Integrative Pain Center of Alaska

(Please fill out with only black pen)
www.alaskapaincenter.com
1275 Sadler Way Ste 200 Fairbanks AK 99701

Dear Patient:

Thank you for choosing Integrative Pain Center of Alaska for your pain management care. We are very happy to have you as a patient and are committed to giving you the best quality medical care possible. This sheet is meant to be a helpful source of information for you.

Please read it thoroughly and initial at the bottom

Please fill out the attached forms completely and return them to be scheduled. Please bring with you any **MRI and/or X-RAY DISKS** when you are turning in your new patient packet. These are an integral part of you evaluation and **your appointment may be rescheduled if you do not bring the disks with you, or the attached forms are not completed.**

We will call you with a reminder the day before your appointment. Should you have any questions before this, please call our office at (907)374-6602.

In order to provide you with the best possible care we encourage you to make arrangements or child care during your appointment. **PLEASE DO NOT BRING YOUR CHILD TO YOUR APPOINTMENT.** This will allow your healthcare provider to give you their undivided attention.

We will do our best to assist you in every way in complying with the particular guidelines of your insurance plan. However**, it is ultimately your responsibility** to make sure that you have the necessary coverage for any services rendered in our facility.

We are obligated to collect your insurance co-pay at the time of your visit. Every time you see any of our providers you will need to make your co-pay. This includes all follow up visits, discussions regarding any medication you are taking, or medical counseling of any kind.

Some insurance plans ask that you go to a particular facility for tests. This may include laboratories, x-ray facilities and hospitals. We make every effort to send you to the appropriate facility; however, it is your responsibility to know if you are limited to a particular facility for these tests and to inform our staff of such. You will need to notify us if your plan requires any pre-certification or prior authorization for any service we provide. This includes office visits, procedures, surgery, and physical therapy. Again, you are responsible for getting any pre-certification or prior authorization if needed. We will assist you with any information you need. For patients from out of town: you may be referred for additional treatment that requires you to stay in Fairbanks overnight. It is your responsibility to arrange for your own accommodations and travel, including taxicabs. If you have Medicaid **you must obtain your travel vouchers from your referring physician.** IPCA will **not** arrange for travel.

Thank you,

Integrative Pain Center of Alaska

Initial _____

This form is to be completed by all patients before their First appointment. Your careful answers will help us to understand your pain problem and begin the best treatment program for you.

It is understandable that you might be concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential and no one outside of your health care team is permitted to see your case record without your written permission.

BACKGROUND INFORMATION

Last Name_____ First Name _____ Date of Birth _____

Is a lawyer involved for disability or injury, if so please provide the name? _____

- ☐ No
- ☐ Yes

Do you receive Disability Compensation?

- ☐ No
- ☐ Yes

Are you here for a work related-injury?

- ☐ No
- ☐ Yes -if yes, how did your injury occur?

_____

Worker's Comp Carrier: _____ Case Manager: _____

Address for Claims: _____ Case#: _____

Please complete the following information about the physician that is referring you to our clinic, along with your primary care physicians Name, Address, Telephone number, and if possible fax number.

****Important to complete thoroughly so that we can update your referring physician(s) with your treatment plan****

Referring physician	**Primary Care Physician**
Name: _____	Name: _____
Address: _____	Address: _____
Phone #: _____	Phone #: _____
Fax #: _____	Fax #: _____

Reason for visit: _____

Current Pharmacy: _____

PAIN DESCRIPTION

There are many ways to describe pain and the impact that pain has on your life. Pain description is very important in the development of a diagnosis and treatment plan. Please carefully consider your pain problem and describe your problem as accurately as possible.

How long have you had pain? _____ Years _____ Months

Where is your pain located ☐ is primarily left Side ☐ Primarily Right Side
☐ Both Right and Left Side ☐ Face ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Wrist ☐ Hand
☐ Finger ☐ Upper Back ☐ Middle Back ☐ Lower Back ☐ Chest ☐ Abdomen ☐ Legs
☐ Feet ☐ Other: _____

When your pain started how was it treated? _____
_____

Describe your Pain,

Timing of Pain
____ Constantly (100%)
____ Frequently (75%)
____ Intermittently (50%)
____ Occasionally (25%)

Pain Quality (mark all that apply)
____ Burning
____Throbbing
____ Dull, Aching
____ Shooting
____ Sharp
____Cramping
____ Pressure
____ Electric like
____ Cutting
____ Numbness
____ Tingling

