# 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: _____

## ***MEDICAL HISTORY*** Circle any that **YOU** have and indicate the year of onset

**Alcohol Abuse**_____
**Allergies, Environmental**_____
**Anemia**_____
**Antiphospholipid Antibody**___
**Anxiety Disorder**_____
**Aortic Aneurysm:**
Abdominal Thoracic
**Appendicitis**_____
**Arthritis:**
Rheumatoid_____
Osteo_____ other_____
**Asthma** _____
**Bipolar Affective Disorder**____
**Bladder Incontinence**_____
**Bowel Incontinence**_____
**Bronchitis:**
Acute_____
Chronic_____
**Cancer:**
Cervical Colon Lung
Breast Melanoma Prostate
Skin Testicular
**Cardiac:**
Explain_____
Year Diagnosed_____
**Cataracts** _____
**Chronic-Obstructive-Pulmonary-Disease**_____
**Coronary-Artery-Disease**____

**Crohn's Disease**_____
**Cushings Disease**_____
**Detached Retina**_____
**Deep Venous Thrombosis**____
**Depression**_____
**Diabetes:**
Adult onset_____
Juvenile onset_____
**Diabetic Neuropethy**_____
**Dilatation and Curretage** ____
**Diverticulosis**_____
**Emphysema**_____
**Endometriosis**_____
**Epilepsy or Seizures**_____
**Fainting Spells (Dizziness)**___
**Fibrocystic Breast Disease**___
**Fibromyalgia**_____
**Gastric ulcer**_____
**Gastro Esophageal Reflux**____
**Glaucoma**_____
**Headache**_____
**Hemophilia**_____
**Hepatitis History:** A B C
**Herpes Zoster:**
Chickenpox Shingles
**Hiatal Hernia**_____
**Hypoglycemia**_____
**Hypothyroidism**_____
**Hyperthyroidism**_____
**Hyperlipidemia**_____

**Irritable Bowel Syndrome**____
**Hypertension**_____
**Kidney:**
explain_____
**Liver Disease**_____
**Osteoporosis**_____
**Ear Infection**_____
Otitis Externa Otitis Media
**Ovarian Cyst**_____
**Pain, Chronic:**
neck back muscle
**Panic Disorder**_____
**Peripheral Vascular Disease**__
**Pneumonia**_____
**Prosthetics:**
explain_____
**Psychosis**_____
**Pulmonary Embolism**_____
**Renal Artery Stenosis**_____
**Schizophrenia**_____
**Sinus Infections**_____
**Systemic-Lupus Erythematosis**_____
**Tuberculosis**_____
**Ulcer**_____
**Ulcerative Colitis**_____
**Urinary Tract Infection**_____
**Other**_____
**Other**_____
**Other**_____

### ***FAMILY HISTORY***-

Father: Age (or age at death)_____ Alive? Y N
Mother: Age (or age at death)_____ Alive? Y N

**Indicate family member:** **M**other, **F**ather, **B**oth

Alcohol use:
Arthritis:
Asthma:
Bleeding disorder:
Bipolar affective disorder:
Cancer (type):
Clotting disorder:
Depression:
Dementia:
Diabetes:
Epilepsy:
Emphysema:
Glaucoma:
Heart Disease:

High Blood Pressure:
Kidney:
Lung:
Miscarriages:
Migraines:
Multiple Sclerosis:
Parkinson's:
Schizophrenia:
*Seizures:
Stroke:
Smoking history:
Thyroid:
Tremor:

### ***Surgery History***-

Please list all previous surgeries and year occurred:

_____
_____
_____
_____
_____
_____
_____

### ***Fracture History***-

Please list all previous fractures and year occurred:

_____
_____
_____
_____
_____
_____
_____

## Neurological History

Please circle any that you have and indicate year.

