INNOVATIVE NEUROSURGERY ASSOCIATES

Visit Date: _____/ _____/ _____

Please Fill Out Completely

Patient Name: _____ Sex: _____

DOB: _____/ _____/ _____ Age: _____ **SSN**: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____ Email address: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

Marital status: _____

Emergency contact: _____Relationship _____ Phone: (_____)_____

Primary care Physician: _____Preferred Pharmacy _____

Reason for today's visit: _____

Is this visit due to an accident?: _____ **Type of accident:** _____ **Date of accident?:** _____/ _____/ _____

Employer

Employer's name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Primary Insurance

Primary insurance : _____

Policy #: _____

Policyholder's name: _____ **DOB:** _____/ _____/ _____ **Relationship to patient:** _____

Phone: (_____)_____

If company policy, employer's name:_____ Group #: _____

Secondary Insurance

Secondary insurance : _____

Policy #: _____

Policyholder's name: _____ **DOB:** _____/ _____/ _____ **Relationship to patient:** _____

Phone: (_____)_____

If company policy, employer's name: _____ Group #: _____

The information above is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to my physician here at Innovative Neurosurgery Associates, LLC. I understand that I am financially responsible for any balance that is due before and after my insurance has been paid. I also authorize Innovative Neurosurgery Associates, LLC to obtain/release any of my information required to process anyclaims. If my insurance does not pay the claim within 30 days of submission, I will be responsible for payment of the claim.

Patient Signature : _____Date _____/ _____/ _____

INNOVATIVE NEUROSURGERY ASSOCIATES

Patient Name: _____

Release of Information (ROI)

I authorize Innovative Neurosurgery Associates, LLC to release some or all of my medical records, medication(s) information, financial and appointment information to the following persons:

Name: _____ DOB: _____/ _____/ _____

Relationship to patient:_____

Name: _____ DOB: _____/ _____/ _____

Relationship to patient:_____

Name: _____ DOB: _____/ _____/ _____

Relationship to patient:_____

Patient signature: _____ Date: _____/ _____/ _____

Representative, if applicable: _____ Date: _____/ _____/ _____

For Office Use

Patient refuses to sign: _____ Patient unable to sign because: _____

Employee signature: _____ Date: _____/ _____/ _____

INNOVATIVE NEUROSURGERY ASSOCIATES

Patient Name: _____

Health Insurance Portability and Accountability Act (HIPAA) Acknowledgment

In order for Innovative Neurosurgery Associates, LLC to comply with federal government regulations we are required to have a document available for you to review that explains our patient privacy information/HIPAA policy. If you wish to review, please ask our front desk receptionist for a copy of this policy

I hereby acknowledge that I have been offered, received or reviewed at copy of Innovative Neurosurgery, LLC Notice of Privacy Practices (NPP).

With my consent, Innovative Neurosurgery Associates, LLC may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations as discussed in the NPP.

With my consent, Innovative Neurosurgery Associates, LLC may call my home or other designated location and leave a message on voicemail or in person in reference to any items that may assist the practice in providing my healthcare.

With my consent, Innovative Neurosurgery Associates, LLC may email or mail to my home or other designated location any items that assist the practice in providing my healthcare.

I may revoke this consent in writing, except to the extent that the practice has already made disclosures relying upon my prior consent. If I do not sign this consent, Innovative Neurosurgery Associates, LLC may decline to provide treatment to me.

I hereby consent to the use or disclosure of my individually identifiable health information by Innovative Neurosurgery Associates, LLC in order to carry out the treatment, obtain payment from my insurance company and continuation of care with my past, present or future health care providers. At any time I have the right to void this consent; such voiding must be submitted in writing to Innovative Neurosurgery Associates, LLC.

By signing below I acknowledge that I have read and understand all sections of this policy.

Patient signature: _____ Date: _____/ _____/ _____

Representative, if applicable: _____ Date: _____/ _____/ _____

- PLEASE LEAVE THE SECTION BELOW THIS LINE BLANK FOR OFFICE USE -

Patient refuses to sign:_____ Patient unable to sign because: _____

Employee signature: _____ Date: _____/ _____/ _____

INNOVATIVE NEUROSURGERY ASSOCIATES

Patient Name: _____

Financial information

Please review the following policy and acknowledge receipt by your signature.

Charges:

Payment Policy: Innovative Neurosurgery Associates, LLC requires full payment of co-pays and any outstanding balances at check-in before your appointment.

Work-Related & Auto Injuries: If your visit is related to a work injury or auto accident, all necessary information and medical payment verification must be completed before scheduling an appointment or seeing a provider.

Insurance Authorization: Patients are responsible for confirming whether their insurance plan requires prior authorization for office visits and ensuring that authorization has been obtained before their appointment.