Describe your typical daily activities _____
_____

Pain Modifiers

Moderates Pain	*Relieves*	*Worsens*	*Unchanged*
Lying Down			
Standing			
Sitting			
Walking			
Exercise			
Medications			
Relaxation			
Thinking about something else			
Coughing/Sneezing			
Urination			
Bowel Movement			

Have you seen other doctors for your pain condition? ☐ Yes ☐ No
If yes, who did you see: _____ Where were they located? _____
How often did you visit them _____

Have you had surgery for your pain? ☐ Yes ☐ No if yes, please list: _____
_____

FUNCTION LIMITS

Activities avoided during past month due to pain

____ Work
____ Yard Work
____ Shopping
____ Recreation
____ Exercise
____ House Work
____ Socializing
____ Sexual Relations
____ Driving
____ Self-Care

Activity Tolerance

____ Unable to walk for more than (feet)
____ Unable to sit for more than (Minutes)
____ Unable to stand for more than (Minutes)

Lying down during the day due to pain

____ Never
____ Seldom
____ Often
____ Constantly

	Approximate Date Of Treatment	**Pain Relief**		
		Excellent	Moderate	None
Bed Rest				
Traction				
Back Brace				
TENS Unit				
Physical Therapy				
Exercise				
Ice				
Heat				
Medication				
Muscle Relaxants				
Aspirin				
Corticosteroid injection				
Cervical Facet injection				
Epidural Injection				
Lumbar Facet injection				
Nerve block				
Surgery				
Previous Hospital				
Chiropractor				
Acupuncture				
Psychotherapy				
Biofeedback				
Hypnosis				
Other Therapy				

Functional Changes Start Date in Month or Years

Please provide the approximate date of functional changes below:

Month/Years	Functional Changes
	Reduced physical activity
	Physical activity tolerance
	Inability to cope with daily life
	Intolerant to activities
	Leisure activities
	Temporary cessation of strenuous physical activity
	Drug use results in reduce in important activities
	General improvement-ability to resume activities
	Physical disability affecting ability to work
	Intolerant to household maintenance maintaining
	Unable to drive

Have you had any of the following diagnostic tests?

Diagnostic Test	*Date*	*Where*
X-Rays		
CAT Scan		
MRI Scan		
Bone Scan		
Myelogram		
EMG Nerve Test		
Other		

How much does your pain interfere with your daily activities? ☐ Not at all ☐ mildly
☐ Moderately ☐ Severely ☐ completely dependent upon others

How would you perceive your pain control at this time ☐ good ☐ adequate ☐ fair ☐ poor

Did an injury cause your pain? ☐ Yes ☐ No if yes what was the Date of injury _____
Describe your injury: _____
☐ Fall ☐ MVA ☐ Lifting ☐ Pulling ☐ I.E.D. ☐ Other _____

General Medical History

Are you allergic to: Iodine ☐ Yes ☐ No
Tape ☐ Yes ☐ No
X-Ray Dye ☐ Yes ☐ No

Do you have any other allergies ☐ Yes ☐ No if yes, please list below

Allergen	*Reaction*

MEDICATIONS

What medications do you CURRENTLY take for your pain?

Medication	*Dosage*	*How Often*

What medications have you taken and tolerated in the past for your pain? _____

_____

_____

What other medications are you currently taking?

Medication	*Dosage*	*How Often*

Have you ever taken the Following?

	Yes	*No*	*When?*	*Any Complications?*
Anticoagulants (blood thinners such as Coumadin or Heparin)?				
Cortisone or Steroids?				
Local Anesthetic (given by a physician)				
Antidepressants, anti-anxiety or other psychiatric meds?				

Past Medical History (please mark all that apply):

Yes	*No*	*History*
		Renal Disorders
		Hypertension (systemic)
		Angina Pectoris
		Prior Myocardial Infarction
		Hepatic Disorders
		Hepatitis
		HIV Infection
		Diabetes Mellitus
		Arthritis
		Long-Term Oxygen Therapy

Yes	*No*	*History*
		Stroke Syndrome
		Cancer
		Chronic Cough
		Psychiatric Therapy
		History of Suicidal ideation
		Recent Infection
		Previous pain medication
		Tuberculosis
		CPAP Ventilation

PAST SURGICAL HISTORY

Check all that apply:

Orthopedic Surgery History
____ Back Surgery
____ Hip Replacement
____ Knee Replacement
____ Rotator Cuff Repair
____ Neck Surgery

