John P. Bursell, MD
Gregg Schellack, DO
Gustavo Garcia, MD

Daniel R. Harrah, MD
Ted L. Schwarting, MD

Patient Information

Name _____ SSN _____

Date of Birth _____ Sex M / F Married / Single / Divorced / Widowed

Mailing Address _____ City/State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Primary Care Doctor/Clinic _____

Occupation _____ Employer _____

Emergency Contact Name _____ Phone _____

Insurance Information

Do you have: Medical Insurance - Yes / No

- Primary Insurance _____ Policy Holder _____ DOB _____

  Policy Number _____ Group Number _____

- Secondary Insurance _____ Policy Holder _____ DOB _____

  Policy Number _____ Group Number _____

Mailing address / phone number of Policy Holder, if different than above _____

_____

Worker's Compensation

Is this a Worker's Comp Injury - Yes / No Date of Injury _____

WC Insurance Carrier _____ Adjustor _____

Claim Number _____ Phone _____

Authorization

I, the undersigned, have insurance, and assign directly to Juneau Bone & Joint Center all medical benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize JBJC to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signed _____ Date _____

3220 Hospital Drive, Juneau, AK 99801 • PH: 907.364.2663 • FAX: 907.364.2662

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Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received a copy of the Juneau Bone & Joint Center (JB&JC) Privacy Notice that describes how my health information is used and shared. I understand that JB&JC has the right to change this notice at any time.

My signature below, constitutes my acknowledgement that I have received a copy of the notice of privacy practices.

_____ _____
Patient name Date

_____ _____
Signature of patient or legal representative Relationship to patient

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I understand my HIPPA rights and I request Juneau Bone & Joint Center to leave messages, including those containing personal health information for me, with either of the two individuals listed below, or by fax, voicemail, answering machine at the numbers below:

Fax _____

Voicemail / Answering Machine _____

Relative / Friend

1) _____

2) _____

_____ _____
Signature of patient or legal representative Relationship to patient

Signature of JB&JC employee/witness: _____

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Dr. Bursell's Health History

Please note that this form should be updated every six months to ensure proper diagnosis and treatment options.

Patient Name: _____ **Date:** _____

Date of birth: _____ Height: ___FT. ___IN. Weight: _____

Primary Physician: _____ Occupation: _____

Reason for Visit: _____

When did your pain start? _____

Has your pain increased recently? ☐No ☐Yes, How recently? _____

Is your pain related to a recent injury? ☐No ☐Yes, Please describe: _____

Did you notice any of the following at the time of injury? ☐A "Pop" ☐Tearing Sensation ☐Swelling

Which of the following describe your pain?

☐Sharp ☐Dull ☐Aching ☐Burning ☐Numbness ☐Tingling

How often does your pain occur? ☐Constant ☐Intermittent (Off and On) ☐ Awakes me from sleep.

What aggravates your symptoms? _____

Does anything improve your symptoms? _____

Do you have difficulty picking up small objects such as coins for buttons? ☐Yes ☐No

Do you have a problem with balance or tripping frequently? ☐Yes ☐No

Have you had any recent falls? ☐No ☐Yes, how many? _____

There are (☐Frequent ☐Occasional ☐No) Headaches in the back of the head.

The worst position for the pain is: ☐Lying Down ☐Sitting ☐Standing ☐ Walking

How many minutes can you stand in one place without pain? ☐0-10 ☐15-30 ☐30-60 ☐60+

How many minutes can you sit in one place without pain? ☐0-10 ☐15-30 ☐30-60 ☐60+

How many minutes can you walk without pain? ☐0-10 ☐15-30 ☐30-60 ☐60+

Lying down: ☐Increases the pain ☐Decreases the pain ☐Does not affect the pain

Bending over: ☐Increases the pain ☐Decreases the pain ☐Does not affect the pain

Current Medications: Please List All Medications As Well As Dose If Known... ☐ **None**

1.	5.
2.	6.
3.	7.
4.	8.

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Drug Allergies: Please List All Known Drug Allergies and Reactions... ☐ **None**

Medication:	Reaction:
1.	
2.	
3.	
4.	

Past Surgical History: ☐ **None**

Type:	Year:	Type:	Year:
Heart Bypass	_____	Spine Surgery	_____
Pacemaker	_____	Hip Surgery	_____
Heart Valve	_____	☐ Left ☐ Right ☐ Both	
Heart Stent	_____	Knee Surgery	_____
Cancer Surgery	_____	☐ Left ☐ Right ☐ Both	
Prostate Surgery	_____	Shoulder Surgery	_____
		☐ Left ☐ Right ☐ Both	

Other Surgeries: _____ Year: _____

_____ Year: _____

Any Prior Treatment: ☐ **None**

☐ Physical Therapy ☐ Oral Steroids ☐ Cortisone Injections ☐ Surgery ☐ Medications

☐ Other: _____

Any Prior Diagnostics: ☐ **None**

☐ X-Ray ☐ MRI ☐ CT ☐ EMG (Nerve Conduction Study) ☐ Other: _____

Medical History: Please check all that apply to you... ☐ **None**

☐ Heart Attack ☐ Heart Failure ☐ High Blood Pressure ☐ Osteoarthritis ☐ Rheumatoid Arthritis

☐ Gout ☐ Osteoporosis ☐ Diabetes ☐ Stroke ☐ Ankylosing Spondylitis

☐ Seizures ☐ Cancer ☐ Mental Illness ☐ Alcoholism ☐ Bleeding Disorders

☐ HIV ☐ AIDS ☐ Tuberculosis ☐ Stomach Ulcer ☐ Blood Clots (Leg OR Lungs)

☐ Liver Trouble ☐ Hepatitis ☐ Lung Disease ☐ Kidney Stones ☐ Kidney Failure

☐ Thyroid Issue ☐ Asthma ☐ Anemia ☐ Other

Social History: How often do you use any of the following substances?

