4551 E Bogard Rd,
Wasilla, AK 99654
Phone 907-373-6500
Fax 888-456-0663
http://akbraincenter.com

ALASKA BRAIN CENTER

Jeffrey L. Sponsler MD, MS

Please Complete all sections (Please Print)			Today's Date:	
Patient's Legal Name: Last	First	Middle Initial	Marital Status ☐ S ☐ M ☐ D ☐ W	Sex ☐ F ☐ M
Mailing Address			Birth Date	Occupation
City	State	Zip	Social Security #	Email Address
Home Telephone May we leave a message? ☐ Yes ☐ No	Cellular Telephone May we leave a message? ☐ Yes ☐ No		Work Telephone May we leave a message? ☐ Yes ☐ No	
Race ☐ Caucasian ☐ African-American ☐ Asian ☐ Indian ☐ Native			Writing Hand ☐ Left ☐ Right	Preferred Pharmacy
Alternate Contact Name	Relationship		Telephone	
Referring Physician	Primary Care Physician		Is there a Medical Power of Attorney (MPOA) ☐ 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 than Patient):			☐ Spouse ☐ Parent ☐ Other_____	
Address (if different than Patient):			Telephone Number	
Primary Health Insurance Co. Name	Policy Holder		Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other_____	
ID/Policy Number	Group Number		Policy Holder's DOB	
Secondary Health Insurance Co. Name	Policy Holder		Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other_____	
ID/Policy Number	Group Number		Policy Holder's DOB	
Tertiary Health Insurance Co. Name	Policy Holder		Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other_____	
ID/Policy Number	Group Number		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_____
Cushing's Disease_____
Detached Retina_____
Deep Venous Thrombosis____
Depression_____
Diabetes:
Adult onset_____
Juvenile onset_____
Diabetic Neuropathy_____
Dilatation and Curettage ____
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 Erythematosus_____
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**________

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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

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Name _____ Height _____ Weight _____ Age_____ Male / Female

Sleep Apnea Questionnaire

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through a closed door)?	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		
BMI more than 35	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference more than 16 inches?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

Yes 5 or above = High risk for Sleep Apnea

Yes 3 to 4 = Intermediate risk for Sleep Apnea

Yes 2 or below = Low risk for Sleep Apnea

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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Acknowledgment of Alternative Imaging Facilities

The Alaska Brain Center, LLC is able to provide MRI Imagine services to our patients at our facility.

As of January 1, 2011, the Patient Protection and Affordable Care Act (PPACA) require physicians who provide in-office MRI services to inform patients of alternative local providers of imaging services.

The following is a list of alternative imaging service providers in our local area:

Mat-Su Regional Medical Center
2500 S Woodworth Loop, Palmer, AK 99645
907-861-6677

Imaging Associates
2280 S Woodworth Loop, Palmer, AK 99645
907-746-4646

Valley Upright Imagine
261 Park Ave. #3, Wasilla, AK 99654
907-373-3700

We strongly prefer that you have your MRI(s) done at Alaska Brain Center, LLC. Our studies are double read by an outside Neuroradiologist and our Neurologist. Having the study done here promotes continuity of care and speed of review. We carefully review all MRIs when obtaining them for extra views necessary.

By signing this form, you acknowledge that you have received the above list of alternative imaging facilities in our local area.

Patient Signature: _____

Printed Name: _____

Date: _____

Please Note: If you would like a copy of the above list please ask the receptionist and they will be glad to provide you with one.

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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 deductible 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 Policy and Accountability Act (HIPPA) 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 heal the healthcare industry control administrative costs. One portion of this act contains rules for protecting the privacy of your health information. Health care facilities must follow this portion of the law by April 14, 2003. Protection of your health information is not new to health care organization 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 HIPPA regulation gives Alaska Brain Center, LLC the right to use and disclose your health information for treatment, payment and certain health care operation purposes without specific authorization from you. In addition, it grants you six specific rights regarding your health information:

- Right to request access 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 situations, 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 restrictions 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 are 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 rights 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 Office, Charlotte M Nelson, ANP at 907-373-6500

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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 singing 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: _____