Dear New Patient,

Welcome to the Algone Interventional Pain Clinic, a division of the Medical Group of Alaska. To ensure your first appointment is successful please bring the items listed below:

- **Completed New Patient Packet** - if you are filling out online you do not need to print a copy.
  - To fill out online, request the file to be sent to you
  visit: https://intakeq.com/new/6qyKRy
- **Current Picture ID**
- **Current Insurance Card(s)**
- **Current Medicaid Card** and $3 copayment (if applicable)
  - Without current card & copayment we will be unable to see you
- **Medication Bottles** that you are currently taking or a detailed medication list with the exact names, milligrams and dosing instructions
- **Imaging** such as MRI, X-Rays, CT scans etc. Please bring them on a CD with the report.
- **Medical records** related to your condition from previous facilities where you have been seen
  - We make every attempt to obtain records from your referring physician, however, it is ultimately your responsibility to provide these to Algone
- Come prepared to give a urine sample as this may be required before you are seen

We try our best to stay on schedule so it is very important that you arrive at your check in time, so we can complete the registration process in time for your appointment time. Patients who are late patients or that do not have the information listed above will be rescheduled per Algone Policy. Again, we would like to welcome you to Algone Interventional Pain Clinic. We realize that you have a choice as to where you go for your care and want to thank you for choosing Algone!

<table>
<thead>
<tr>
<th>Appointment Date</th>
<th>Check in Time</th>
<th>Appt. Time</th>
<th>Provider</th>
<th>Location</th>
</tr>
</thead>
</table>

www.AlgoneAlaska.com
**Patient Demographics**

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Initial:</th>
<th>Date of Birth:</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Previous name(s) used:</th>
<th>Biological Gender:</th>
<th>SSN #:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Male □ Female □</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address:</th>
<th>City</th>
<th>State/ ZIP</th>
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<table>
<thead>
<tr>
<th>Residence/ Street Address</th>
<th>City</th>
<th>State/ ZIP</th>
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<table>
<thead>
<tr>
<th>Primary Phone:</th>
<th>Secondary Phone:</th>
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<table>
<thead>
<tr>
<th>Race:</th>
<th>Ethnicity:</th>
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<table>
<thead>
<tr>
<th>Language:</th>
<th>Marital Status</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>If yes, work phone:</th>
<th>E-Mail:</th>
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</thead>
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</table>

May we e-mail you information relevant to your condition, clinic announcements, etc.?  □ Yes  □ No

**RESPONSIBLE PARTY (MINORS ONLY)**

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>MI:</th>
<th>Date of Birth:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>City</th>
<th>State/ ZIP</th>
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<table>
<thead>
<tr>
<th>Phone:</th>
<th>SSN #:</th>
<th>Relation to Patient:</th>
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</table>

<table>
<thead>
<tr>
<th>PRIMARY Insurance:</th>
<th>Policy #:</th>
<th>Group #:</th>
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</table>

<table>
<thead>
<tr>
<th>Policy Holder:</th>
<th>DOB:</th>
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<table>
<thead>
<tr>
<th>Relationship:</th>
<th>Social Security #:</th>
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</table>

<table>
<thead>
<tr>
<th>SECONDARY Insurance:</th>
<th>Policy #:</th>
<th>Group #:</th>
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<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Insured:</th>
<th>DOB:</th>
<th>Social Security #:</th>
</tr>
</thead>
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</tbody>
</table>
GENERAL INFORMATION

Person to contact if unable to reach patient (not living in your home)

Name: ____________________________ Phone/Cell: ____________________________ Relationship: ____________________________

How did you hear about us?

Preferred Pharmacy: ____________________________

Primary Care Provider to send office note to: ____________________________ Who do you authorize to pick up your prescriptions?

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans, Medicaid, RR Medicare, and all other health plans to Medical Group of Alaska. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance (including Medicaid). I hereby authorize said assignee to release all information needed to secure the payment.

________________________________________  ____________________________
Signature  Date
New Patient Intake Form*
Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (907) 373-9460 Option #2 if you have any question on how to complete any section of this form.

Patient Information
Name: ___________________________________________ Date of Birth: ________________________________

Height: ____________________________ Weight: ____________________________

Referring Physician: ___________________________________________ Primary Care Physician: ____________________________

Pain History:
Chief Complaint (Reason for your visit today)?

________________________________________________________________________

Does this pain radiate?
☐ Yes
☐ No

If yes, where?

________________________________________________________________________

Please list any additional areas of pain:

________________________________________________________________________

Onset of Symptoms:
Approximately when did this pain begin?

________________________________________________________________________
What caused your current pain episode?

How did your current pain episode begin?  
- Gradually  - Suddenly

Since your pain began how has it changed?  
- Improved  - Worsened  - Stayed the same

Pain Description:
Check all of the following that describe your pain:
- Dull/Aching  - Hot/Burning  - Shooting  - Stabbing/Sharp  - Cramping  - Numbness  - Spasming
- Throbbing  - Squeezing  - Tingling/Pins and Needles  - Tightness  - N/A

When is your pain at its worst?  
- Mornings  - Daytime  - Evening  - Middle of the night  - Always the same

How often does the pain occur?  
- Constant  - Changes in severity but always present  - Intermittent (comes and goes)

If pain “0” is no pain and “10” is the worst pain you can imagine, how would you rate your pain?

Right Now:  

The Best It Gets:  

The Worst It Gets:  

Mark the effect each of the following have on your pain level.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Increases</th>
<th>Decreases</th>
<th>No Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bending Backward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bending Forward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes in Weather</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climbing Stairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coughing/Sneezing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifting Objects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looking upward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looking downward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rising from seated position</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
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</tr>
</tbody>
</table>

What other factors worsen or affect your pain which is not mentioned above?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
## Associated Symptoms:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>No</th>
<th>Yes</th>
<th>Comments (Where?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness/Tingling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in the arm/leg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder Incontinence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel Incontinence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint Swelling/Stiffness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fevers/chills</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please mark all of the following treatments you have used for pain relief:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>No Change</th>
<th>Worsened Pain</th>
<th>Helped Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spine Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brace Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hot/Cold Packs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massage Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TENS Unit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If other, specify:

__________________________

## Interventionsal Pain Treatment History

- [ ] Epidural Steroid Injection  
  Check all levels that apply:  
  - [ ] Cervical  
  - [ ] Thoracic  
  - [ ] Lumbar

- [ ] Joint Injection  
  Joint(s):  
  ____________________________
Medial Branch Blocks/Facet Injections

Check Levels:
- Cervical
- Thoracic
- Lumbar

Comments:

Nerve Blocks

Area/Nerve(s):

Radiofrequency Nerve Ablation

Check Levels:
- Cervical
- Thoracic
- Lumbar

Spinal Cord Stimulator

Trial or Permanent:
- Trial Only
- Permanent Implant

Trigger Point Injections

Where?

Vertebroplasty/Kyphoplasty

Level(s):

Other

Specify:

Which of these procedures listed above have helped with your pain?

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

<table>
<thead>
<tr>
<th>Body Part</th>
<th>YES</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI of the:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-Ray of the:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT Scan of the:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMG/NCV study of the:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Other Diagnostic Testing
- I have not had ANY diagnostic tests for my current pain complaint

If Other, specify:

Mark the following physicians or specialists you have consulted for your current pain problem(s):

- Acupuncturist
- Chiropractor
- Internist
- Neurosurgeon
- Orthopedic Surgeon
- Physical Therapist
- Psychiatrist/Psychologist
- Rheumatologist
- Neurologist
- Other

If other, specify:
Past Medical History

Please list the names of other Pain Physicians you have seen in the past?

Mark the following conditions/diseases that you have been treated for in the past:

**General Medical:**
- Cancer (Type): __________
- Diabetes (Type): __________
- n/a

**Cardiovascular/Hematologic:**
- Anemia
- Heart Attack
- Peripheral Vascular Disease
- Coronary Artery Disease
- Stroke/TIA
- High Blood Pressure
- Heart Valve Disorders
- n/a

**Gastrointestinal:**
- GERD (Acid Reflux)
- Gastrointestinal Bleeding
- Stomach Ulcers
- Constipation
- n/a

**Urological:**
- Chronic Kidney Disease
- Kidney Stones
- Urinary Incontinence
- Dialysis
- n/a

**Neuropsychological:**
- Multiple Sclerosis
- Peripheral Neuropathy
- Seizures
- Depression
- Anxiety
- Schizophrenia
- Bipolar Disorder
- n/a

**Head/Ears/Eyes/Nose/Throat:**
- Headaches
- Migraines
- Head Injury
- Hyperthyroidism
- Hypothyroidism
- Glaucoma
- n/a
- Bronchitis/Pneumonia
- Emphysema/COPD
- n/a
Musculoskeletal/Rheumatologic:
- Bursitis
- Carpal Tunnel Syndrome
- Fibromyalgia
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Chronic Joint Pains
- n/a

Other Diagnosed Conditions:

Pain Level:
- 0 - No Pain
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 - Worst Possible

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

<table>
<thead>
<tr>
<th></th>
<th>Surgical Procedure</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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</tr>
</tbody>
</table>

- I have NEVER had any surgical procedures performed

Current Medications

Are you currently taking any blood thinners or anti-coagulants?
- Yes
- No

If YES, which ones?
- Aspirin
- Plavix
- Coumadin
- Lovenox
- Other

If other, specify:
Please list all medications you are currently taking including vitamins.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Reason for Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>2</td>
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<td>3</td>
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<td>9</td>
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<tr>
<td>10</td>
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</tbody>
</table>

Please list all past pain medications that you have been on at any point for your current pain complaints?