Cardiovascular Surgery History
____ Heart Valve Replacement
____ Coronary Artery Bypass Graft
____ Cardiac Catheterization
____ Cardiac Pacemaker

General Surgery History
____ Appendectomy
____ Gallbladder Surgery
____ Hernia Repair
____ Upper EGD
____ Colonoscopy
____ Sigmoidoscopy
____ Hemorrhoidectomy
____ Lung Surgery
____ Tonsillectomy/Adenoidectomy
____ Nephrectomy
____ Lithotripsy

Head Surgery History
____ Temporal Artery Biopsy
____ Carotid Endarterectomy
____ Cataract Surgery

Reproductive Surgery History
____ Tubal Ligation
____ Cesarean Section
____ Prostate Surgery
____ Vasectomy

Thyroid History
____ Radiation of the Thyroid
____ Thyroid Surgery
____ Hysterectomy

What Treatments have helped your pain: _____

FAMILY HISTORY

Yes	*No*	*Family History Detail*	*Family Member Affected*
		Suicide	
		Mental Illness (not retardation)	
		Alcoholism	
		Medication/Drug use Disorders	
		Cancer	
		Acute MI prior to age 50	
		Heart Disease	
		Hypertension	
		Early Deaths	
		Depression	

SOCIAL HISTORY

Please mark all that apply:

Living situation

____ Married living with spouse
____ Married living without spouse
____ Divorced
____ Living with significant other
____ Living with a friend
____ Living with adult children
____ Living with and caring for Child
____ Living independently alone

Smoking Use:

Yes	No	
____	____	Smoking
____	____	Current Smoker
____	____	Never Smoked
____	____	Previous Smoker
____	____	Interested in Cessation

Type: ☐ Cigarettes ☐ Pipes ☐ Smokeless (Chew) (snuff)

____ Years ____Packs per day

Substance Use:

____	____	History of Abuse
____	____	Narcotics Anonymous

Alcohol Use:

Yes	No	
____	____	Alcohol Use
____	____	Alcoholics Anonymous
____	____	previous problem with alcohol

Drinks Per week: _____

Type: □ Wine □ Beer □ Hard Liquor

Caffeine Use:

Yes	No	
____	____	Caffeine Use

Type: □ Coffee □ Tea □ Sodas □ Energy Drinks Cups Per Day: __

If you are employed, please describe your job. Occupation:

_____

_____

☐ Full-time ☐ Part-Time ☐ Unemployed

☐ Disability (list Disability) _____ ☐ Retired

Education Level

____ GED
____ High School Diploma
____ Associates Degree
____ Baccalaureate Degree
____ Master's Degree
____ Doctorate

Systemic Symptoms

Yes	No	
____	____	Weight Change
____	____	Chills
____	____	Fever
____	____	Night Sweats
____	____	Feeling tired

Head Symptoms

Yes	No	
____	____	Head ache
____	____	Facial Pain
____	____	Sinus Pain

Otolaryngial Symptoms

Yes	No	
____	____	Mouth Sores
____	____	Difficulty Swallowing
____	____	Difficulty Chewing

Pulmonary Symptoms

Yes	No	
____	____	Shortness of breath
____	____	Difficulty breathing at rest
____	____	Difficulty during exertion
____	____	Sleep Apnea
____	____	Wheezing

Cardiovascular Symptoms

Yes	No	
____	____	Chest Pain/Discomfort
____	____	Fast heart rate
____	____	Palpitations
____	____	Swelling of lower extremities

Gastrointestinal Symptoms

Yes	No	
____	____	Decreased Appetite
____	____	Recent Weight loss
____	____	Heartburn
____	____	Nausea
____	____	Vomiting
____	____	Frequent Bowel movements

Genitourinary Symptoms

Yes	No	
____	____	Pain During Urination
____	____	Increased urinary frequency
____	____	Urinary loss of control
____	____	Using incontinence devices
____	____	Hematuria (blood in urine)
____	____	Genital Lesion

Urinary Frequency____

Times during the night ____

Endocrine Symptoms

Yes	No	
____	____	Excessive Sweating
____	____	Excessive Thirst
____	____	Libido has changed
____	____	Endocrine Symptoms

Musculoskeletal Symptoms

Yes	No	
____	____	Joint pain Localized
____	____	Joint Stiffness
____	____	Muscle Aches

Psychological Symptoms

Yes	No	
____	____	Sleep Disturbances
____	____	Anxiety
____	____	Depression
____	____	Previous Psych Treatment
____	____	Passing out with needles

