New Patient Registration Form

Please complete all sections (Please Print)

Today's Date: / /

Patient's Legal Name: Last First Middle Initial

Marital Status ☐ S ☐ M ☐ D ☐ W

Sex ☐ M ☐ F

Mailing Address

Birth Date: / /

City State Zip

Home Telephone

May we leave a message? Yes ☐ No ☐

Social Security #

Cellular Telephone

May we leave a message? Yes ☐ No ☐

Work Telephone

May we leave a message? Yes ☐ No ☐

Email Address

Handedness ☐ Left ☐ Right

Race ☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Indian ☐ Native

Preferred Pharmacy

Occupation

Alternate Contact Name

Relationship

Telephone

Referring Physician

Primary Care Physician

Is there a Medical Power of Attorney (MPOA) for this patient? ☐ Yes (signed copy must be provided) ☐ No

If yes, name of MPOA:

Chief Complaint (What is the reason for your appointment today?):

Who are we authorized to speak with about your health information?

INSURANCE INFORMATION

Name of Financially Responsible Person (if different from Patient):

☐ Spouse ☐ Parent ☐ Other_____

Address (if different from Patient):

Home Telephone

Alternate Telephone

Primary Health Insurance Co. Name

Policy Holder

Policy Holder's Relationship to the Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

ID/Policy No.

Group No.

Policy Holder's DOB / /

Secondary Health Insurance Co. Name

Policy Holder

Policy Holder's Relationship to the Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

ID/Policy No.

Group No.

Policy Holder's DOB / /

Tertiary Health Insurance Co. Name

Policy Holder

Policy Holder's Relationship to the Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

ID/Policy No.

Group No.

Policy Holder's DOB / /

I understand that I am responsible for all charges for services provided by Alaska Brain Center, LLC. As a courtesy, Alaska Brain Center, LLC will bill my insurance company. I authorize my insurance benefits to be paid directly to Alaska Brain Center, LLC. I authorize Alaska Brain Center, LLC to release any information necessary to my insurance company required to process my claims. I am responsible for any coinsurance, co-pays, or deductibles due at time of service. I understand that I am responsible for any portion not paid by my insurance company, and that any balance due must be paid within 90 days. I understand that after 90 days, my unpaid account balance will be turned over to collections, and a service charge may be assessed.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

Printed Name: _____

ALASKA BRAIN CENTER, LLC
Jeffrey L. Sponsler MD, MS
Diplomate of American Board of Psychiatry and Neurology
Board Certified in Electrophysiology
4551 East Bogard Road
Wasilla, Alaska 99654
Phone: (907) 373-6500 Fax: (888) 456-0663

Office Policies for Alaska Brain Center, LLC

Services:
Alaska Brain Center, LLC is a specialty clinic. We do not treat primary care issues. We require our patients to have a primary care physician. If you do not have a primary care physician, we can provide you with a list of local physicians.

Medication Policy:
Please be aware that the providers in this office do not prescribe pain medications classified as controlled substances. Examples include: codeine, hydrocodone, oxycodone, morphine, Demerol, methodone, cannabis, and Marinol. Requests for controlled substance medications may be grounds for discharge from our clinic. We will make a referral to a pain management specialist if appropriate.

Professionalism:
The providers and staff of Alaska Brain Center, LLC strive to maintain the upmost professionalism with our patients and with colleagues in other medical offices. Complaints regarding other providers are not clinically useful. Our providers and staff will not make adverse statements against other offices.

Financial Policy:
Alaska Brain Center requires payment in full at the time of the visit with check, cash or debit/credit card. The other option is for us to submit a claim to your insurance company as a courtesy. ANY INSURANCE CLAIMS DENIED OR REMAINING UNPAID AFTER 60 DAYS WILL BE SENT TO COLLECTIONS. **Account Responsibility:** Many people are under the impression that if they have insurance, it is the insurance company that owes the doctor for their services. This is not the case. **The insurance contract is between you and the insurance company.** Therefore you are responsible for the charges incurred, regardless of the insurance coverage. Any expense incurred collecting delinquent accounts is added to the account balance. Insurance companies may deny claims based on factors in your contract which may include: High Individual deductibles, Fee limitations and claim percentages, Well care or preventative services. "USUAL and CUSTOMARY" fee limitations on services. (Insurance companies set their national standards arbitrarily and they are not required to reflect the higher cost of living in Alaska.) If you have no insurance, we require payment in full cash or check at the time of service provided. If the check comes back as NSF a $30.00 collection fee is added. All co-pays and deductibles are due at the time of service. It is the patient's responsibility to know their co-pay amount, and if they have met their deductible and out-of-pocket for the year. Patients with Medicaid are expected to make their $3.00 co-pay at each visit. Patients with Medicare, TRICARE (standard), are not required to make a payment at the time of service unless yearly deductable has not been met. Patients with multiple insurances are not required to make a payment at the time of service unless the patient responsibility from an old claim has not been paid, or both insurance deductibles have not been met. We DO NOT accept Workman's Comp or Auto Insurance.

