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
Fax (907) 374-1983

NEW PATIENT INFORMATION

Todays Date: _____

First name:_____Last:_____MI:_____

Address:_____

City:_____State:_____Zip code: _____

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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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:_____

INFORMED CONSENT FOR MEDICAL CARE

I hereby request and consent to the performance of chiropractic adjustments and other medical care. Including various modes of physical therapy by all medical providers or other staff, who now or in the future treat me while employed by or associated with Alaska Brain and Spine.
I may not have had an opportunity to discuss with Dr. Costello or his staff, the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in any medical practice there are some risks to chiropractic treatment including but not limited to; fractures, disc injuries, strokes, dislocations and sprains. I understand that it is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit. I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that Alaska Brain and Spine will keep records of my health history, symptoms, examinations, test results, diagnosis and treatments to serve a purpose for planning my treatment. I understand that these records are a means of communication among other health care professionals who may contribute to my care. I understand that these records are a source of information for applying my diagnosis to my bill and a means by which a third-party payer can verify that the services billed were actually provided.
I understand that I have the right to object to the use of my health information for directory purposes.
I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

I have read or have had read to me, the Informed Consent to Chiropractic Adjustments and Other Medical Care. I have also had an opportunity to ask questions about this content. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from: Alaska Brain and Spine.

_____ _____ _____

Patient Name (Printed) Date Legal Representative (Printed)

_____

Patient Signature

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 that 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: _____

Patient Name: _____ Date: _____

Past Medical History (Include dates if possible)

Significant Illness_____Cancer_____Diabetes_____
High Blood Pressure_____Heart Disease_____Hepatitis_____
Rheumatic Fever_____Thyroid Disease_____Seizure_____
Other_____
Surgeries_____
Heart Attack _____
Significant Trauma (Auto accident, falls, emotional, etc.) _____
Birth History (prolonged labor, forceps delivery, etc.)_____
Allergies(drugs, chemicals, foods) _____

_____
Prescription Medication _____

_____
Herbs/Supplements _____

_____
Occupational Stresses (chemical, physical, psychological, etc.) _____
Exercise_____

Average Daily Diet:

Do you follow a special diet? If yes, please describe: _____

Habits:

Cigarettes: #/day _____ Coffee: cups/day_____ Tea: cups/day _____
Soda: #/day_____ Alcohol: drinks/week _____
Drugs_____ Sugar_____ Salt_____ Other_____

Family Medical History:

□ Diabetes □ Cancer □ High Blood Pressure □ Heart Disease □ Stroke □ Asthma
□ Alcoholism □ High Cholesterol □ Depression □ Bleeding disorder □ Arthritis □ Osteoporosis
□ Thyroid disease □Other _____

General:

□Poor Appetite □Tremors □Poor Sleep □Heavy Sleep □Light Sleep □Insomnia
□Fatigue □Chills □Vertigo □Cold Hands □Cold Feet □Cold back
□Cold Abdomen □Night Sweats □Cravings □Sweats easily □Fever □Heavy Appetite
□Change of Appetite □Localized Weakness □Poor Coordination
Sudden drop in energy at (time) _____ Strong thirst (cold/hot drinks) _____
Peculiar Taste/Smells_____ Bleed or bruise easily (where) _____

Head, Eyes, Ears, Nose, and Throat:

□Dizziness □Blurry Vision □Jaw Clicks □Concussion □Sinus Problems
□Teeth Problems □Migraines □Poor Hearing □Teeth Grinding □Night Blindness
□Ringing in Ears □Gum Problem □Glasses □Eye Strain □Earaches
□Facial Pain □Eye Pain □Nose Bleeds □Spots in Eyes □Poor Vision
□Dry Throat □Lip Sores □Mucous □Dry Mouth □Tongue Sores
□Color Blindness □Copious Saliva □Cataracts □Recurrent Sore Throat_____/month
□Headaches (where/when) _____ Other_____

Dental:

□Amalgams □Crowns □Tooth Decay □Periodontal Disease □Root Canals
□Bridges □Braces

Respiratory:

□Cough □Blood in Sputum □Asthma □Bronchitis
□Pneumonia □Difficult breathing while lying down
Production of Phlegm/color_____ Other Lung Problems_____

Cardiovascular:

□Chest □High Blood Pressure □Low Blood Pressure
□Fainting □Dizziness □Irregular Heartbeats
□Blood Clots □Phlebitis □Cold Hands
□Cold Feet □Swelling Hands □Swelling Feet Other_____

Gastrointestinal:

□Nausea □Vomiting □Diarrhea □Bowel Movements
□Gas □Belching □Constipation Frequency _____
□Bad Breath □Rectal Pain □Rectal Itch Color_____
□Hemorrhoids □Bloody Stools □Sensitive Abdomen Odor_____
□Pain or Cramps Laxative Use: _____/week Type _____ Texture_____

Genitourinary/Prostate:

□Pain w/urination □Frequent Urination □Blood in urine □Kidney Stones
□Impotency □Venereal Disease
□Urgency to Urinate □Unable to hold urine □Wake up to urinate (how often) _____ /a night

GYN/Pregnancy:

□Irregular Periods □Vaginal Discharge □Vaginal Sores Douche (when) _____
Inter-menstrual Spotting (when) _____ Last normal menstrual Period _____
# of Pregnancies _____ Births _____ Premature Births _____ Miscarriages _____
Age of 1st Menses _____ # of Days in Cycle _____ Period (duration in days) _____
Flow (describe) _____ PMS (describe):_____
Menstrual Cramping: None Mild Moderate Severe
Menopause (when) _____ Breast Lumps_____
Birth Control (type and duration) _____
Sexually Transmitted Disease: □Gonorrhea □Chlamydia □Syphilis □HPV/HIV/Herpes
Last Pap Smear _____ Abnormal Pap (when) _____
Last Mammogram _____ Self Breast Exam (how often) _____

Skin and Hair:

□Rashes □Ulcerations □Hives □Itching □Eczema □Acne
□Dandruff □Hair Loss Change in Hair/Skin texture _____ Other_____

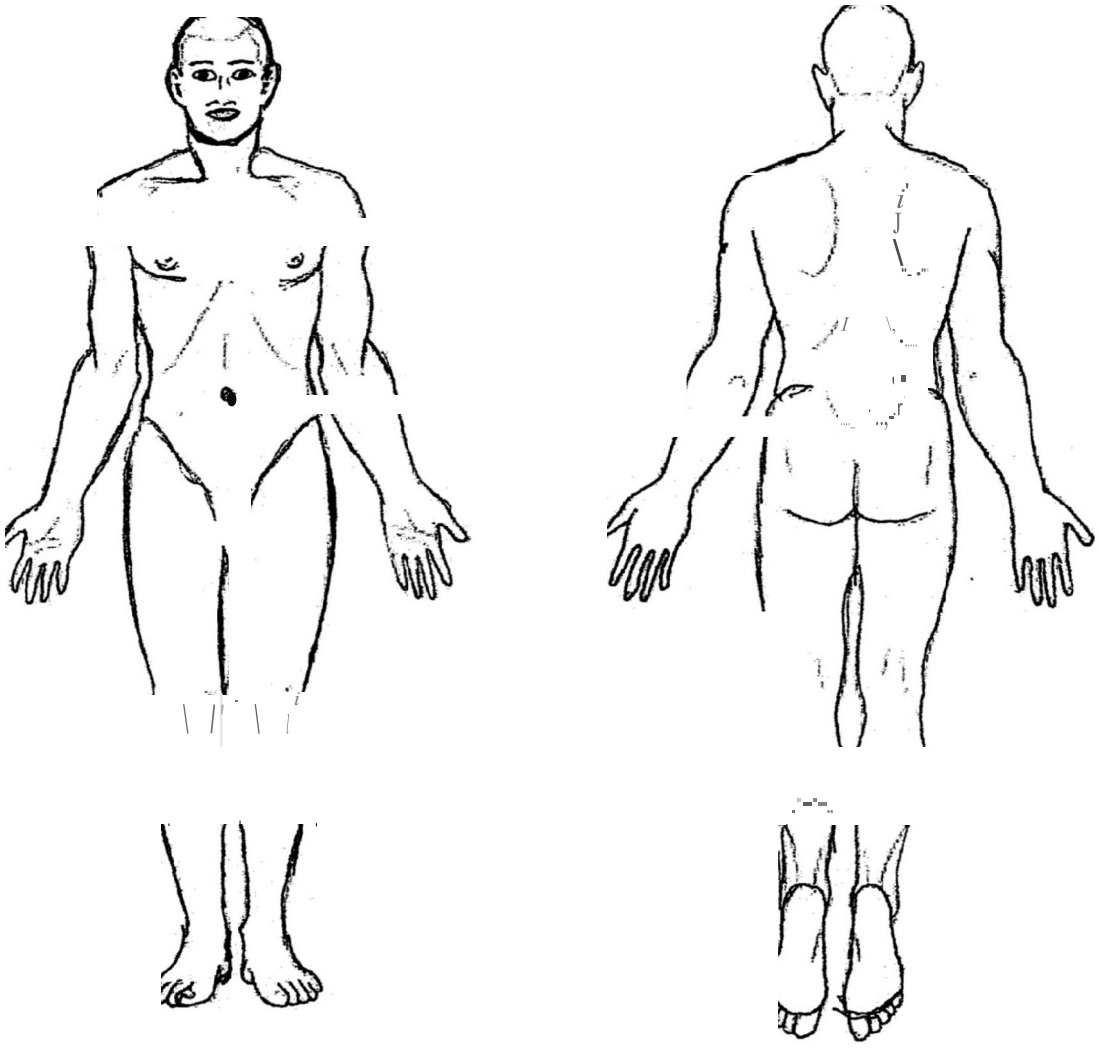
Neuropsychological:

□Seizures □Areas of Numbness □Poor Memory □Depression □Anxiety
□Concussion □Bad Temper □Easily Stressed □Suicidal Thoughts
□Suicide Attempts □Counseling Other_____

Musculoskeletal

Please indicate on the diagrams below the location of your symptom(s). Mark the area(s) on the body where you feel the described sensation(s). Use the appropriate symbols as indicated. Make sure to include all affected areas.

Aches: XXX Numbness: 0000 Pins/needles: •••• Burning: ^^^ Stabbing:////



How long has this issue been bothering you?
Please add any additional details: