APEX Neurosurgery, LLC

2925 Debarr Rd. Ste. D 210, Anchorage, AK 99508

P: (907) 222-2739 F: (907) 222-2746

Today's Date: _____ Primary Doctor: _____

How did you hear about us? _____ Friend _____ Ref'd By Doctor _____

Patient Name: _____ ____ M _____ F Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Phone: _____ Cell Phone: _____

E-mail Address: _____ Race: _____ ____ Hispanic _____ Non-Hispanic

Occupation: _____ Employer: _____ Employer Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information (Please give Insurance Cards to the Receptionist)

Primary Insurance Information:

Insurance Name: _____ ID#: _____ Group#: _____

____ Self ____ Spouse _____ Other Name of Policy Holder (if not you): _____ DOB: _____

Secondary Insurance Information:

Insurance Name: _____ ID#: _____ Group#: _____

____ Self ____ Spouse _____ Other Name of Policy Holder (if not you): _____ DOB: _____

Injury Information:

Is this visit due to an injury? ____ Yes _____ No If yes, how did you get injured? _____

Is this Workman's Comp? _____ Insurance Name: _____

Claim#: _____ Date of Injury: _____ Adjuster's Name: _____

Phone #: _____

By signing this form I am stating that the above information is true to the best of my knowledge. I authorize my insurance benefits be paid to the physician. I understand that I am financially responsible for any balance and that my insurance is being billed by Apex Neurosurgery as a courtesy. I also authorize Apex Neurosurgery, LLC or insurance company to release any information required to process my claims. If my insurance company does not pay within 90 days, I understand I will be responsible for payment of any and all claims.

Patient/Guardian Signature: Date:

Apex Neurosurgery

Name: _____ **Referring Provider:** _____

Primary Care Provider: _____

Reason for visit: _____

Date of Onset: _____ **Is this a work related injury?** _____

Personal History

High Blood Pressure	Heart Disease	Stroke	Diabetes	High Cholesterol
Emphysema	Asthma	Cirrhosis	Hepatitis	Hypothyroidism
Ulcer	Acid Reflux	Arthritis	HIV/AIDS	Bleeding Disorder
Kidney Problems	Depression	Anxiety	Blood Clots	Enlarged Prostate
Osteoporosis	Cancer	Other		

Past Surgeries, Illness, injuries (please include dates and surgeon, if known): _____

_____

Drug Allergies: _____

Medications, Dosage and how you take it: _____

_____

Social History

Occupation: _____ **Last day worked:** _____

Tobacco Use: Yes / No **Packs per day:** _____ **Years:** _____ **Quit Date:** _____

Marijuana Use: Yes / No **Daily?** _____ **Occasional?** _____ **Quit Date:** _____

Alcohol Use: Yes / No **# of Drinks Per Week:** _____ **Any Other Drugs or Substances used:** _____

Family History

High Blood Pressure	Heart Disease	Stroke	Diabetes	High Cholesterol
Emphysema	Asthma	Cirrhosis	Hepatitis	Hypothyroidism
Ulcer	Acid Reflux	Arthritis	HIV/AIDS	Bleeding Disorders
Kidney Problems	Depression	Anxiety	Blood Clots	Enlarged Prostate
Osteoporosis	Cancer	Other		

REVIEW OF SYSTEMS (Please circle any symptoms you have currently)

Constitutional:
Recent weight Loss
Fatigue
Diminished energy

Neurologic:
Visual Loss or Change
Double Vision
Eye pain
Hearing loss
Ringing in ears
Feeling Depressed
History of seizures
Numbness/Tingling
Unexplained loss of Consciousness
Sleep Disturbances
Vertigo
Difficulty with speech
Swallowing Difficulty
Headache
Weakness
Change in Bowel Habits
Gait/Balance/Coordination Problem
Sexual Disfunction

Gastrointestinal:
Abdominal Pain
Diarrhea
Abdominal Distention
Constipation

Genitourinary:
Incontinence
Blood in Urine
Polyuria-increased urine output
Frequent Urination
Hallucinations
Nocturia-Wake up a lot at Night to Urinate
Recurrent Infections
Hesitancy

Hematology:
Bleeding Episodes

Respiratory:
Wheezing
Orthopnea-SOB when lying flat
Hemoptsis-spitting up blood
Cough

Integumentary:
Rashes
Skin Lesions
Bruises
Tattoo

Cardiovascular:
Chest Pain
Palpitations
Edema

Endocine:
Weight gain
Weight Loss
Recent Change in Weight
Heat intolerance
Bone Loss

Musculskeletal:
Muscle Loss/Atrophy
Muscle Cramps
Muscle Twitching
Muscle Pain
Neck Pain
Back Pain
Joint Pain/Swelling