Caffeine: ☐ Occasionally ☐ Often ☐ Never

Alcohol: ☐ Occasionally ☐ Often ☐ Never

Marijuana: ☐ Occasionally ☐ Often ☐ Never

How many drinks per week? _____

Drugs: ☐ Occasionally ☐ Often ☐ Never ☐ Previously

Tobacco: ☐ Occasionally ☐ Often ☐ Never

☐ Narcotics ☐ Recreational ☐ Other: _____

Cigarettes: _____ Packs per day

Do you have a history of Alcohol or Drug treatment? ☐ No ☐ Yes, if so when? _____

Review of Systems:

☐ **None**

☐ Change of Vision	☐ Heart or Chest Pain	☐ Frequent Diarrhea
☐ Loss of Hearing	☐ Abnormal Heartbeat	☐ Frequent Constipation
☐ Ear Pain	☐ Swollen Ankles	☐ Hemorrhoids
☐ Hoarseness	☐ Calf Cramps w/ Walking	☐ Frequent Urination
☐ Nosebleeds	☐ Poor Appetite	☐ Frequent Headaches
☐ Difficulty Swallowing	☐ Toothache	☐ Seizures
☐ Chronic Cough	☐ Nausea or Vomiting	☐ Rashes
☐ Shortness of Breath	☐ Stomach Pain	☐ Weight Changes
☐ Fever or Chills	☐ Ulcers	☐ Nervousness

Family History:

Relation	Age	Current state of health	Age at death	Cause of death	Check (X) if any of your blood relatives had any of the following:	
Father					☐ Arthritis	
Mother					☐ Gout	
Brothers					☐ Cancer	
					☐ Diabetes	
					☐ Heart Disease	
Sisters					☐ High Blood Pressure	
					☐ Rheumatoid Arthritis	
					☐ Stroke	
					☐ Other	

Patient Signature

Date

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Patient Payment Policy
** Signature Required **

Thank you for choosing our practice! We are committed to providing you with quality health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered; we have developed this financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance: We participate in most insurance plans. We will bill your insurance company as a courtesy to our patients. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You are required to pay any co-pay and/or deductible.

Copayments and Deductible: It is the patient's responsibility to know information regarding deductible and co-pay. Please contact your insurance company to determine these amounts. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. This is a requirement for all patients. If you do not know what your co-pay amount is, you will be charged 20% of the visit fee at the time of service.

Medicaid: All Medicaid patients must provide their Medicaid coupon each month, and provide their $3 co-pay at each visit. If we do not have a Medicaid coupon, the patient's services will be considered self-pay.

Medicare: Payment is not required at the time of service for Medicare patients. We will submit your claim to Medicare and your supplementary insurance. You will be responsible for any deductible co-pay left over.

Non-covered services: Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered necessary by Medicare or other insurers. This is something decided by your insurance company and it will still be your responsibility to pay for these services.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

~ continued on back ~

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you do not notify us of changes, any balances of services will be the patient's responsibility to pay.

Methods of Payments: We accept payment by cash, check, VISA, and Mastercard.

Patient Statements: Unless other arrangements are approved by us in writing, the balance on your statement is due 30 days from when the statement is issued.

Nonpayment: If your account is past due, you will receive a letter from us stating you have 10 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will not be able to be seen in the office until your balance is paid in full and all charges for future visits will be collected upfront. Until the balance is paid in full, our physicians will only be able to treat you on an emergency basis.

Returned Checks: There is a fee of $25 for any checks returned by the bank.

Divorce: In case of divorce or separation, the party responsible for the account is the parent authorizing treatment for a child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Missed Appointments: Our policy is 24-hours notice on an appointment change. We understand emergencies arise. If an emergency keeps you from keeping your appointment, please contact us as soon as you know you will not be able to keep the scheduled appointment. Please help us to serve you better by keeping your regularly scheduled appointments. After 3 no-show appointments, you will no longer be able to be seen at our office.

Surgery: If your physician recommends surgery, you will be escorted to the Surgery Scheduler. She will answer any specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. If you do not have insurance coverage, you will be required to pay at least 75% of the surgery cost before your surgery, unless otherwise arranged with your physician.

By signing below, I agree to the payment policy of Juneau Bone & Joint Center

Patient Name: _____
(If patient is under the age of 18, parent or legal guardian sign below)

Patient Signature: _____ **Date** _____

Please return this signed form to the front desk receptionist. A copy of this form will be kept in your patient chart. You will be provided a copy of this form upon your request.