Alaska Internal Medicine and Pediatrics

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Ph: (907) 770-7800 Fax: (907) 929-4660

Date:		**Primary Phone #:**	
Legal Name: Last	**First**	**Middle Initial**	**Preferred Name:**
Date of Birth:	**Male ☐ Female ☐ Other_____**		**State ID # /License#:**

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐	**Racial Groups: Check all that Apply**
Ethnicity: Non-Hispanic ☐ Hispanic/Latino/Latina ☐	**African American/Black ☐ Asian ☐**
Preferred Language:	**Caucasian/White ☐ Pacific Islander ☐**
Referral Source:	**Native American/Alaska Native ☐**
	Other_____

******PROVIDE PICTURE ID and ALL ACTIVE INSURANCE CARDS AT CHECK IN******

Occupation:	**Insurance ☐ Cash Pay ☐**	**Veteran: Yes ☐ No ☐**
Employed ☐ Retired ☐ Student ☐ Unemployed ☐	**Employer:**	

Your answers to the following questions will help us to contact you quickly and discreetly with important information.

Home Phone ( ) **Okay to Leave Voicemail: Yes ☐ No ☐**	**Cell Phone ( )** **Okay to Leave Voicemail: Yes ☐ No ☐**	**Work Phone ( )** **Okay to Leave Voicemail: Yes ☐ No ☐**	**Best Number to Use: Home ☐ Work ☐ Cell ☐**
Address:	**City**	**State**	**Zip**
Spouse/Significant Other Name:		**Phone Number: ( )**	
Emergency Contact Name:	**Phone Number:**	**Relationship to you:**	

Assignment and Release

I understand I am financially responsible for charges incurred for services rendered by AK Internal Medicine & Pediatrics.
I understand I may be charged a $50 fee for appointments cancelled less than 24 hours before the appointment time.
I understand I may be charged a $25 fee for checks returned due to Non-Sufficient Funds.
I authorize my insurance benefits to be paid directly to the attending physician for any bills not paid in full at time of service.
I authorize the physician to release to my insurance company any information necessary to process my claims.
I understand that accounts unpaid for over 120 days may be sent to collections with additional collection cost/fees added.

Signature: _____ **Date:** _____
Self/Parent/Guardian

Authorization and Release of Information and Assignment of Benefits

Consent to Treat

The term "health care provider(s)" in this document means Alaska Internal Medicine and Pediatrics (AKIMP), its agent and employees, members of the medical staff, their agents and employees and other health care practitioners who provide care to patients.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, examinations, test results, diagnosis, treatments and any plan of care including future treatments. I understand that this information serves as:

1. Basis for planning my treatment and care
2. Information used to file my claim with the insurance company (procedure and diagnosis)
3. Means by which a third-party can verify that billed services were actually provided
4. A tool for routine health care operations including assessing and reviewing competency of your staff and/or other health care providers.

I understand that I have been provided with the Notice of Privacy Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the organization reserves the right to change their notice and practices; prior to implementation of changes a copy of any revised notices will be mailed to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment or health care operations, and that the organization is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf. Permission is herby granted to all health care providers involved in my care to administer such examination, treatment, testing and procedures as are deemed necessary in the course of my care.

Release of Information

Information about me necessary to substantiate my insurance claims may be released by the health care provider involved in my care.

Financial Responsibility/ Assignment of Benefits

For those health care providers who accept assignments, I hereby authorize insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignments. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health care providers are not paid after reasonable notice, that account shall be deemed delinquent and a service charge shall be added to the amount due. In the event that I default on payment of account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collections, I agree to be responsible for collection fees and interest due on amounts in default.

Medicare Lifetime Beneficiary Claim Authorization & Release of Information

I request that payment of authorized medical benefits be made either to me, or on my behalf, to Alaska Internal Medicine and Pediatrics for any services provided to me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agent any information needed to determine benefits or the benefits payable for related services.

I understand my signature requests that payments be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on item 9 of the HCFA-1500 claim form or elsewhere on the approved claim form or electronically submitted claim, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accepts the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-Insurance and deductibles are based upon the charge determination of the Medicare carrier.

Printed Name of Self/Parent/Guardian	Signature	Date