Neurological Symptoms

Yes	No	
____	____	Dizziness
____	____	Vertigo
____	____	Fainting
____	____	Arm/Leg Weakness
____	____	Numbness
____	____	Decreased concentrating
____	____	Memory Loss or Lapses

Hematologic Symptoms

Yes	No	
____	____	Easy Bleeding
____	____	Easy Bruising

Skin Symptoms

Yes	No	
____	____	Itching
____	____	Skin Lesions
____	____	Rashes

Implanted Devices

Yes	No	
____	____	Intravenous Catheter
____	____	Cardiac Defibrillation
____	____	Pacemaker
____	____	Surgical Screws (devices)
____	____	Spinal Cord Stimulator
____	____	Peripheral Nerve Stimulator
____	____	Intrathecal Pump

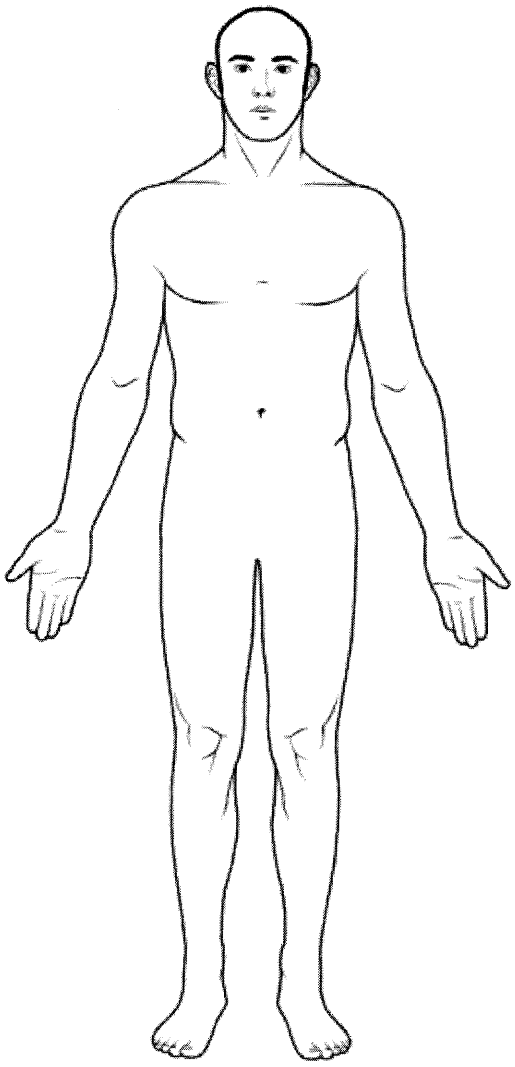
Please describe how you have felt during the PAST WEEK by making a check mark in the appropriate box. Please answer all the questions, do not think too long before answering.

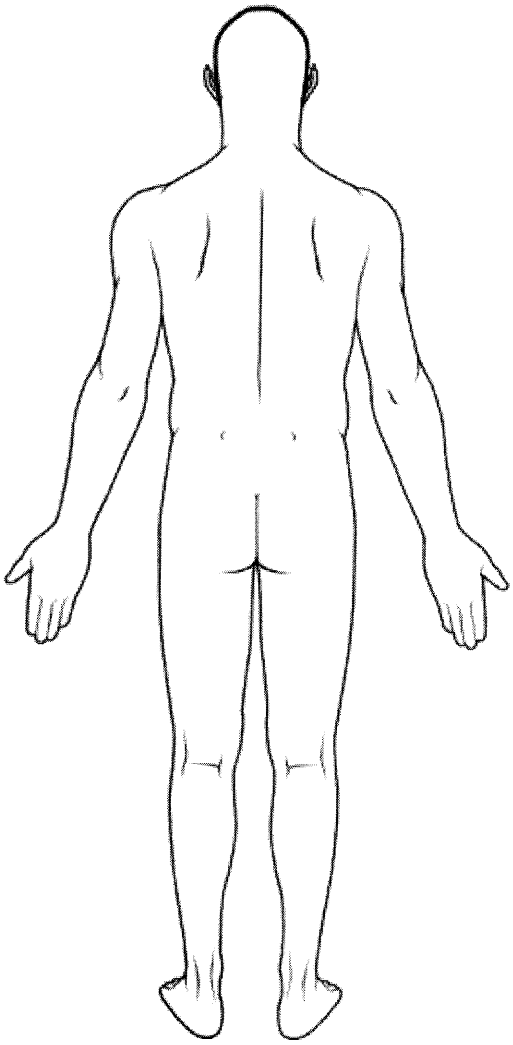
	Not at all	A Little	A Great Deal	Extremely
1. Heart rate Increase				
2. Feeling hot all over				
3. Sweating all over				
4. Sweating in particular body part				
5. Pulse in neck				
6. Pounding in Head				
7. Dizziness				
8. Blurring of Vision				
9. Feeling Faint				
10. Everything appearing unreal				
11. Nausea				
12. Butterflies in stomach				
13. Pain or ache in stomach				
14. Stomach Churning				
15. Desire to urinate				
16. Mouth becoming Dry				
17. Difficulty swallowing				
18. Muscle in neck aching				
19. Legs feeling Weak				
20. Muscles twitching or jumping				
21. Tense feeling across Forehead				
22. Tense feeling in jaw muscles				