Medical Records Request:
Requests for a copy of a patient's records must be made by the patient or authorized contact. Records will be placed in a CD unless otherwise specified. First copies are free of charge. Any other copies after that will have a $20 service charge for CDs, $30 for paper records, and $35 for any amount over 25 pages. Pre-payment is required. There is no charge for records sent to another provider for coordination of care for further treatment. We will make every effort to process your request within 48 hours.

Missed Appointments:
We reserve your scheduled appointment time specifically for you. When you cancel or miss your appointment, this takes valuable time away from another patient waiting to be seen in our clinic. Patients who cancel or miss appointments without a valid reason may be discharged from our clinic. If you arrive 15 minutes late your appointment will be rescheduled. After 3 rescheduled/missed/canceled appointments you will be discharged from our clinic.

Prescription Refills:
Please allow 24-48 hours for prescription refill requests. You may contact your pharmacy and ask them to fax us a refill request form.

I have read, understand, and agree to comply with the above policies.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Authorization to Release Medical Information

1. I AUTHORIZE:

_____
Name of organization/Dr. Office

_____
Street Address

_____
City State Zip Code

2. TO RELEASE TO:

JEFFREY L. SPONSLER, MD
ALASKA BRAIN CENTER, LLC
4551 E. BOGARD ROAD
WASILLA, AK 99654
Phone: 907-373-6500
Fax: 888-456-0663

3. **INFORMATION TO BE RELEASED:** (Check all applicable)

☐ All Information ☐ History and Physical ☐ Progress Reports ☐ Imaging Reports
☐ EEG Reports ☐ EMG Reports ☐ Lab Reports ☐ Operative Reports
☐ Other: _____

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

4. **RECORDS FROM THE TIME PERIOD:** ____/____/____ through ____/____/____
5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal ☐ Personal
☐ Workers' Compensation Claim ☐ Other: _____

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken.
7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.
8. The requestor may be provided with a copy of this authorization.

Patient's Signature: _____ Date: _____

Patients' Name (Please Print) _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Revised 12-30-14

Acknowledgment of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy my mail, fax, or in person.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Signature: _____

Print Name: _____

Date: _____

Witness: _____

MEDICAL HISTORY **Do you have or had any of the following?**

Arthritis? Yes No If yes, (please circle) Osteo Rheumatoid Gout Other: _____ Year diagnosed: _____

Allergies, Enviornmental? Yes No If yes, Year diagnosed: _____

Anemia? Yes No If yes, Year diagnosed: _____

Asthma? Yes No Year diagnosed: _____

Mental Illness? Yes No If yes, (please circle) Bipolar Affective Disorder Schizophrenia Panic Disorder Other: _____ Year diagnosed: _____

Incontinence? Yes No If yes, (please circle) Bladder Bowel Year diagnosed: _____

Bronchitis? Yes No If yes, (please circle) Acute Chronic Year diagnosed: _____

Cancer? Yes No If yes, (please circle) Breast Cervical Colon Lung Melanoma Prostate Skin Testicular Year diagnosed: _____

Cardiac (heart)? Yes No If yes, please explain: _____ Year diagnosed: _____

COPD? Yes No Year diagnosed: _____

Vision ? Yes No If yes, (please circle) Cataracts Glaucoma Detached Retina Other: _____ Year diagnosed: _____

Thyroid? Yes No If yes, (please circle) Cushing's Disease Hypothyroidsim Other: _____ Year diagnosed: _____

Vascular? Yes No If yes, (please circle) Deep Vein Thrombosis Peripheral Vascular Disease Pulomonary Embolism Other: _____

Depression? Yes No Year diagnosed: _____

Diabetes? Yes No If yes, (please circle) Adult Onset Juvenile Onset Year diagnosed: _____

Abdominal? Yes No If yes, (please circle) Diverticulosis Gastric Ulcer GERD Hiatal Hernia Other: _____ Year diagnosed: _____

Hepatitis? Yes No If yes, (please circle) A B C Year diagnosed: _____

Herpes Zoster? Yes No If yes, (please circle) Chicken Pox Shingles Year diagnosed: _____

High Blood Pressure? Yes No Year diagnosed: _____

Low Sodium? Yes No Year diagnosed: _____

Low Potassium? Yes No Year diagnosed: _____

Low Magnesium? Yes No Year diagnosed: _____

Kidney? Yes No If yes, (please circle) Infection Transplant Stones Failure Year diagnosed: _____

Liver Disease? Yes No Year diagnosed: _____

Overian Cyst? Yes No Year diagnosed: _____

Pain? Yes No If yes, (please circle) Chronic Neck Chronic Low Back Chronic Muscle Year diagnosed: _____

Pneumonia ? Yes No Year diagnosed: _____

Phychosis? Yes No Year diagnosed: _____

Reynauld's Phenomenon? Yes No Year diagnosed: _____

Sarcoidosis? Yes No Year diagnosed: _____

Sinus Infections? Yes No Year diagnosed: _____

Skin Disorder? Yes No Year diagnosed: _____

Tuberculosis? Yes No Year diagnosed: _____

Other: (please explain) _____ Year diagnosed: _____

FRACTURE HISTORY Please list all previous fractures and the year it occurred.

