Alaska Brain and Spine

Dr. Joshua Costello

EMPOWERING YOU TO LIVE THE BEST LIFE POSSIBLE

4001 Geist Rd, suite 12, Fairbanks, AK 99709
www.alaskabrainandspine.com
Phone (907) 374-1981

Todays Date: _____

First:_____ Last:_____ MI:____

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

SSN:_____ Birthdate: _____ Sex: Male ◯ Female ◯ Transgender ◯

Home Phone:_____ Cell:_____ OK to leave message? _____

Circle all that apply: Single ◯ Married ◯ Partnered ◯ Separated ◯ Divorced ◯ Widowed ◯

Employed ◯ Retired ◯ Not employed ◯ FT student ◯ PT student ◯ Child ◯ Other_____

[ ] Minor | If minor, legal guardian name: _____

How did you hear about Alaska Brain and Spine: _____

Primary Doctor Name and Phone Number: _____

Person(s) allowed to receive my medical information: _____

My E-mail address is:_____

EMPLOYMENT INFORMATION (does not apply for minor)

Employer Name: _____

Occupation:_____ Employer Phone: _____

Employer Address: _____

EMERGENCY CONTACT

Contact Name:_____ Relation to patient: _____

Contact phone:_____ Address: _____

EMAIL CONSENT

Alaska Brain and Spine offers you the ability to communicate with us via email. However, due to HIPPA regulations we need the consent from you before we are able to send or receive any emails including but not limited to; chart notes, ledgers, appointments, intake and history information, imaging/lab results, etc.

By signing below states that I understand, most email services (Hotmail, Gmail, Yahoo) do not utilize encrypted email and Alaska Brain and Spine is not liable. I give my consent to communicate by email with Alaska Brain and Spine. (Leave blank if you do not wish to ever receive health information via email)

_____ _____ _____

Signature Date Printed name

INSURANCE & BILLING INFORMATION

1. Primary Insurance Company:_____ID#:_____

Policy Holder's name:_____Group Number: _____

Address if different from patient:_____

Birthdate:_____SSN:_____Relationship to Patient: _____

2. Secondary Insurance Company:_____ID#:_____

Policy Holder's name:_____Group Number: _____

Address if different from patient:_____

Birthdate:_____SSN:_____Relationship to Patient: _____

We recommend that you research your insurance benefits and eligibility.

- Insurance coverage is not a guarantee of payment.
- I understand that Alaska Brain and Spine is not "In-network" with my insurance company and that I am responsible for verifying my out-of-network benefits.
- I understand that copays/coinsurance/deductibles and/or patient balances are due at the time of service.
- We will bill your insurance based on the information you provide us. You are responsible for informing our office of any changes/updates to insurance information.
- You are ultimately responsible for payment of services rendered. If we do not hear from the insurance within 60 days of submission the balance will become patient responsibility.
- After claims process through insurance patient will receive a statement and payment is due at that time. If payment has not been received within 60 days your account may be sent to a collection agency. In the event your account is sent to collections this may result in discharge from care.
- I hereby authorize Alaska Brain and Spine to release my information to my insurance company and my insurance company to release information to Alaska Brain and Spine. I hereby assign benefits to be paid directly to Alaska Brain and Spine for this date and any future visits I may have.

Payment in full is required at the time of service in the following circumstances:

- You do not have insurance coverage _____
- You have not met your deductible _____
- Any services rendered or treatment related supplies not covered by insurance _____
- You have Federal Blue Cross Blue Shield _____
- You are at maxed benefits with your insurance company _____
- Any supplements/products _____

By signing below I acknowledge I have read and understand the above and I accept responsibility to pay for all services rendered which my insurance does not cover.

_____ _____

Patient Signature (or Responsible Party) Date

_____ _____

Printed Name Relationship to Patient

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Fax (907) 374-1983

Insurance Prior Authorization

Your health insurance may require prior authorization for certain services either through their own offices or a third party administrator.