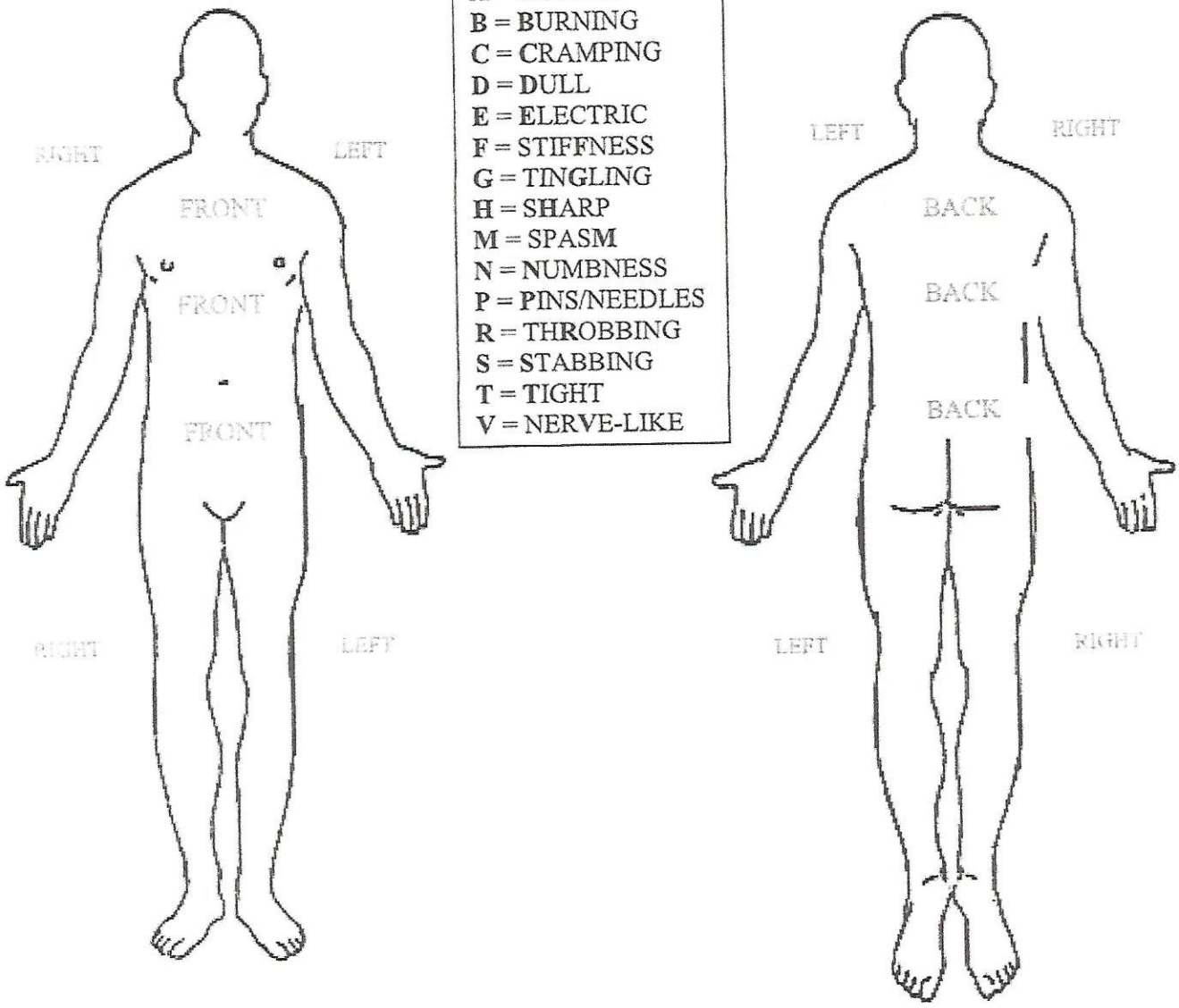
Psychiatric:
Feeling Suicidal
Anxious
Delusions
Appetite change
Loss of Interest

Name: _____ Date of Birth:_____

Today's Date:_____ MRN(Office Use):_____ P: 5/5

Please indicate the location and type of pain you experience on the diagram below, using the appropriate letter(s) from the chart below.

A = ACHING	**N** = NUMBNESS
B = BURNING	**P** = PINS/NEEDLES
C = CRAMPING	**R** = THROBBING
D = DULL	**S** = STABBING
E = ELECTRIC	**T** = TIGHT
F = STIFFNESS	**V** = NERVE-LIKE
G = TINGLING	
H = SHARP	
M = SPASM	



NO PAIN |---------|---------|---------|---------|---------|---------|---------|---------|---------|---------| WORST PAIN

PATIENT Signature: _____ Date: _____

If this packet was completed by someone other than the patient, please list name, relation to the patient and the reason the patient was unable to complete the packet: _____

Apex Neurosurgery

Medicine Refill Agreement

Apex Neurosurgery would like to make sure the medication refill process as easy as possible for all our patients. Therefore, we have developed a few guidelines to inform you of the process for requesting refills on your medications.