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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<td>4</td>
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<tr>
<td>5</td>
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</table>

**Allergies**

Do you have any drug/medication allergies?

- [ ] Yes
- [ ] No

If so, please list all medications you are allergic to:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Allergic Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
Topical Allergies:
- Latex
- Iodine
- Tape
- IV Contrast

Family History

Mark all appropriate diagnoses as they pertain to your first-degree relatives:
- Arthritis
- Seizures
- Diabetes
- Headaches/Migraines
- Cancer
- Kidney Problems
- Liver Problems
- High Blood Pressure
- Rheumatoid arthritis
- I have no significant family medical history

If other medical problems, please specify:

Social History

Which best describes you?
- Temporary Disability
- Permanent Disability
- Retired
- Unemployed
- Employed

Occupation: ____________

When was the last time you worked?

Who is in your current household?

Are there any stairs in your current home?
- Yes
- No

If so, how many?

Are you currently under worker’s compensation?
- Yes
- No

Is there an ongoing lawsuit related to your visit today?
- Yes
- No
Alcohol Use:
- History of alcoholism
- Current alcoholism
- Daily use of alcohol
- Social Use
- Never

Tobacco Use:
- Current user
- Former user
- Never used

Packs per day? How many years? Quit Date:

Illegal Drug Use:
- Denies any illegal drug use
- Currently uses illegal drugs
- Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications?
- Yes
- No
Review of Systems

Mark the following symptoms that you currently suffer from:

1. General:
   - Fever
   - Chills
   - Weight Loss
   - Fatigue
   - Weight Gain
   - Night Sweats
   - Low Sex Drive
   - n/a

2. ENT:
   - Hearing Loss
   - Dental Problems
   - n/a
   - Sinus Congestion
   - Nose Bleeds
   - Ear Pain
   - Sinus Congestion

3. Genitourinary:
   - Painful Urination
   - Bladder Habit Change
   - n/a
   - Blood in Urine
   - Flank Pain

4. Eyes:
   - Visual Changes
   - n/a

5. Cardiovascular:
   - Chest Pain
   - Shortness of Breath with Exertion (DOE)
   - Palpitations
   - n/a
   - Swelling (Edema)

6. Respiratory:
   - Cough
   - Wheezing
   - n/a
   - Shortness of Breath at Rest

7. Gastrointestinal:
   - Constipation
   - Vomiting
   - n/a
   - Nausea
   - Heartburn
   - Diarrhea
   - Abdominal Pain

8. Muscles and Joints:
   - Cramps
   - Stiffness
   - n/a
   - Neck Pain
   - Joint Pain
   - Joint Swelling
   - Back Pain
9. Neurologic:
  - Fainting
  - Seizures
  - Numbness / Tingling
  - Weakness
  - Dizziness
  - Tremors
  - Dizziness
  - Headaches
  - n/a

10. Hematologic:
  - Easy Bruising
  - n/a
  - Bleeding
  - Blood Clots
  - n/a

11. Psychiatric:
  - Anxiety
  - Suicidal Thoughts
  - Depression
  - Thoughts of Harming Others
  - Sleep Problems
  - n/a

12. Pain Level:
  - 0 - No Pain
  - 1
  - 2
  - 3
  - 4
  - 5
  - 6
  - 7
  - 8
  - 9
  - 10 - Worst Possible

Patient Signature (legal guardian if patient is a minor)

__________________________________________  __________________________
Signature                                      Date
Authorization Form

I, ________________________________, authorize Medical Group of Alaska to verbally discuss my medical records with:

1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________
4. __________________________________________________________________________
5. __________________________________________________________________________
6. __________________________________________________________________________

By signing this authorization form, I understand that:

- Some records may contain extremely confidential information. This may include alcohol/substance abuse/testing, mental health conditions/psychotherapy notes and psychological evaluations, HIV testing, status or care and treatment for AIDS, sexually transmitted disease/testing, and genetic records.
- Once the office discloses health information, the person or organization that receives it may redisclose it and privacy laws may no longer protect it.
- I may revoke this authorization in writing. If revoked, it would not affect any actions already taken by Medical Group of Alaska based upon this authorization. Two ways to revoke this authorization are: Fill out a revocation form (available from the office) or write a letter to the office.
- This is not an authorization to release printed medical records.

Patient Name: ___________________________          Date of Birth: ___________________________

_____________________________________________________________________________________

Patient or Parent/Guardian Signature          Date
Consent to Treat

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any necessary anesthetics
- Performance of such procedures as may be deemed medically necessary or advisable as part of my treatment
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this document was given to me and executed in advance to any specific diagnosis or treatment.