Alaska Brain and Spine will make every effort to inform the patient/parent when this prior authorization is required. Insurance requirements can differ with carriers and plans. We will send for a prior authorization after your initial visit. Please be aware that this process could take up to 2 weeks. If the prior authorization department deems the services are not medically necessary, your insurance will not cover these services. We will inform the patient/parent of the denial as soon as we receive this information. We will give the patient/parent the option to receive further services. If patient consents to these services, the patient/parent will be responsible for payment in full at the time of service. We will try to bill your secondary insurance as a courtesy but please be aware that they may deny these services also.

As treatment continues, it may be necessary to obtain an additional authorization for services if approved originally. We are informing you that the insurance could deem further services as not medically necessary in which case the above process will be followed.

By signing below, I am acknowledging the understanding of the above information. I have had the opportunity to ask questions regarding fees and payment.

Patient:_____
Printed

Signature: _____ Date: _____
Patient/Parent/Guardian

Staff Signature:_____ Date:_____

Cancellation and No Show Policy

Alaska Brain and Spine is a multidisciplinary clinic. We provide services for chiropractic care, physical therapy, massage therapy, naturopathy, counseling, acupuncture and pilates. We have various types of appointments for our providers. Chiropractic has four types of appointments: 20 min, 40 min, 60 min Intensive and a New Patient. Physical Therapy has 60 min appointments. Naturopathy has New Patient and 30 min appointments. Counseling has New Patient, 60 min and 30 min sessions. Our massage appointments are either 60 min or 90 min. Our clinic has a wait list for initial and follow up appointments. A late cancellation or a "no-show" denies us the time necessary to schedule these wait-listed patients. We respect our patient's time greatly and strive to deliver the best care possible in a timely manner. The policy below enables us to utilize all available appointment times for patients in need of medical care.

We require that you call at least 24 hours in advance to cancel your scheduled appointment. If this time frame is not met it will be considered a "same day cancellation". Failure to do so will result in a late cancellation fee outlined below.

A "No-Show" is someone who misses an appointment without canceling it. Failure to be present at the time of your scheduled appointment will result in a "no-show" fee outlined below.

Fees for Late/Same Day Cancellations and No-Shows

New Patient visit	$250.00
40 Min Appointment	$150.00
30 Min Appointment	$125.00
20 Min Appointment	$75.00
Counseling Initial	$175.00
Counseling Follow-up 45-60min	$97.50
Physical Therapy Appointment	$200.00
Massage Therapy Appointment	$150.00

Thank you for your cooperation.

Sincerely,

Providers and Staff of Alaska Brain and Spine

_____ _____

Patient or Legal Guardian Signature **Date**

_____

Printed Patient or Legal Guardian Name

PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

USES AND DISCLOSER OF YOUR MEDICAL INFORMATION

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services.

FOR PAYMENT: We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and may be collected from you, an insurance company, or a third party.

FOR HEALTH CARE OPERATIONS: We may use and disclose health information about you for operations of our health care practice.

FOR INDIVIDUALS INVOLVED IN YOUR CARE AND PAYMENT FOR YOUR CARE: We may release medical information about you to a friend or family member who is involved in your medical care.

AS REQUIRED BY LAW: We will disclose medical information about you when required to do so by federal, state, or local law.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed.

YOUR RIGHT TO AMEND: If you feel the medical information, we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request.

YOUR RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request in writing, a list of any disclosures of your medical information we have made, except for disclosures for treatment, payment, and health care operations, as previously described.

YOUR RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations.

Your Right to Request Confidential Communications: You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location.

YOUR RIGHT TO A PAPER COPY OF THESE FORMS: You have the right to a paper copy of this notice at any time. **CHANGES TO THIS NOTICE:** We reserve the right to change this notice and will post the current notice in our facility. **COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Counseling Intake Form

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

PATIENT (S)_____ Date of Birth _____

Gender _____ Preferred Pronoun _____

***If Patient is a Minor**

Parent/Guardian _____

Address (if different) _____

City, State _____ Zip_____

Phone if Different _____

May we call you at your Phone? ___Yes___No May we leave a message? ___Yes ___No

Patients' relationship to Responsible Party (check one): Self_____ Spouse_____ Child_____ Other _____

Source of referral _____ Reason for referral _____

Please list family members, and anyone that lives in your home with you.