**Aneurysm**_____

**Aneurysm Coiling**_____

**Amyotrophic Lateral Sclerosis, ALS**_____
(Lou Gehrig's Disease)

**Arteriovenous Malformation**_____

**Autism**_____

**Bells Palsy**_____

**Blindness:** right left _____

**Brain Tumor:**_____
Astrocytoma Benign Malignant

**Carotid Stenosis** right left _____

**Carpal Tunnel Syndrome** right left

**Cervical neck pain** _____

**Closed Head injury LOC no LOC** _____
If LOC how long_____

**Degenerative Disc Disease:** _____
Cervical Lumb Thoracic

**Dementia or Alzheimer's**_____

**Developmental delay**
mild moderate severe _____

**Diabetic: retinopathy neuropathy** _____

**Encephalitis**_____

**Epilepsy**_____

**Fainting spells**_____

**Fetal Alcohol Syndrome**_____

**Headache:** _____
migraine cluster sinus tension

**Hydrocephalus**_____

**Meningitis**_____

**Meniere's disease**_____

**Multiple sclerosis**_____

**Myasthenia Gravis**_____

**Huntington's disease**_____

**Meningioma glioblastoma** _____

**Neuropathy** _____

**Parkinson's Disease**_____

**Restless leg syndrome**_____

**Seizures**_____

**Stroke**_____

**Transient Ischemic Attack**_____

**Tremor Essential tremor** _____

**Trigeminal neuralgia**_____

**Tourette's Syndrome**_____

**Optic neuritis**_____

**Vertigo**_____

**Other (please explain)**_____

## Social History

**Marital status:**

single married divorced

separated cohabitation widowed

**Street Drugs:** _____

**Alcohol:** number of drinks

per day_____ Per week_____

**Tobacco use:** packs per day_____

**Are you driving?** Yes No

## Personal history

Who do you live with?_____

Education level_____

Occupation_____

Number of children_____

## Drug Allergies

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

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

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

## Medications

**Drug:** _____ **Dosage:**_____ **Year**_____

**Drug:** _____ **Dosage:**_____ **Year**_____

**Drug:** _____ **Dosage:**_____ **Year**_____

**Drug:** _____ **Dosage:**_____ **Year**_____

**Drug:** _____ **Dosage:**_____ **Year**_____

**Drug:** _____ **Dosage:**_____ **Year**_____

**Drug:** _____ **Dosage:**_____ **Year**_____

ALASKA BRAIN CENTER

4551 East Bogard Road,
Wasilla, Alaska 99654

Phone 907-373-6500
Fax 888-456-0663
http://akbraincenter.com

**Jeffrey L. Sponsler MD, MS**

## EPWORTH SLEEPINESS SCALE

Name: _____ Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 – Would **never** doze
1 – **Slight chance** of dozing
2 – **Moderate chance** of dozing
3 – **High chance** of dozing

***It is important that you answer each question as best as you can.***

| SITUATION | CHANCE OF DOZING (0-3) |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting, inactive in a public place (e.g., in a theater or a meeting) | |
| As a passenger in a car for an hour without a break | |
| Lying down to rest in the afternoon when circumstance permit | |
| Sitting and talking to someone | |
| Sitting quietly after lunch without alcohol | |
| In a car, while stopped for a few minutes in traffic | |
| TOTAL SCORE: | |

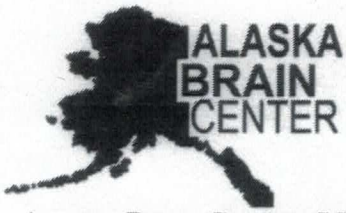
****Any score above 9 indicates that you may have a treatable Sleep Disorder.***
****Please schedule a Sleep Consult to see if you need an overnight Sleep Test.***

Have you ever had an overnight Sleep Test? YES NO

When were you tested? _____ Do you have Sleep Apnea? YES NO

Are you using a CPAP device? YES NO Is your CPAP therapy working for you? YES NO

*Revised 1/9/19*




**ALASKA BRAIN CENTER, LLC**
**Jeffrey L. Sponsler MD, MS**
**Diplomat 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