My intent is for this consent to be continual in nature, even after a specific diagnosis has been made and treatment recommended. The consent will remain in full effect until revoked in writing.

I understand that Algone Interventional Pain Clinic may include this consent to apply to services, procedures, and tests at satellite offices under common ownership if applicable.

I, the undersigned, acknowledge that Algone Interventional Pain Clinic will use and disclose my information for the purposes of treatment, collection of payment, and healthcare operations as described in the Notice of Privacy Practices that I have been given.

A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize Algone Interventional Pain Clinic to release my medical information to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Algone Interventional Pain Clinic.

**By signing below, I certify that I have read and fully understand the above statements and consent entirely and voluntarily to its contents.** I also acknowledge that I have been offered a complete copy of Algone Interventional Pain Clinic's “Notice of Privacy Practices”. I understand that if I have questions or complaints that I should contact Algone’s Patient Privacy Officer.

Legal guardian if patient is a minor

____________________________  __________________________
Patient Signature                Date
Financial Policies

Please review and initial:

- If proof of insurance/eligibility cannot be provided, payment will be due in full. ____________
- MGA will collect any deductibles, copay, or coinsurance on the date of service. ____________
- Medical insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, “usual and customary” charges, etc. ____________
- Please be advised if you are here for a preventative visit/physical and have health problems you want to discuss with your provider during your well visit, this could result in an additional charge, which may or may not be covered by your insurance. For clarification or to update the reason for your visit, please see the front desk. ____________
- Balances on your account must be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel. If you are in need of an arrangement, please contact the billing department in a timely manner as any claim over 90 days will be due in full. ____________
- Statements are not generated for an amount due of less than $10.00; please watch your insurance explanations to see if you owe a balance. ____________
- Please be aware you may receive a separate charge from an outside lab (i.e. Quest Diagnostics) for specialized lab tests. ____________
- MGA is in network with the following insurances: Medicare, Medicaid, Blue Cross, Tricare, Cigna, Aetna, Moda, and United Healthcare. If your insurance is not one of these, please be aware your claim(s) will be processed as “out of network”. ____________
- Delinquent account (>90 days) are subject to collections processes which may include the account being transferred to Cornerstone Credit Services (CCS). You will be responsible for any fees and/or commission charged to MGA by CCS. Patients whose accounts have been sent to CCS will be reviewed for possible discharge from the clinic. ____________
- MGA will charge a fee of $30.00 for any checks returned as NSF. The patient’s account be flagged until the debt has been repaid. ____________
- Any appointment cancelled less than 24 hours prior to the scheduled appointment time will incur a $25.00 cancellation fee. After five missed appointments an account may be reviewed for discharge from the practice. ____________
- It is important to clarify the reason for your visit(s). Please do this at the time of your visit as it is MGA’s policy to not change a diagnosis code after the visit. Do feel free to clarify/confirm what diagnosis will be used with your provider before you leave the office. ____________

________________________________________  __________________________
Patient or Parent/Guardian Signature Date
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Medical Group of Alaska to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Medical Group of Alaska describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Medical Group of Alaska reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Medical Group of Alaska
3066 E. Meridian Park Loop
Wasilla, AK 99654

With this consent, Medical Group of Alaska may call my home or other alternative location and leave a message on voice mail if needed (unless a Refusal to Voicemail form is completed) or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Medical Group of Alaska may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Medical Group of Alaska may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Medical Group of Alaska restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Medical Group of Alaska to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Medical Group of Alaska may decline to provide treatment to me.

Patient's Name: ________________________________

Legal Guardian's Name (if applicable): ________________________________

____________________  ______________
Patient/ Guardian Signature  Date
Rescheduling Policy

Algone Interventional Pain Clinic strives to maintain an efficient schedule that limits the patient’s wait time. In order to accomplish this, we ask our patients to take the following steps and provide the following documents:

- Current insurance card. The policy information will not be enough. For verification purposes, the Insurance card must be on file. This includes Medicaid.
- Valid photo ID
- Must have copayment if required by your insurance company
- Payment for service must be paid in full prior to your appointment time.

Paperwork Requirements

- New Patients must have all paperwork completed before they arrive and must arrive 15 min prior to their scheduled appointment time to complete the registration process.
- Any forms that need to be filled out by the doctor must be completed to the extent possible by the patient prior to their appointment.

Late Arrivals – the scheduled appointment time is the time that the patient should be in the exam room, not the time the patient should be walking in the door. To avoid having your appointment rescheduled please arrive 10-15 min prior to your scheduled appointment time at all times.

Please keep in mind that your appointment will be rescheduled if you do not follow the guidelines outlined above:

Signing this form indicates that you have read and understand the policy stated above.

Patient Name: ________________________________

Patient or Parent/Guardian Signature ____________________________ Date ____________________________