NEUROVERSION
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New Patient Checklist

Name: _____ DOB: _____

To ensure that you are seen in a timely manner, have the following items with you complete prior to your visit. If you have completed ALL of the items below, arrive 15 minutes before your appointment time. If you need assistance or have not completed ANY of the below, arrive one hour before your appointment time. If you have sent in these items by other means (faxed, e-mailed, etc.) contact the clinic to confirm that they have been received. Failure to have these completed and/or received prior to your scheduled appointment time will result in your appointment being rescheduled.

Appointment Date: _____ Appointment Time: _____

Below items are **complete**, arrive 15 minutes before your appointment: _____

Below items are **not complete**, arrive one hour before your appointment: _____

Document	Office Staff Initial Completion
☐ Driver's license or other government issued ID	☐ Scanned (front) ☐ Scanned (back)
☐ Insurance card(s)	☐ Scanned (front) ☐ Scanned (back)
☐ Patient Registration Form (Admin Packet)	☐ Completed ☐ Signed and dated ☐ Scanned
☐ Email Communication Agreement (Admin Packet) ☐ Declined	☐ Completed ☐ Signed and dated ☐ Scanned
☐ Financial Agreement (Admin Packet)	☐ Completed ☐ Signed and dated ☐ Scanned
☐ Acknowledgement of Receipt of Notice of Privacy Practices (Admin Packet)	☐ Completed ☐ Signed and dated ☐ Scanned
☐ Clinical Agreement (Admin Packet)	☐ Completed ☐ Signed and dated ☐ Scanned
☐ Release of Information to Person(s) (Admin Packet) ☐ Declined *Inform front desk if additional forms are needed for multiple persons at check-in*	☐ Completed ☐ Signed and dated ☐ Scanned
☐ Past Medical History Packet	☐ Completed ☐ Signed and dated ☐ Scanned or/ ☐ Given to MA
☐ New Patient Medical Summary Packet (multiple may apply) ☐ Pain, other ☐ PTSD ☐ Long Covid, ME/CFS, Havana Syndrome	☐ Completed ☐ Signed and dated ☐ Scanned or/ ☐ Given to MA
☐ Imaging Studies (disc) ☐ Not applicable	☐ Uploaded to drive ☐ Returned to patient or/ ☐ Stored
☐ Medical Records ☐ Not applicable	☐ Scanned

NEUROVERSION

We are located on the Alaska Regional Hospital campus, Medical Office Building D:

2925 Debarr Road
Suite 240
Anchorage, Alaska

Patient parking is available on parking level P3 accessible through the front of MOB D with elevator access. Please note that P1 is parking reserved for employees and P2 is reserved for physicians.

Our office is located on the second floor (level 2).

PATIENT PARKING ACCESS LEVEL P3

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Patient Registration Form

PATIENT INFORMATION: (Please print) Date: _____/_____/_____

Last name: _____ First name: _____ MI: _____

Preferred name (if applicable): _____ SS#: _____-_____-_____

Sex: ☐ Male ☐ Female ☐ Transgender Age: _____ DOB: _____/_____/_____

Marital status: ☐ Married ☐ Divorced ☐ Partner ☐ Single ☐ Widowed

Home phone: _____ Work phone: _____ Cell phone: _____

Best number to contact: ☐ Home ☐ Work ☐ Cell Can we leave message: ☐ Yes ☐ No

E-mail address: _____

Physical address: _____

City: _____ State: _____ Zip code: _____

☐ Mailing address is same as physical address

Mailing address: _____

City: _____ State: _____ Zip code: _____

Employment status (if applicable): _____

PLEASE COMPLETE THE FOLLOWING THREE SECTIONS AS PER GOVERNMENTAL HEATH CARE REGULATIONS

Race (Please check all that apply):

☐ American Indian ☐ Alaska Native ☐ Native Hawaiian ☐ Black or African American
☐ Asian ☐ White ☐ Other Pacific Islander ☐ More than one race
☐ Other ☐ Decline to specify

Ethnicity (Please check one):

☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to specify

Preferred language:

☐ English ☐ Spanish ☐ Other Do you require an interpreter: ☐ Yes ☐ No

HEALTH CARE PROVIDERS:

