Wasilla Medical Clinic
1700 E. Parks Hwy #200 Wasilla,
AK 99654
(907)373-6055 Fax (907)373-6077

DEMOGRAPHIC FORM

Patient name: _____ SS#:_____
First name Middle initial Last name

Mailing Address: _____

City: _____ State: _____ Zip: _____ Patient's Employer: _____

Home Phone #:_____ Work #: _____ Cell #: _____

Date of Birth: _____ Sex: M F

Emergency Contact: _____ Phone Number: _____

GUARANTOR/BILLING INFORMATION

Person responsible for patient: _____ Sex: M F
Relationship to patient: _____ Date of Birth: _____ SS#: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____ Phone #:_____

INSURANCE INFORMATION

Primary Insurance Company: _____ ID #: _____ GP #: _____
Name of Policyholder: _____ Relationship to patient: _____
SS#: _____ Date of Birth: _____ Sex: M F
Mailing Address & Phone # _____
(if different from patient): _____

Secondary Insurance Company: _____
ID #: _____ GP #: _____
Name of Policyholder: _____ Relationship to patient: _____
SS#: _____ Date of Birth: _____ Sex: M F
Mailing Address & Phone # _____
(if different from patient): _____

HIPAA PRIVACY RULE CONSENT, INFORMATION DISCLOSURE, AND INSURANCE AUTHORIZATION
All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used as follows only with patient consent. I hereby authorize Alaska Medical Clinics, LLC, dba Wasilla Medical Clinic, to furnish information to other providers, healthcare or treatment facilities, and my insurance companies for purposes of treatment, payment, and healthcare operations. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

_____ _____
Patient/Guardian Signature Date

Alaska Medical Clinics, LLC
Wasilla Medical Clinic
1700 E. Parks Hwy., #200
Wasilla, AK 99654
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●Maury Oswald, DO● Don Smith, PA-C●
● Adam Greathouse, DO ● Glen Jones PA-C ● Jason Collins, PA-C ● LeaAnne Abernathy ANP●

Alaska Medical Clinics Billing and Payment Policy

As a courtesy to you our patient, we will bill your insurance and accept assignment of benefits for most insurance companies. However, it must be understood that the contract is between the patient and the insurance company. The patient is fully and ultimately responsible for any and all charges that are not paid by the insurance company. Our office policy regarding insurance claims is as follows:

- It is the patient's responsibility to provide us with complete insurance and billing information at the time of service. If this is not available, the fees must be paid at time of service.
- The patient is required to pay their portion at the time of service. This includes deductibles, co-pays, and non-covered services.
- We cannot guarantee the amount that your insurance company will pay or what they will cover. Any unpaid balance after 90 days from the date of service will be the patient's responsibility to pay. It is the patient's responsibility to be familiar with their insurance.
- We will not go into dispute with any insurance company over a claim. This is the patient's responsibility and obligation to resolve. If a dispute over payment goes beyond 90 days, the patient must pay all balances. If we eventually receive payment from the insurance company we will refund your portion.
- Any balances not paid after 90 days from date of service will be turned over to a collections agency. The patient's credit rating will be affected, and the patient is responsible for any collection fees.
- A charge of $30.00 will be assessed for any returned checks.
- The patient may make payments over the 90 days from the date of service, without an interest charge. We do not offer other payment plans.
- Patients with unpaid balances over 90 days will be denied services, except in the case of an emergency, until those balances are paid in full.
- All Medicaid and Denali Kid Care recipients are required to provide proof of coverage for the current month and a $3.00 co-pay is due at the time of service if the patient is over 18 years of age.

Patients without insurance coverage must pay in full at the time of service. The normal office visit charge will be collected before services are provided, and any additional charges will be collected at the end of the visit.

I have read, understand and agree to the above policies.

_____ _____

Patient or Responsible Party Signature Date

Wasilla Medical Clinic

NOTICE OF PRIVACY, CONSENT, AND HIPAA

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Release for Protected Health Information:

Indicate any persons authorized to discuss your Protected Health Information with our office or our billing office. Include the person's name and relationship to yourself. Include a start date and an end date to set restrictions for any individual(s).

Name	Relationship	Start Date	End Date

Patient Name Print: _____ DOB: ____/_____/_____

Patient Signature: _____ Date: _____

Guardian Signature if minor child: _____ Date _____

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Medical History

Patient Information

Patient Name: _____ Sex: □ M □ F DOB: ___/___/_____
Primary Care Physician: _____
Allergies: _____
Current Medications and/or Supplements/Vitamins: _____
_____
Medical History (list all past and current medical conditions):
_____
_____
Surgical History (list all surgeries): _____
_____

Social History

Tobacco Use: □ No □ Yes, _____ packs/day for _____ years □ Quit: if so, when? _____

Alcohol Use: □ Never □ Occasional □ Daily □ Quit: if so, when? _____

Recreational Drug Use: □ No □Yes □ Quit: if so, when? _____

Do you live with someone who uses recreational drugs? □ No □ Yes

Traveled Abroad? □ No □ Yes: if so, location: _____ Year: _____

Family History

Mother: □ Deceased □ Diabetes □ Cancer □ Hypertension □ Coronary Heart Disease □ Other

Father: □ Deceased □ Diabetes □ Cancer □ Hypertension □ Coronary Heart Disease □ Other

Sibling(s): □ Deceased □ Diabetes □ Cancer □ Hypertension □ Coronary Heart Disease □ Other

Notes: _____
_____
_____
_____

Preferred Pharmacy: _____