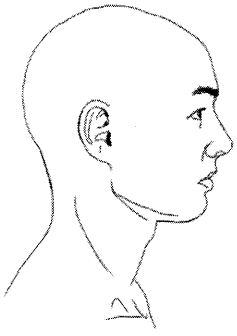
Please indicate for each of these questions which answer best describes how you have been feeling recently.

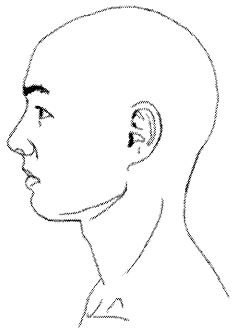
	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1-2 days a week)	Moderate amount of time (3-4 days a week)	Most of the time 5-7 days a week)
1. I feel downhearted and sad				
2. Morning is when I feel best				
3. I have crying spells or feel like it				
4. I have trouble getting to sleep at night				
5. I feel that nobody cares				
6. I eat as much as I used to				
7. I still enjoy sex				
8. I notice that I'm losing weight				
9. I have trouble with constipation				
10. My heart beats faster than usual				
11. I get tired for no reason				
12. My mind is as clear as it used to be				
13. I tend to wake up too early				
14. I find it easy to do things I used to				
15. I am restless and can't keep still				
16. I feel hopeful about the future				
17. I am more irritable than usual				
18. I find it easy to make a decision				
19. I feel quite guilty				
20. I feel that I am useful and needed				
21. My life is pretty full				
22. I feel others would be better off if I were dead				
23.I am able to enjoy things I used to do				

Please Mark the areas on your body where you feel pain.









Name: _____ Date: _____

Integrative Pain Center of Alaska, LLC

Patient Registration From: PLEASE PRINT

Patient name_____ SS# _____ Birth date_____
(Last) (First)
Address_____
(Street) (City) (State) (Zip)
Home Phone_____ Cell Phone _____
Marital Status: Married, Single, Other Gender M – F
Race_____ Language Spoke_____ (race and language information used anonymously for public health statistics)
Employer_____ Business# _____
Occupation_____ Employer Address_____
Spouse_____ Spouse Employer _____Work#_____
Emergency Contact (other than spouse) _____ Relationship_____
Emergency contact Home# _____ Work # _____

How did you Hear about Integrative Pain Center of Alaska (circle one) Referring Physician Radio TV Other

PRIMARY INSURANCE INFORMATION Insurance Comp. Name _____
Ins. Comp Address _____ Ins. Comp # _____
Relationship to Patient_____ Policy Holder Name_____
Policy Holder SS# _____ Birth date _____
Group # _____ Identification # _____

WORKER'S COMP INFORMATION Worker's comp insurance comp Name_____
W/C comp. Address _____ W/C Claim# _____
Date of injury _____ Employer at time _____
Name of Adjustor _____ Adjustors # _____ Site of injury_____

SECONDARY INSURANCE INFORMATION Insurance Comp. Name _____
Ins. Comp Address _____ Ins. Comp # _____
Relationship to Patient_____ Policy Holder Name_____
Policy Holder SS# _____ Birth date _____
Group # _____ Identification # _____

I understand that I am **fully responsible for any and all charges** for services rendered by the Integrative Pain Center of Alaska; LLC if insurance information is provided my insurance company will be billed as a courtesy to me. I am responsible for my portion of the bill at the time that services are rendered. I hereby authorize payment under my insurance company for payment of claims. I understand a finance charge of 1.5% will be applied to any outstanding balance due after insurance payment or denial after 90-day grace period

I, the undersigned, hereby authorize Integrative Pain Center of Alaska; LLC providers to examine me, to administer such treatment as is necessary and to perform such procedures as are considered therapeutically or diagnostically necessary.