Referring physician: _____ Phone number: _____

Location: _____

Primary care physician: _____ Phone number: _____

Location: _____

INSURANCE INFORMATION: (Subscriber Name & DOB are required as these are not printed on insurance card)

If you have Tricare, Triwest, or ChampVA, please use subscriber SS number as ID. DOD doesn't work with electronic eligibility checks

Primary insurance: _____ ID #: _____ Group #: _____

Insurance address: _____ Phone number: _____

Subscriber's name: _____ Subscriber's DOB: _____/_____/_____

Secondary insurance: _____ ID #: _____ Group #: _____

Insurance address: _____ Phone number: _____

Subscriber's name: _____ Subscriber's DOB: _____/_____/_____

Is this visit related to an accident: ☐ No ☐ Yes, workers compensation ☐ Yes, auto accident ☐ Yes, other

If YES, the following information must be provided:

Is there an open claim related to this? ☐ Yes ☐ No Date of injury: ___/___/___ Claim #: _____

Employer (workers comp): _____ Adjuster's name: _____

Adjuster's phone number: _____ Adjuster's fax number: _____

PHARMACY INFORMATION:

Preferred local pharmacy: _____ City: _____ Phone:_____

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship to patient: _____

Home phone: _____ Work phone: _____ Cell phone: _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

□ Referring doctor □ Friend □ Self
□ Newspaper □ Internet ☐ Other _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign):

I hereby authorize Neuroversion to furnish information to insurance carriers concerning my illness and/or treatments. I assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____/_____/_____

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Financial Agreement

Patient Name: _____ DOB: _____/_____/_____

Patients are responsible for any and all charges incurred resulting from treatment provided at Neuroversion. As a service to our patients, Neuroversion will file claims with most insurance carriers directly; however, you are primarily responsible in full for your balance and for all services rendered. Please be aware that the contractual agreement is between yourself and your insurance company, not the physician's office. It is your responsibility to call and verify your coverage, know your benefits and know if authorization is required prior to scheduling your appointment. In cases where we participate with your insurance as a preferred provider; deductibles, co-pays, and co-insurance payments are due in full and expected at the time of service. All quotes given by our billing department for services, co-pays, co-insurance, etc. are estimates only. We accept money orders, personal checks, and cash, Visa, MasterCard, and Discover as payment options.

Collection Procedure

For any surgery center procedures, you will receive two statements; one for the professional physician service, Luke Liu, MD and one for the ambulatory surgery center facility. These separate statements conform to current standards of billing practices within the healthcare industry. For clinic visits, you will receive only one statement from Neuroversion. If you have a urine drug screen, you should expect to see a bill and/or an explanation of benefits from the lab company as well. You will receive monthly statements which will reflect the total amount owing on your account until a payment has been received. If your account does not clear in a timely manner and you have not supplied requested information to our billing department, your account will be turned over to a third party collection agency. To prevent this from happening, we ask that you keep in communication and comply with our billing department in regards to your account.

It is your responsibility to update Neuroversion with any insurance changes prior to a scheduled appointment.

All billing questions are to be directed to our billing department.

We will process patient charges as follows:

Self-Pay/No Insurance

A $250.00 non-refundable deposit is required at the time of scheduling a New Patient Consultation. Future appointments will be given a 20% discount and payment is due in full at the time services are rendered.

Medicare

Neuroversion is a participating provider of Medicare. All Medicare supplemental insurances will be filed. Patients are responsible for their deductibles, co-pays, and co-insurance payments which are due in full at the time services are rendered.

Commercial Insurance

As a courtesy to you, we will file your primary and secondary insurance. It is your responsibility to verify your benefits if authorization is required for our participation with you insurance company prior to your appointment. You must provide correct insurance billing information, along with a copy of your insurance card(s) at your appointment. Patients are responsible for the full balance on their accounts.

Workers Compensation

The injury must have been reported to your employer, reported to the workers compensation carrier, and approved for coverage prior to your appointment. You will need to provide us with the name of the workers compensation carrier, billing address, adjustor's name and phone number, claim number, and date of the injury. Verification must be received prior to you appointment(s). It is your responsibility to verify if authorization has been received.

No Show Policy

Neuroversion requires a 24 hour cancellation notice for all scheduled appointments not kept or the patient may be charged a $25.00 fee for the missed appointment. Insurance does not cover this charge.

Returned Check Policy

You will be charged a $25.00 fee on all returned checks regardless of the reason.

I understand that by signing this Financial Agreement form, I agree to all the above (regardless of insurance status). I am ultimately responsible in full for all charges and balances on my account(s) for all services rendered, to Neuroversion. A copy of this agreement will be provided upon request.

Signature: _____ Date: _____/_____/_____
(Parent or guardian if minor.)

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Your Health Information Rights

The health and billing records we maintain are the physical property of the clinic. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosure of your health information by delivering the request to our clinic – we are not required to grant the request, but we will comply with any request granted.
- Request restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full – we must comply with this request.
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information.
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our clinic. Access to your health records will include information to which your access is restricted by law. We may charge a reasonable for providing a copy of your health records or a summary of those records you requested, which includes the cost of copying, postage, and preparation or an explanation of summary of the information. Electronic copies are also available on CD or through the Patient Portal.
- Appeal or denial of access to your protected health information, except in certain circumstances.
- Requested that your health care record be amended to correct incomplete or incorrect information by delivering a request to our clinic. We may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the health information kept by or for the clinic;
    - Is not part of the information that you would be permitted to inspect and copy; or,
    - Is accurate and complete

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.
- Request the communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our clinic.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our clinic. An accounting will not include uses and disclosures for treatment, payment, or operations; disclosures made to you or made at your request; disclosures made pursuant to an authorization signed by you; to family members; to friend relevant to that person's involvement in your care or in payment for such care. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve month period.
- Revoke authorizations that you made previously to use or disclose information by delivering written revocation to our clinic, except to the extent information or action has already been taken.
- You have the right to be notified of any breach of your information that occurs.

To Request Information or File a Complaint

If you have any questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Practice Administrator for Neuroversion at (907) 339-4650.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Practice Administrator. You may also file a complaint with the Department of Health and Human Services (DHSS). We cannot, and will not, require you to waive the right to file a complaint the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

NEUROVERSION
Break the cycle of pain

Notice of Privacy Practices for Protected Health Information

This notice describes how your Protected Health Information (PHI) may be used and disclosed and how you can get access to this information. Please review it carefully.

Neuroversion takes the privacy of your health information seriously. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

We are required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. We will act according to the terms of this Notice. We are required to notify you if we cannot accommodate a requested restriction or request and accommodate your reasonable request regarding methods to communicate health information to you. We reserve the right to change this Notice of Privacy Practices and to make any new practices effective for all Protective Health Information that we keep. Any changes made to the Notice of Privacy Practices will be prominently displayed, available at our offices and posted on our website (www.neuroversion.com).

The clinic is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. We will attempt in good faith to obtain your signed Acknowledgement that you were offered a copy of this Notice to use and disclose your confidential medical information for the following purposes:

Treatment Purposes:

- A medical assistant or scribe obtains treatment information about you and records it in a health record.
- During the course of your treatment, the provider determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Payment Purposes: We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given. **EXCEPTION: If you have paid a visit in full and have requested the information not be shared with your insurance carrier, we will not disclose that particular visit.**

Health Care Operations: We obtain services from our insurers and other business associates such as quality assessment and improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, and legal services. We will share information about you with such insurers or business associates as necessary to obtain these services.

Other Disclosures and Uses: Examples of other types of disclosures and uses of your PHI are listed below (note that his is not an exhaustive list). If you would like additional information on these, please contact us.

- Communication with family
- Notification of persons responsible for your care
- FDA, related to adverse events
- Threat to health or safety
- Law enforcement as required by law; judicial proceedings
- Abuse and neglect
- Public health
- Health oversight to agencies for health oversight activities

We will not sell your PHI without written authorization. We will not use your PHI for marketing purposes without your written authorization. Patients do have a right to 'opt out' of such marketing information. Except where required by law, we will not disclose your psychotherapy notes without your written authorization. Other uses and disclosures, besides those identified in this Notices, will be made only with your written authorization and you may revoke the authorization as stated under "Your Health Information Rights."

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Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ DOB: _____/_____/_____

I, _____, acknowledge and agree that I have been offered a copy of Neuroversion's Clinic Privacy Practices.

Signature: _____ Date: _____/_____/_____

Relationship to Patient (if unable to sign): _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reasons:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining the acknowledgement
□ Other (Please specify):

_____

_____

_____

_____

_____

Employee name (Please print): _____ Initials: _____

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Email Communication Agreement

For Our Patients: Information About Email Communication and Our Email Policies

You have asked to communicate with our office via email. To do so with safety and confidence, you must understand and agree to our guidelines. Please read the following information about email communication and our email policies. If you have any questions about what you read, please ask us or a member of our staff.

Following this information is an agreement that will protect your well-being and your confidentiality. If you understand our email policies and agree to adhere to them, please sign and date the form. We will give you a copy to take home if requested. If, at any time, you wish to discontinue email communication with this office, please submit your request in writing to us or a member of our staff. Thank you for your cooperation.

- Please be aware that email communication is not a substitute for a face-to-face encounter with a physician.
- It is our practice to make every effort to protect your confidential information in all communication. We acknowledge, however, that no email is 100% secure. Even the most carefully protected messages are stored on a computer's hard drive. Though it is unlikely, this information *could* be retrievable. We cannot guarantee against unknown privacy violations such as unauthorized access achieved by illegal activity.
- We ask you to limit your email communication with us: to ask routine, non-urgent medical questions; to schedule an appointment; or to report a mild reaction to treatment.
- We will try to respond to email messages within 2 business days. However, there is no way to guarantee that this will occur, for a variety of legitimate reasons. If you do not get a response from this office within 2 business days, it is up to you to contact us by telephone, mail, fax, or in person.
- We do not accept medication refill requests by email unless the request was preceded by a recent exam in the office. Even then, good medical practice may mean that it is necessary for you to be seen before we can refill your medication.
- We will do our best to avoid technical problems. However, if a computer virus infiltrates our system, we cannot guarantee that we could prevent it from inadvertently passing to your computer.
- If we are out of the office or if we are with other patients, a medical assistant will print out email messages for us and, at our direction, may respond to you on our behalf.
- If you fail to adhere to our email policies, we will discontinue our communication with you via email.

Please alert us to any questions you have about what you have read.

Patient Name
(please print): _____ DOB: _____/_____/_____

Patient Signature: _____ Date: _____/_____/_____

E-mail address: _____

NEUROVERSION

Clinical Agreement

I**, _____,** (DOB: _____/_____/_____) understand that in order to receive care for the treatment of pain at Neuroversion, I agree to comply with the following:

(Please initial next to each)

_____ A. **MEDICAL RECORDS RELEASE:** I will inform all of my health care providers that I receive pain management through Neuroversion and will maintain an unrestricted and current medical records release on file with Neuroversion. I authorize Neuroversion to provide a copy of the Pain Agreement to release medical information to necessary pharmacies.

_____ B. **MENTAL HEALTH:** A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with the healthcare providers of Neuroversion.

_____ C. **DRIVING AND OPERATING EQUIPMENT:** Many pain medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment while under the influence of prescription medications (i.e. narcotics/opiates) and whenever I feel drowsy.

_____ D. **APPOINTMENTS:** I will contact the clinic if I will be 5 to 10 minutes late. If I arrive more than 15 minutes late, I will be rescheduled. We require a 24 hour notice to cancel or reschedule your appointment. Appointments missed, rescheduled due to tardiness, or cancelled/rescheduled without a 24 hour notice will result in a $25.00 fee to the patient. This fee may be waived due to extenuating circumstances. If you require an interpreter and miss your appointment for any reason, you will be charged a $65.00 fee.

_____ E. **CHARGES:** All fees from patients are due at the time of visit. Non-payment of fees may result in the account being sent to collections and patient termination from Neuroversion.

_____ F. **TERMINATION:** I will no longer be eligible for care at Neuroversion if I am in possession of illicit drugs or substances, trafficking of controlled or illegal substances, intoxicated or convicted for DUI. If I forge or alter the prescriptions in any way, sell or share medications, or fail to comply with this contract, I will no longer be eligible for care at Neuroversion.

_____ G. **TREATMENT OF STAFF:** I will be courteous and respectful to all staff members. Neuroversion does not tolerate verbal or physical abuse towards our staff. Swearing, yelling at, or threatening our staff may result in forfeiture of appointment and/or termination from Neuroversion.

I have thoroughly read this agreement before receiving treatment at Neuroversion. I understand and agree to the conditions of care described above and will comply with them. All of my questions about the terms of this agreement have been answered. I know that failure to comply with any of the terms of this agreement may result in immediate termination of service.

_____ _____

Patient Signature Date

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Release of Information to Person

Patient Name: _____ DOB: _____

I, _____, give permission to Neuroversion to provide information regarding my care to the following person:

Name: _____ DOB: _____

Relationship to Patient: _____

The following items may be released to the above named person. Note that releasing the information to the above named person to pick up items does not necessarily give them the right to open any sealed information or read any of the information labeled strictly for the patient.

- ☐ **Prescription pick-up**
- ☐ **Receive medical information in person and/or over the phone**
- ☐ **Appointment information**

Signature: _____ Date: _____

Relationship to Patient (if unable to sign): _____

This document expires one year from date signed. A copy of this signed form will be provided to patient or legal representatives as well as the specified recipient upon request. An original copy will reside in patient chart.

NEUROVERSION
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Alcohol/Opioid/Benzodiazepine (CNS Depressant) Risk Acknowledgement

Name: _____ DOB: _____

Neuroversion acknowledges the serious responsibility of caring for patients with pain, and the inherent risks of pain medications that act as central nervous system (CNS) depressants. While you may or may not be prescribed medication while in our care, nevertheless we want you to be aware of these risks so that you can make informed decisions.

In 2016, the FDA and CDC addressed the rising number of deaths associated with the opioid crisis by issuing guidelines for prescribing opioids for chronic pain. One of the chief concerns is the risk of opioids in combination with other CNS depressants; up to 30% of deaths from opioid overdose also involve benzodiazepines (a class of medications used for anxiety and insomnia), and up to 20% of opioid overdose deaths involve consumption of alcohol.[1] The guidelines state that opioids and benzodiazepines should not be used together, unless there is no other reasonable alternative medication available.

The FDA requires "black box warning" (the strongest warning possible) and patient-focused Medication Guides for prescription opioids and benzodiazepines, warning of the increased risks when taking them together.[2]

Example of FDA warning:

Important Information for Patients

FDA is warning patients and their caregivers about the serious risks of taking opioids along with benzodiazepines or other central nervous system (CNS) depressant medicines, including alcohol. Serious risks include unusual dizziness or lightheadedness, extreme sleepiness, slowed or difficult breathing, coma, and death. These risks result because both opioids and benzodiazepines impact the CNS, which controls most of the functions of the brain and body.

- Opioids are powerful prescription medicines that can help manage pain when other treatments and medicines cannot be taken or are not able to provide enough pain relief. They are also approved in combination with other medicines to reduce coughing. Common side effects include drowsiness, dizziness, nausea, vomiting, constipation, and slowed or difficult breathing. Opioids also carry serious risks, including misuse and abuse, addiction, overdose, and death. Examples of opioids include oxycodone, hydrocodone, codeine, and morphine.
- **Benzodiazepines** are drugs prescribed for to treat conditions like anxiety, insomnia, and seizures. Examples of these drugs include: alprazolam, clonazepam, and lorazepam. Common side effects include drowsiness, dizziness, weakness, and physical dependence.

If you are taking both opioids and benzodiazepines together, consult your health care provider to see if continued combined use is needed. For more information, please see the FDA Drug Safety Communication.

The following risks have been identified when opioids and benzodiazepines are used together:

1. Extreme sleepiness
2. Coma
3. Respiratory depression
4. Death (Four times greater risk than with either independently)

We ask that you sign below to acknowledge that you have been made aware of the risks of combining opioids with other CNS depressants such as benzodiazepines and alcohol. Your signature will indicate that you are aware of and accept these risks if you are prescribed or use opioids or CNS depressants while in our care.

Signature: _____ Date: _____

1. Tori ME, Larochelle MR, Naimi TS. Alcohol or Benzodiazepine Co-involvement With Opioid Overdose Deaths in the United States, 1999-2017. JAMA Netw Open. 2020;3(4):e202361.
2. https://www.fda.gov/drugs/information-drug-class/new-safety-measures-announced-opioid-analgesics-prescription-opioid-cough-products-and