	State:

Home Phone:	Cell Phone:
Emergency Contact Number: Emergency Name: Relationship:	Patient Email:

Social Security Number (Required for insurance purposes):	Gender:	Marital Status: Single/Married/Divorced/Widowed
Primary Care Physician:	Referred By:	

Ethnicity: Hispanic or Latino / Not Hispanic or Latino
Race: Asian / Black or African American / Native American / White/Caucasian / Other:

Primary Insurance:	**Secondary Insurance:**
Subscriber/Member Name & Date of Birth:	Subscriber/Member Name & Date of Birth:
Insurance Company:	Insurance Company:
Member ID No:	Member ID No:
Group No:	Group No:

Workers Comp or Auto Accident

Insurance Company:	Adjustor's Name:		
Phone:	Case #:	Date of Injury:	
Insurance Company Address:	City:	State:	Zip:

Preferred Pharmacy:

Name & Address:	Phone:

Preferred LAB Facility:

Name & Address:	Phone:

Employment:

Employer:	Occupation:		
Work Address:	City:	State:	Zip:
Work Phone:	Start Date:	End Date:	

ARCTIC SURGICAL GROUP FINANCIAL POLICY

- We are an out-of-network provider, but your plan may process your claims with us at an in-network benefit level. Our office can assist you in obtaining an 'out-of-network exception' or 'benefit level exception' (if applicable). 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 Surgical Group'. (_____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 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 SURGICAL GROUP 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 SURGICAL GROUP 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.

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 those you authorize us to send information about your health status:

1. Name: _____ Relationship: _____
   Preferred method of communication:
   - ☐ Phone: _____ Able to leave a detailed voice message? Yes ___ No ___
   - ☐ Email: _____

2. Name: _____ Relationship: _____
   Preferred method of communication:
   - ☐ Phone: _____ Able to leave a detailed voice message? Yes ___ No ___
   - ☐ Email: _____

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** _____