Name _____ Height _____ Weight _____ Age _____ Male / Female _____

# STOP-BANG Sleep Apnea Questionnaire

| **STOP** | | |
|---|---|---|
| Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)? | Yes | No |
| Do you often feel **T**IRED, fatigued, or sleepy during daytime? | Yes | No |
| Has anyone **O**BSERVED you stop breathing during your sleep? | Yes | No |
| Do you have or are you being treated for high blood **P**RESSURE? | Yes | No |

| **BANG** | | |
|---|---|---|
| **B**MI more than 35kg/m2? | Yes | No |
| **A**GE over 50 years old? | Yes | No |
| **N**ECK circumference > 16 inches (40cm)? | Yes | No |
| **G**ENDER: Male? | Yes | No |

| **TOTAL SCORE** | | |
|---|---|---|

**High risk of OSA: Yes 5 - 8**

**Intermediate risk of OSA: Yes 3 - 4**

**Low risk of OSA: Yes 0 - 2**

# Authorization to Release Medical Information

1. I AUTHORIZE:

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

2. TO RELEASE TO & OBTAIN RECORDS FROM:

_____
Name of receiving person/organization

_____
Street Address

_____
City State Zip Code

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: _____

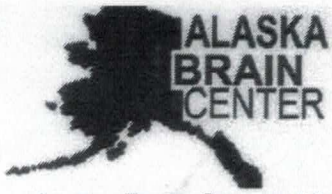
6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken.
7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges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

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# 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:** _____

# Notice of Privacy Practices

In 1998, the Health Insurance Portability and Accountability Act (HIPAA) was passed into law. The primary goal of the federal legislation was to make it easier for people to maintain basic health insurance benefits and help the health care industry control administrative costs. One portion of this act contains rules for protecting the privacy of your health information. Health care facilities must be in compliance with this portion of the law by April 14, 2003. Protection of your health information is not new to health care organizations in Alaska. Alaska Brain Center, LLC has always been committed to protecting your privacy. However, this federal law does strengthen protection of your privacy and gives you more control over the use and disclosure of your health information.

The HIPAA regulation gives Alaska Brain Center, LLC the right to use and disclose your health information for treatment, payment, and certain health care operations purposes without specific authorization from you. In addition, it grants you six specific rights regarding your health information:

- Right to request access to or a copy of your health information. We will ask that you make the request specific and in writing. We may charge a reasonable fee for the cost of producing and mailing copies. In certain situation, we may deny your request and will tell you why we are denying it. In some cases, you may have the right to ask for a review of our denial.
- Right to request an amendment to your health information if you believe your records are incomplete or inaccurate. Your request for amendment must be in writing and provide the reason for your request. In certain cases, we may deny your request. If so, we will notify you in writing. You may respond by filing a written statement of disagreement with us and ask that the statement be included with your health information.
- Right to request restrictions by asking that we limit the way we use or disclose your medical information for treatment, payment, or health care operations. You may also ask that we limit the information that we give to someone who is involved in your care, such as a family member or friend. We are not required to agree to your request. If we do agree, we will honor your restriction unless it is an emergency. We may ask you to make your request in writing.
- Right to request that we communicate with you by another means to preserve confidentiality. For example, if you want us to communicate with you at a different address or telephone number we can usually accommodate your request if it is reasonable.
- Right to seek an accounting of certain disclosures by asking us in writing for a list of the disclosures we have made of your health information, except for disclosures for treatment, payment, health care operations, information provided to you, facility directory listings, and certain government functions.
- Right to receive a paper copy of our **Notice of Privacy Statement**. Beginning in December 2005, we will offer you a copy of our notice the first time you register or present for treatment or health care services at Alaska Brain Center, LLC. You may also request a copy of this notice at any time.
- This notice lists all the different ways that we might use or disclose your health information and provides you with information about exercising your various rights.

Alaska Brain Center, LLC respects your right and we will continue to do our best to protect your privacy and the privacy of your health information. If you have questions relating to the protection of your health information or Alaska Brain Center, LLC privacy practices, please contact Alaska Brain Center LLC's Privacy Officer, Charlotte M. Nelson, ANP at 907-373-6500.

Copy Available upon request.

# Acknowledgement 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 by 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:** _____