Date_____ Patient Signature _____

FINANCIAL POLICY

Thank you for choosing us as your Pain Management Specialists. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment in our office.

All patients (parents or guardians) must complete our Patient Information and Financial Policy before seeing the Provider.

- PAYMENT IS DUE AT THE TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD.
- WE OFFER A PAYMENT PLAN WITH PRIOR BUSINESS APPROVAL.
- THE WILL BE A $25.00 SERVICE CHARGE ON ALL NSF CHECKS.
- **APPOINTMENTS MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE, OR YOU WILL BE BILLED FOR A "NO-SHOW" . PLEASE NOTE THAT MOST INSURANCE COMPANIES DO NOT COVER NO SHOW APPOINTMENTS, THIS WILL BE BILLED DIRECTLY TO YOU.**

Regarding Insurance:

It is our goal to provide fast and efficient billing as a courtesy to you. We need your help to accomplish this goal by providing complete and accurate insurance information. Knowledge of your deductible and co-pays is YOUR responsibility. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If for any reason your insurance coverage changes, it is your responsibility to inform Integrative Pain Center of Alaska, LLC in a timely manner. If you fail to inform us within 60 days of the change, the Integrative Pain Center of Alaska, LLC will not be responsible for billing your insurance. Please be aware that some and perhaps all of the services provided may be non-covered services. Some insurance companies reduce or deny benefits saying they are not considered UCR (usual, customary or responsible). Please be advised that our fees are based on a national geographic standard and are, in fact, UCR for Alaska.

All deductibles and co-pays are due and payable at the time of treatment. The balance is your responsibility whether your insurance company pays or not. In the event your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rate.

Minor patients.

The adult accompanying a minor, the parents (or legal guardians) of the minor, are responsible for payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY:

X_____ _____

Signature of Parent or Responsible Party | Relationship to patient

Patient Name: _____ Date: _____

Consent for involvement in Care

Integrative Pain Center of Alaska, LLC

In order to comply with specific rules regarding HIPPA, we ask that our patients complete and sign this privacy and security of health information. **Unless this form is completed, we cannot talk to or share any medical information with anyone but you.**

Billing and Payment Information

I, _____, hereby authorize Integrative Pain Center of Alaska, LLC billing department to speak to the person(s) listed below regarding my billing and payment information.

1. _____ Relationship to patient _____

2. _____ Relationship to patient _____

Medication Information

I, _____, hereby authorize Integrative Pain Center of Alaska, LLC to release prescriptions that need to be picked up on my behalf to the person(s) listed.

1. _____ Relationship to patient _____

2. _____ Relationship to patient _____

Appointment Reminders

I, _____, hereby authorize Integrative Pain Center of Alaska, LLC and staff to leave appointment reminders by the following methods.

1. **Home Telephone/Voicemail** _____ **Yes**_____ **No**_____ **N/A** _____
2. **Work Telephone/Voicemail** _____ **Yes** _____ **No** _____ **N/A** _____
3. **Cellular Phone/ Voicemail** _____ **Yes** _____ **No** _____ **N/A**_____

Personal Health Information

I, _____, hereby authorize Integrative Pain Center of Alaska, LLC to speak to the person(s) listed below regarding my personal health information

1. _____ Relationship to patient _____

2. _____ Relationship to patient _____

I understand and assume responsibility of notifying IPCA whenever the listed information changes. I understand this release **excludes;** insurance companies, attorneys and other health care providers.

_____ _____

Patient Signature Date

_____ _____

Witness/Staff Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received a copy of Integrative Pain Center of Alaska, LLC'S Notice of Privacy Practices.

_____	_____
Patient Signature	Date
_____	_____
Patient Legal Representative	Date
_____	_____
Print Name of Legal Representative	Relationship to Patient

FOR CLINIC USE ONLY

Integrative Pain Center of Alaska, LLC made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice Privacy Practices:

(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained)

Integrative Pain Center of Alaska, LLC is dedicated to maintaining the privacy of your Protected Health Information (PHI). IPCA provides health care items and services through its schools of medicine, nursing, pharmacy and allied health sciences. IPCA provides services at its main community hospitals, primary care specialty clinics, pharmacies, research units and several community services outreach centers throughout Alaska. IPCA is required by law to maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices. This notice of privacy practices describes how IPCA may use or disclose your PHI. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; (3) the past, present, or future payment for you healthcare. This notice also tells you about your privacy rights and IPCA's legal duties with respect to your PHI. The terms of this notice shall apply to IPCA's privacy practices until it is chanced by IPCA