Insurance Billing:

Patient Responsibility: You are responsible for providing accurate billing information and notifying us of any changes to your demographics, including name, address, phone number, and insurance details.

Insurance Claims Submission: As a courtesy, we will submit claims to your insurance provider, except for third-party insurers, and will assist you in the claims process to the extent reasonably possible. Any balances not covered by your insurance are due upon receipt of a statement from Innovative Neurosurgery Associates, LLC.

Surgical Billing: We will bill your insurance for surgical procedures; however, a deposit may be required prior to surgery. If surgery is recommended, a patient account representative will provide further details.

Insurance Follow-Up: It is your responsibility to follow up with your insurance provider if a claim is denied, paid at a lower rate than expected, or remains unpaid after 45 days. Any outstanding charges not paid in a timely manner by your insurance will become your responsibility.

Benefit Verification: Patients are responsible for verifying their insurance benefits and responding promptly to any information requests from their insurance provider.

Overdue Accounts:

Monthly Statements & Insurance Payments: Innovative Neurosurgery Associates, LLC will issue monthly statements for any outstanding account balances. If your insurance company does not process payment within 90 days, the remaining balance will be billed directly to you.

Delinquent Accounts: Accounts that remain unpaid for more than 120 days may be referred to a collection agency. Once your account has been transferred, all further inquiries and payments must be directed to the collection agency rather than Innovative Neurosurgery Associates, LLC.

Authorization and Release:

Patient Acknowledgment & Authorization: I have read and understand the information provided above. I authorize Innovative Neurosurgery Associates, LLC to submit my medical claims to my insurance company and to release or obtain any necessary medical records to facilitate payment for services rendered. If I have any questions, I may contact the INA Billing Specialist at 907-243-0695.

_____ Date: _____/_____/_____

Patient or Responsible Party

INNOVATIVE NEUROSURGERY ASSOCIATES

Visit Date: _____/ _____/ _____

NEW PATIENT

Patient Name: _____ DOB: _____/ _____/ _____ Age: _____

Past Medical History (check all that apply)

Family	Self		Family	Self		Family	Self	
☐	☐	Diabetes	☐	☐	Arthritis	☐	☐	Parkinson's disease
☐	☐	High blood pressure	☐	☐	Lupus (SLE)		☐	GERD
☐	☐	Coronary artery disease	☐	☐	Crohn's; Ulcerative colitis	☐	☐	Depression
☐	☐	Heart attack	☐	☐	IBS	☐	☐	Bipolar disorder
	☐	Atrial fibrillation	☐	☐	Fibromyalgia	☐	☐	Schizophrenia
	☐	Congestive heart failure (CHF)	☐	☐	Migraine headaches		☐	Hepatitis (liver disease)
	☐	Heat valve problem	☐	☐	Thyroid disease		☐	Cirrhosis
	☐	Pace maker	☐	☐	Peripheral vascular dis.		☐	Stroke
	☐	Angina	☐	☐	Peripheral neuropathy		☐	Osteoporosis
	☐	Asthma	☐	☐	Psoriasis		☐	Spinal stenosis
	☐	COPD / Emphysema	☐	☐	Multiple sclerosis		☐	Scoliosis
☐	☐	Bleeding disorder		☐	Sleep apnea		☐	Obesity
	☐	DVT / Blood Clots		☐	Renal (Kidney) disease		☐	Drug abuse
	☐	HIV / AIDS	☐	☐	Alzheimer's disease	☐	☐	Cancer

Other/details_____

_____

_____

Past Surgical History

_____

_____

_____

_____

_____

Social History

☐ I do not use alcohol ☐ I drink less than 2 drinks per day ☐ I drink more than 2 drinks per day

☐ I do not use nicotine ☐ I smoke cigarettes _____ ☐ I dip ☐ Other nicotine _____

☐ I do not use marijuana ☐ I smoke marijuana _____ ☐ I use edible marijuana _____

☐ I do not use Illicit drugs ☐ I am a former user ☐ I am using _____

Medications

Medication	Dose	Frequency	Medication	Dose	Frequency

Allergies

_____

_____

Review of Systems (check all that apply)

General/constitutional

- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue
- ☐ Weight loss _____
- ☐ Weight gain _____

Ophthalmologic

- ☐ Blurred vision
- ☐ Vision loss

ENT

- ☐ Ringing in ear
- ☐ Sore throat
- ☐ Sinus congestion
- ☐ Hearing loss

Endocrine

- ☐ Chng in hat/ring/shoe sz.
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger

Respiratory

- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheeze

Cardiovascular

- ☐ Chest Pain
- ☐ Pounding in chest
- ☐ Swelling in feet/ankles

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Incontinence of stool

Hematology

- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Swollen lymph nodes

Genitourinary

- ☐ Frequent urination
- ☐ Urinary urgency
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Sexual dysfunction

Musculoskeletal

- ☐ Weakness
- ☐ Difficulty walking
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain/swelling
- ☐ Use of cane/walker

Skin

- ☐ Itching
- ☐ Rash
- ☐ Skin lesion

Neurologic

- ☐ Shooting pain
- ☐ Numbness
- ☐ Tingling
- ☐ Poor balance
- ☐ Headaches
- ☐ Confusion
- ☐ Memory loss
- ☐ Speech difficulty
- ☐ Seizures

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping

INNOVATIVE NEUROSURGERY ASSOCIATES

Patient Name: _____ Date _____/ _____/ _____

David P. Paulson, MD -

2751 DeBarr Road | Regional Hospital Complex | Building B Suite 285 | Anchorage | Alaska | 99508

www.InnovativeNeurosurgery.com

Important Considerations When Deciding Whether to Proceed with Spine Surgery

Four Key Questions

I. **Are there appropriate indications for surgery?**
(Is surgery truly necessary based on your diagnosis and symptoms?)

II. **What are the surgeon's capabilities and comfort level with this specific procedure?**
(Does your surgeon have the necessary experience and expertise to handle your condition effectively?)

III. **Should the procedure be performed?** (Comprehensive risk-benefit analysis)
What is the natural course of your condition if left untreated?
What non-surgical treatment options are available?
What are the realistic goals and expected outcomes of the surgery?
How will the surgery impact your lifestyle and daily activities?
What are the common and uncommon risks associated with the procedure?

IV. **If surgery is deemed necessary, what is the optimal timing?**
(Should the surgery be performed on an elective, urgent, or emergent basis?)

Seven General Categories of Potential Spine Surgery Complications

I. **Pain** (Postoperative pain that may persist or become chronic)

II. **Infection** (Surgical site infections, deep infections, or systemic infections such as sepsis)

III. **Bleeding** (Excessive intraoperative or postoperative bleeding, hematoma formation, or the need for transfusions)

IV. **Damage to nerves, vessels and surrounding tissue** (Injury to nearby structures, leading to neurological deficits, vascular injury, or organ dysfunction)

V. **Failure to treat presenting symptoms** (persistence or recurrence of symptoms despite surgical intervention)

VI. **Need for additional procedures** (early and late) (The possibility of revision surgery, hardware removal, or other corrective procedures.)

VII. **Other unfortunate hospitalization related complications** (Issues such as blood clots (DVT/PE), anesthesia-related complications, pressure ulcers, or hospital-acquired conditions.)

Seven Additional Considerations About the Permanence of Spine Surgery

I. **Spine surgery is a tool, not a cure, and its success depends on the right patient, the right procedure, and the right timing.** (Surgery can effectively address specific mechanical problems, such as nerve compression or instability, but it is not a guaranteed solution for all symptoms. A comprehensive approach, including lifestyle modifications, physical therapy, and realistic expectations, is essential for achieving the best outcomes)

II. **Spine disease is a chronic condition which is ongoing …even after surgery.** (Surgery may address specific issues, but the underlying degenerative process continues over time)

III. **Spine surgery often increases the likelihood of requiring additional procedures in the future.** (Adjacent segment disease, hardware failure, and progression of degenerative changes can necessitate further interventions)

Iv. **Revision spine surgery is typically more extensive and complex than the initial procedure.** (Addressing scar tissue, altered anatomy, and structural changes often requires a broader surgical approach with higher risks and longer recovery)

V. **Once surgery is performed, it cannot be undone or scaled back.** (The changes made during surgery are permanent, and conservative treatment options may become less effective afterward)

VI. **The only guaranteed way to avoid surgical complications is to avoid surgery altogether.** (Every surgical procedure carries inherent risks, and careful consideration should be given before proceeding)

VII. **While spine-related pain is not life-threatening, spine surgery carries serious risks.** (No one has died from back,

INNOVATIVE NEUROSURGERY ASSOCIATES

New Patient Information

Visit Date: _____/ _____/ _____

Patient Name: _____

DOB: _____/ _____/ _____ Age: _____ Sex: _____

Occupation: _____

Work status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Disabled

Referral source: _____

Reason for referral: _____

Primary care provider: _____

Pain management specialist: _____

Chiropractor: _____

Prior to this current episode for which you are being seen do you have a history of neck/back issues? If so please elaborate:

_____

_____

_____

_____

_____

_____

_____

Have you ever had surgery on your spine? If so, when and how did it go?

_____

_____

_____

_____

_____

_____

_____