1. Please allow at least 48-72 hours to process your medication refills. Due to unpredictable surgery schedule medication refills will not be approved or signed same day.
2. Be aware, we do not refill any medications on Fridays or over the weekend. Once your refill is approved by the provider, we will call you it pick up the prescription at the office during usual office hours of 9:00am-5:00pm.
3. Please give the office advanced notice if your mediations are due to run out over a holiday weekend or if you are going out of town. Again, it could take 48-72 hours for the request to be approved.
4. Please notify us immediately if you have any drug allergies or side effects from any medications.
5. Some medications can be phoned or faxed into the pharmacy. Prescription will still need to be approved by the provider. Once your prescription has been approved we will call or fax it to the pharmacy of your choice.
6. If you live out of town we will mail your prescription(s) to you or the pharmacy of your choice. It can take up to 7 days for the prescriptions to reach them or you. The prescription will be sent registered mail with return receipt, so it will need to be signed for. If sent to you, you will then need to take it to the pharmacy to be filled. Our office has no control over how quickly the prescription will arrive in the mail. Please give us plenty of notice to avoid running out of medication.
7. For your safety, it is important that you take all medicines **as prescribed** and routinely update your current medication list in our records to avoid contraindications with your prescriptions. You may only receive pain medications from one (1) provider. **Under NO circumstance we will replace lost, stolen or destroyed narcotics or any other type of medication.** We will not refill medications until that prescription is due to be filled.
8. **We will be checking medication history with your pharmacy**. If at any time there is a question of medication abuse, for example reports from a pharmacy of multiple prescribers, police department or other healthcare provider reporting a problem, we reserve the right to refuse to refill medications. We would be happy to refer you to a Pain Management provider for monitoring of medications.

Please tell us your preferred pharmacy:

Pharmacy name: _____

Phone #: _____ Fax # (if known): _____

By signing below, you acknowledge that you have provided Apex Neurosurgery the correct information and have read an **CLEARLY understand** the instructions above.

Patient Signature: _____ Date: _____

****IF YOU HAVE A PAIN MANGEMENT PROVIDER OR PAIN CONTRACT PLEASE LIST THAT INFORMATION BELOW**

Office/Providers Name: _____

Phone #: _____ Contract date (if known): _____

Employee Signature: _____ Date: _____

Apex Neurosurgery

Financial Policy

- If you wish Apex Neurosurgery to bill your insurance, please provider our office with your Social Security Number and a copy of your insurance card or if it's work comp we will need the Adjuster's name, phone number, your claim number and date of injury. If you do not have an insurance card, please contact your HR person or insurance to have a new card sent to you. This information is necessary to enable us to file the claim for you. Also, if work comp please notify your adjuster that you have an appointment with Apex Neurosurgery.
- If you have insurance Apex Neurosurgery will, as a courtesy, bill your insurance. If your insurance does not respond or pay the claim within 90 days of the date of service, you may be billed for the full amount. We will make every effort to contact your insurance to find out the status of your claim and make any necessary corrections to the claim to get it paid within a reasonable amount of time. Please understand the ultimate responsibility for payment is yours as the patient. Should your insurance deny payment or only cover a portion of the claim the balance on your account will become your responsibility.
- You are responsible for payment of any copay that is due at the time of your visit. If you have not met your deductible you will be responsible for paying the remaining amount of your deductible in addition to any copay you might have.
- If you are covered by Medicaid/Denali Care you will have a $3.00 copay for each visit. Please have that with you for each visit. You must have your card available to be copied at your initial visit.
- At any time if you have questions regarding your account please feel free to call our billing service at (907) 563-1777.
- If you have a balance on your account and would like to make payment arrangements, please call the billing service to set up a payment plan with them. All delinquent accounts may be turned over to collections after the third billing cycle.
- There will be a $35 insufficient fund charge for all returned checks.
- Surgery patients with no insurance will be asked to pay a portion of the amount being charged for surgery. Payment arrangements will then be made for the remaining balance.

Patient's Name: _____

Patient's Signature: _____

Date: _____

Apex Neurosurgery

HIPAA Compliance Agreement

In order to comply with the federal government regulations, Apex Neurosurgery, is required to have a document available to you that explains our patient privacy information policy. There is a copy of this policy located at the Front Desk Reception area if you wish to review it.

Please sign and date to acknowledge you have been informed of our policy.

Patient's Name (print please): _____

Patient's Signature: _____

Authorization to release information to the following person(s)

I authorize Apex Neurosurgery to release all medical and financial information to include medication, surgical and appointment details to the following:

Person's Name	**Relationship to Patient**	**Date of Birth**
1.		
2.		
3.		
4.		

Consent to use for Disclosure of Health Information

For Treatment, Payment or Coordination of care with other healthcare Providers

I hereby consent to the use or disclosure of my individual identifiable health information by Apex Neurosurgery in order to carry out treatment, payment or coordination of care with other healthcare providers.

At all times I retain the right to revoke this consent. Such revocation must be submitted to Apex Neurosurgery in writing. This revocation shall be effective except in those instances that occurred prior to revocation. By signing below, I have read and understand this information. I am the patient or the individual authorized to act on behalf of the patient.

Patient/Authorize Individual Signature: _____

Date: _____

APEX
NEUROSURGERY, LLC.
DR. BRIAN MILLER

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Printed Name of Patient or Personal Representative	Relationship to Patient
_____	_____
Printed Name of Witness	Employee Job Title
_____	_____
Signature of Witness	Date