_____

_____

SURGICAL HISTORY Please list all previous surgeries and the year.

_____

_____

FAMILY HISTORY **Father**: Age (or age at death) _____ Alive? ___ **Mother**: Age (or age at death) _____ Alive? ___(please list Mother, Father, or both below)

Alcohol Heavy Use: _____ **Arthritis**: _____ **Asthma:** _____ **Bleeding disorder**: _____ **Bipolar Affective Disorder**: _____

Cancer: (type) _____ Father Mother Both **Clotting Disorder**: _____ **Depression**: _____ **Dementia**: _____

Diabetes: _____ **Epilepsy**: _____ **Emphysema**: _____ **Glaucoma**: _____ **Heart Disease:** _____

High Blood Pressure: _____ **Kidney**: _____ **Lung**: _____ **Miscarriages**: _____ **Migraines**: _____ **Multiple Sclerosis** _____

Parkinson's: _____ **Schizophrenia**: _____ ***Seizures**: _____ **Smoking History**: _____ **Stroke**: _____ **Thyroid**: _____

Tremor: _____ **Tuberculosis**: _____ **Other**: _____

NEUROLOGICAL HISTORY **Do you have or had any of the following?**

Aneurysm? Yes No Aneurysm Coiling? Yes No Year diagnosed: _____

Lou Gehrig's Disease? Yes No Year diagnosed: _____

Autism? Yes No Year diagnosed: _____

Bells Palsy? Yes No Year diagnosed: _____

Blindness? Yes No If yes, (please circle) Left eye Right eye Year diagnosed: _____

Brain Tumor? Yes No If yes, (please circle) Astrocytoma Benign Malignant Year diagnosed: _____

Carotid Stenosis? Yes No If yes, (please circle) Left Right Year diagnosed: _____

Carpal Tunnel Syndrome? Yes No If yes, (please circle) Left Right Year diagnosed: _____

***Closed Head Injury**? Yes No If yes, (please circle) No Loss of Consciousness (LOC) LOC <1hr LOC >1hr Year: _____

Degenerative Disc Disease? Yes No If yes, (please circle) Cervical Lumbosacral Thoracic Year diagnosed: _____

Dementia? Yes No If yes, (please circle) Alzheimer's Vascular Year diagnosed: _____

***Development Delay**? Yes No If yes, (please circle) Mild Moderate Severe Year diagnosed: _____

Diabetic? (please circle) Neuropathy Retinopathy Year diagnosed: _____

Eclampsia? Yes No Year diagnosed: _____

***Epilepsy/Seizures/Febrile Seizures?** Yes No

Fainting Spells? Yes No Year diagnosed: _____

Fetal Alcohol Syndrome? Yes No Year diagnosed: _____

Headache? Yes No If yes, (please circle) Migraine Cluster Sinus Tension Year diagnosed: _____

Huntington's Disease? Yes No Year diagnosed: _____

***Meningitis, Bacterial**? Yes No Year diagnosed: _____

Menieres Disease? Yes No Year diagnosed: _____

Multiple Sclerosis? Yes No Year diagnosed: _____

Neuropathy? Yes No Year diagnosed: _____

Parkinson's Disease? Yes No Year diagnosed: _____

Restless Leg Syndrome? Yes No Year diagnosed: _____

Stroke/ Transient Ischemic Attack (TIA)? Yes No Year diagnosed: _____

Tremor? Yes No Year diagnosed: _____

Vertigo? Yes No Year diagnosed: _____

Venriculo Peritoneal Shunt? Yes No Year diagnosed: _____

Other: (please explain) _____ Year diagnosed: _____

SOCIAL HISTORY

Marital Status (please circle) Single Married Divorced Separated Cohabitation Widowed

Street drugs: (please list) _____

Alcohol: Number of drinks per week _____

Tobacco: (please circle current use) None ½ pack 1 pack 2 packs 3 packs Chew Number of years (if if quit) _____ Year quit _____

Are you driving? Yes No

PERSONAL HISTORY

Live with: (please circle) Alone Spouse Parents Son/Daughter Friend Family Sibling Grandparent

Education: (please circle highest level) 6 7 8 9 10 11 12 Some College AA BA Masters PHD MD

Occupation: _____

Number of Children: _____

DRUG ALLERGIES

Drug: _____ **Reaction**: _____ **Year**: _____

Drug: _____ **Reaction**: _____ **Year**: _____

Drug: _____ **Reaction**: _____ **Year**: _____

CURRENT MEDICATIONS

Prescription Name: _____ **Dose**: _____ **Number**: _____ **How often**: _____

Prescription Name: _____ **Dose**: _____ **Number**: _____ **How often**: _____

Prescription Name: _____ **Dose**: _____ **Number**: _____ **How often**: _____

Prescription Name: _____ **Dose**: _____ **Number**: _____ **How often**: _____