_____

_____

_____

TREATMENT HISTORY

Have you ever received treatment for mental health (When and Where?)

_____

_____

_____

To your knowledge, were you ever given a mental health diagnosis in the past?

_____

_____

How is your general health? Any chronic health issues?

_____

_____

_____

Are you currently taking any medications or supplements? Please list medication and prescriber…

_____

_____

_____

Mental Health Concerns

What is the primary reason for your visit today? _____

_____

_____

_____

_____

Average hours of sleep per night? _____ Difficulty falling asleep ___ Yes ___No

I feel rested in the am ___ Yes ___No

Has anyone in your family been diagnosed with a mental health diagnosis i.e Depression, Anxiety, Trauma, Substance Abuse?

_____

_____

_____

_____

Is there anything else that you would like me to know prior to our appointment?

_____

_____

_____

Stress Indicators

Patient Name: _____ Date: _____

PLEASE RATE YOUR LEVEL OF DISTRESS FOR THE FOLLOWING SYMPTOMS IN THE PAST MONTH

6	5	4	3	2	1	0
Maximum	**Very Considerable**	**Considerable**	**Moderate**	**Little**	**Very Little**	**No Distress**

___Anxiety
___Worry
___Stress
___Rapid Thoughts
___Impulsiveness
___Rapid Speech
___Excessive Energy
___Feeling Panicky
___Nightmares
___Sleep Disturbance
___Anger
___Irritability
___Mood Swings
___Physical Aggression
___Problems Focusing
___Depressed Mood
___Suicidal Thoughts/Attempt
___Thoughts of Harm to Self/Others
___Changes in Appetite/Eating Habits
___Weight Gain/Loss (circle one)
___Decreased Energy
___Excessive Crying
___Feelings of Guilt
___Feelings of Hopelessness
___Loss of Interest/Pleasure
___Issues with Self-esteem/Feelings of Worthlessness
___Legal Issues
___See/Hear/Smell Things Others Do Not
___Feelings of Paranoia
___Physical Abuse
___Sexual Abuse
___Emotional/Verbal Abuse
___Family Conflict
___Relationship/Marital Problems
___Sex Problems
___Grief
___Issues at School/Work
___Physical Health Problems
___Issues with Alcohol/Drug Use
___Other Addiction (Gambling, Electronics, Food, etc.)

Informed Consent/Disclosure Statement

To My Patients:
I wish to take this opportunity to welcome you to Alaska Brain and Spine and thank you for choosing to work with us. I want to ensure you are informed of some basic principles I believe are essential in establishing a good counseling relationship, as well as informing you of Alaska Brain and Spine's policies, state and federal laws, and your rights as a patient. Please read through this information, asking questions as needed.

DISCLOSURE STATEMENT: My name is Olivia Foote. I am a licensed Professional Counselor (LPC) as provided by the State of Alaska Professional Counselors, since October of 2016. I have a Masters of Education in Community Counseling from the University of Alaska Fairbanks. I am also a member of the American Counseling Association since 2014. I am an employee of Alaska Brain and Spine at 4001 Geist Rd #12, Fairbanks, AK, 99701 and can be reached at (907) 374-1981. I utilize a holistic, strength based approach that focuses on empowering patients to reach their identified goals and find wellness in all areas of their lives. I accept patients 14 years and older and have experience treating a variety of mental health issues including anxiety, depression, PTSD, attention-deficit disorders, addiction, issues with regulating emotion, and women's health issues. I specialize in the treatment of trauma and utilize a trauma reprocessing therapy called Brainspotting.

1. THE THERAPUETIC PROCESS
   You have taken a very positive step by deciding to seek therapy. There are risks and benefits related to engaging in this process. The outcome of your treatment depends largely on your willingness to engage, and at times, may result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

2. INITIAL ASSESSMENT: Your first visit is considered a diagnostic or evaluation interview, which can last up to 90 minutes. At the time of this appointment, the following decisions will be made with you:
   a) Type of therapy needed (individual, group, referrals, etc.)
   b) Frequency of therapy sessions (weekly, biweekly, etc.)
   c) Goals of therapy (what you hope to gain from this process.)