CHANGE IN NOTICE OF PRIVACY PRACTICES

IPCA reserves the right to change this notice of privacy practices at any time. Any changes will apply to all PHI and IPCA created or maintained for you. If this notice is changed, it will be posted at out clinic and on our website (www.alaskapaincenter.com) and you can request a copy of this notice. **IPCA PERMITTED USES AND DISCLOSURES OF PHI FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION.** IPCA may use or disclose your PHI without your written authorization the following:

TREATMENT

Your PHI may be used and disclosed to provide, coordinate or manage your healthcare and related services. This may include talking with other health care providers about your treatment or coordinating and managing your healthcare with others. For example, when your family physician refers you to another doctor tour family physician may tell the other doctor about any drug allergies you may have so the other doctor can diagnose or treat you.

PAYMENT

Your PHI may be used to disclose to obtain payment for your health care services. For example, IPCA may share your PHI with your health insurance plan for payment of health care items or services provide to you.

HEATLTH CARE OPERATIONS

Your PHI may be used and disclosed to support our business activities. These include, but are not limited to, quality evaluation, work force reviews, education and training of students and physicians in training, licensing, and conducting or arranging for other business activities. For example, IPCA may use your PHI to evaluate the performance of our staff in caring for you. **OTHER USES AND DISCLOSURES OPPORTUNITY FOR YOU'RE TO AGREE OR OBJECT AMCA MAY USE OR DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION FOR THE FOLLOWING PURPOSE UNLESS YOU OBJECT:**

- **INVOLVEMENT IN PATIENT CARE AND NOTIFICATION PURPOSE –** to a family member, other relative, close personal friend or other person you have identified as involved with your treatment or payment for healthcare services. We may also use your PHI to notify or assist in notifying such persons of you location or health.
- **DISASTER RELIEF EFFORTS –** To public or private relief agencies to assist in disaster relief efforts.
- **APPOINTMENT REMINDERS –** We may contact you to remind you of your healthcare appointments or to provide you with information about treatment alternatives or other health related benefits and services that may be interest to you.

USE AND DISCLOSEURES OF PHI WITHOUT YOUR WRITTEN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT IPCA MAY BE ALLOWED OR REQUIRED TO USE OR DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY FOR YOU TO AGREE OR OBJECT FOR THE FOLLOWING REASONS:

- **REQUIRED OR AUTHORIZED BY LAW –** As required by federal, state, or local law. Any disclosure must comply with the law and is limited to the requirements of the law.
- **PUBLIC HEALTH ACTIVITIES –** To public health authorities or other authorized persons to carry out certain public health activities, including the following:

– To report, prevent, or control disease, injury or disability; **To report vital statistics, such as birth or death; To report child abuse or neglect; To report bad reactions to medications or problems with produces or devices regulated by the FDA;**

– **To locate and notify you of recalls or products you may be using; To notify a person who may have been exposed to a contagious disease in order to control who may be risk of contracting or spreading the disease; or To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.**

- **ABUSE, NEGLECT, OR DOMESTIC VIOLENCE –** in certain cases to proper government authorities if we have reason to believe that you have been the victim of domestic violence, abuse or neglect.
- **HEALTH OVERSIGHT ACTIVITIES –** To a health oversight agency for oversight activities authorized by law such as audits, investigations. Inspections, and licensure activities or as necessary for certain government agencies to monitor the Healthcare system, government programs, and compliance with civil rights laws.
- **JUDICIAL, ADMINISTRATIVE AND LAW ENFORCEMENT PURPOSES –** Where requested by law enforcement, and as authorized or required by law, we may disclose your PHI;

In response to a court order, subpoena, warrant, summons or similar process; In response to requests for limited information necessary to identify or locate a suspect fugitive, material witness, or missing person; If we suspect that you are a victim of a crime and if you agree to the disclosure, or under certain circumstances, where we are unable to obtain your permission; About your death if we suspect it is the result of criminal conduct; About criminal conduct that

occurs at IPCA: and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime. **OTHER USES AND DISCLOSURES CONTINUED-**

- **DECEDENTS –** To a coroner or a medical examiner to identify you and determine the cause of your death in addition, we may disclose your PHI to funeral directors, as authorized by law, so that they may do their jobs.
- **ORGANIZATIONS THAT OBTAIN ORGANS –** If you are an organ donor, after your death we may use or disclose your PHI to organizations that help get, locate, store, and transplant organs to help with organ, eye, or tissue donation and transportation.
- **RESEARCH-** For research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPPA privacy rule.
- **TO STOP SERIOUS THREAT TO HEALTH OR SAFETY –** In limited circumstances when necessary to help stop a threat to the health or safety of a person or to the public. This disclosure can be made only to a person who is able to help stop the threat.
- **NATIONAL SECURITY; INTELLIGENCE ACTIVITIES; AND PROTECTIVE SERVICES –** To Federal officials for intelligence counterintelligence, and other national security activities authorized by law, including activates related to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.
- **CORRECTIONAL INSITUTIONS –** Of inmates or other individuals under lawful custody to a correctional institution or law enforcement officer for the provision of healthcare, health and safety matters, law enforcement purposes or security of the correctional institution.
- **WORKERS COMPENSATION –** To comply with worker's compensation programs or other similar programs that provide benefits for work-related injuries or illness without regard to fault.
- **LIMITED DATA SET –** We may use and disclose limited PHI that does not fully identify you only for purposes of research, public health, or health care operations.
- **PARENTAL ACCESS –** To your parents or legal guardian if you are under the age of 18, unless it is prohibited by Alaska Law. Other than the categories mentioned above, IPCA will not disclose your PHI without your written authorization. You may revoke your written authorization at any time in writing; however, your written revocation will only apply to PHI that has not already been used or disclosed by IPCA under your written authorization.
- **YOUR PRIVACY RIGHTS, RIGHT TO INSPECT AND COPY –** You have the right to inspect and request a copy of your PHI that is in a designated record set. This includes your insurance and billing records but not counseling notes of a mental health professional. Information prepared by or for our attorneys to defend IPCA, or where prohibited by law. You may be charged a reasonable fee to obtain a copy of your PHI. IPCA reserves the right to deny your request to access or receive a copy of your PHI as provided by law. All requests must be in writing using the IPCA authorization for release of patient information form.
- **RIGHT TO REQUEST RESTRICTIONS –** You have the right to request IPCA limits its use or disclosure of you PHI for treatment, payment, or healthcare operations. You may also request that IPCA limits its disclosure of your PHI to family members, relatives, close personal friends or others you have identified as being involved in your care. We are not required to agree to your request. If we agree to your request, we will limit use or disclosure of your PHI except in certain cases, including where the information is needed to treat you or to verify coverage in the case of an emergency. To request restrictions, you must make your written request to an IPCA privacy official. Your request must include 1) the information that your want to limit, 2) how you want to limit the information, and 3) to whom you want those limitations to apply.
- **RGHT TO REQUEST CONFIDENTIAL COMMUNICATION –** You have the right to request other means or locations to receive communications about your PHI. All requests must be in writing using a IPCA confidential communication request form. IPCA will agree to readable requests for other means or locations to receive communications about your PHI.
- **RIGHT TO REQUEST YOUR PHI –** You have the right to request IPCA change information in your PHI for as long as IPCA keeps your PHI. IPCA can deny your request to change your PHI as provided by law. All requests must be in writing using a IPCA amendment request form.
- **RIGHT TO AN ACCOUNTING OF DISCLOSURES –** You have the right to request an accounting of certain uses and disclosures of your PHI by IPCA. This is a use of disclosures made by IPCA during the past six years; except for uses or disclosures made: For treatment, payment and health care operations; to family members or friends involved in your care; to you directly; pursuant to a written authorization; for certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes); or before April 14, 2003. If you wish to make a request for an accounting contact the privacy official to obtain a IPCA accounting request form, the first list of accounting that you request in a 12-month period will be free, but we may charge you for any additional ones requested during the same 12- month period. We will tell you about these costs, and you may cancel your request at any time before costs are incurred.
- **RIGHT TO A PAPER COPY OF THIS NOTICE-** You have the right to receive a paper copy of this notice of privacy practices upon request. Even if you have agreed to receive this notice electronically, you can still receive a paper copy of this notice.
- **COMPLAINTS –** if you believe your privacy rights have been violated, you may file a complaint in on of the following ways
- The PCA privacy official at the address indicated below

Integrative Pain Center of Alaska
1275 Sadler way STE 200
Fairbanks AK, 99701
(907)374-6602

We will not retaliate or take action against you for filing a complaint

QUESTIONS – if you have any questions about this notice or would like additional information, please contact the privacy official at the address and telephone number listed above.