3. APPOINTMENTS: Each follow-up appointment is approximately 45-50 minutes. At the end of each appointment you can discuss future appointments with your therapist, or make a recurring appointment with the front desk.

4. FEES:

Services	Duration	Rate
Initial assessment	60-90 minutes	$350
Follow-up Individual Therapy	45-50 minutes	$195
Follow-up Individual Therapy	90 minutes	$282.50
Follow-up Family/Couples	50 minutes	$282.50
Court Fees	60 minutes	$300

5. EMERGENCY SITUATIONS: In case of emergency outside of my business hours please contact:
   a. Crisis Hot Line at 452-4357

b. Fairbanks Community Behavioral Health Center On-Call Service at 452-1575
c. Call 911 for immediate emergency care or go to Fairbanks Memorial Hospital's emergency room department

6. CONFIDENTIALITY: All information regarding the specific nature of your counseling is maintained at the Holistic Clinic and is considered confidential within the office unless specified by you in writing. Confidentiality is a cornerstone of the therapeutic relationship and will be protected, except in the following situations:
    a. Any suspected/reported abuse of a vulnerable populations (children, elders, people with disabilities)
    b. Threats of harm to yourself/others or disabled due to a mental disorder
    c. Information required by your insurance company (diagnosis, dates of service, etc.)
    d. If you have signed a release of information for an individual
    e. Information necessary for peer consultation (no identifying information is used)
    f. Treatment records can be subpoenaed in a court of law

This information is required by the Board of Professional Counselors, which regulates all licensed professional counselors. To reach the board by mail, please write the Department of Commerce, Community and Economic Development, Division of Occupational Licensing, P.O. Box 110806, Juneau, Alaska, 99811. To reach the board by telephone, call 907-465-2550.

Acknowledgement and Consent

Please Initial

_____ I have received a copy of the Informed Consent and Olivia Foote's Disclosure Statement

_____ I have received a copy of Alaska Brain and Spine's Notice of Privacy Practices

_____ I agree to Alaska Brain and Spine's Financial Policy

_____ I consent to receive treatment by Olivia Foote, LPC

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient _____

Consent to Telehealth with Alaska Brain and Spine

I consent to engaging in Telehealth services with Olivia Foote through Alaska Brain and Spine. I understand that this service includes the practice of diagnosis, consultation, and mental health treatment utilizing interactive audio, video, or data communication technology. I understand that participation requires transfer of medical data and mental health information through secure platforms.

I understand that I have the following rights with respect to Telehealth:

1) I may withdraw my consent at any time.

2) The information disclosed by me during the course of therapy is confidential with exception to the following situations: Suspected/reported abuse of a vulnerable population (children, elders, people with disabilities), threats of harm to yourself or others, information required by insurance companies, if you have signed a release of information for an individual, information necessary for peer consultation (no identifying information given), a treatment record subpoenaed in a court of law.

3) I understand that there are risks involved with Telehealth. These include disrupted sessions due to technology failures, the transmission of my medical information being interrupted by unauthorized persons, the electronic storage of my medical information being accessed by unauthorized persons.

4) I understand that Telehealth is not the appropriate level of care for all individuals, and if my therapist believes I would be better served by in person services I will be referred to a therapist who can provide those services in my area.

5) I understand that mental health treatment is complex, and that Telehealth services are not guaranteed to improve my condition.

6) I understand that my therapist will try to respond to all messages within one business day, however it is not always possible. In case of emergency I have been directed to call 911 or the nearest emergency room.

7) I understand that in accordance with Alaska state law I can access my medical information and obtain copies of medical records.

I have read and understand the information above. Any questions I had were discussed and answered by my therapist to my satisfaction. My signature below indicated my informed consent to Telehealth treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient _____