Alaska Internal Medicine and Pediatrics

4048 Laurel St. Suite 306 Anchorage, AK 99508
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

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

Pharmacy Name_____ Phone_____

ALLERGIES To medications or substances

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

_____ Reviewed By

_____ Date

Patient Financial Policy Agreement

We appreciate your business and make every effort to make your visits here financially unproblematic and affordable. We hope these guidelines help to clear up any misunderstandings and answer any questions you may have regarding our billing policy. Unfortunately, we are unable to change a billing code or visit type after the visit is over, so if your insurance only pays for a specific type of visit you must let your provider know beforehand so they can conduct the visit accordingly and appropriately for proper billing.

Copays
It is patient responsibility to present insurance card(s) at each visit. All copayments and past balances are due and must be received at the time of service. We will then bill the insurance company. If the deductible has not been met, we require payment in full at time of service.
*****If you pay your bill in full at time of service, you are eligible for a 20% discount*****

Insurance Plans
Once payment is received from the insurance company, the patient will then be billed for the remaining balance on the account. Payment of this balance must be made within **30 business days** of the notification. If **NO** payment is made or received within **90 business days**, the account will go to a collections agency and you will be discharged from the practice.

Self-Pay Accounts
Self-Pay accounts are patients who do not have insurance. Payment in full is required at the time of service for all services including procedures.
*****If you pay your bill in full at time of service, you are eligible for a 20% discount*****

Extended Payment Arrangements
Patients that have a balance owed that they are unable to pay in full may contact our billing department and make arrangements for scheduled payments. Once a patient commits to making payments on a scheduled plan, if the patient defaults on those payments they will be sent to a collection agency and will be terminated from our practice.

Patient Refunds
All patient refunds will be kept as a credit on the account to go towards their next visit ***unless*** a refund is requested or initiated by the patient. The following criteria must be met prior to issuing a patient refund:

- The patient has not been seen in the office for 90 days.
- There is no outstanding insurance claims on the account
- There are no outstanding patient balances on the account.

Divorce Cases
In cases of divorce, the individual who received the care is responsible for payment of copays and coinsurance balances at the time of service. We will not bill a divorced spouse for the patients' insurance.

Child Custody Cases
The parent with primary custody is usually the parent with whom the child lives with, and who usually brings the child to the clinic for care. The custodial parent is responsible for payment at the time of service whether the account is considered self-pay or insurance. If the noncustodial parent carries the insurance on the child, the clinic will bill that insurance company. The clinic does not get involved with divorce specifics. It is the parents obligation to work out an agreement themselves or through the court system.

This financial policy helps the clinic to provide quality care to our valued patients. If you have any questions or need clarification on any of the above policies, please feel free to contact us.

_____ _____
Patient Signature Date

ALASKA INTERNAL MEDICINE + Pediatrics

Michele O'Fallon, M.D. Laurie Montano, M.D.
Board Certified Internal Medicine & Pediatric Specialists

FAMILY AND FRIENDS APPROVED DISCLOSURE LIST

NAME OF PATIENT (PRINT)_____

WE UNDERSTAND YOU MAY HAVE CONCERNED RELATIVES, FRIENDS, OR SIGNIFICANT OTHERS.

PLEASE LIST THE NAMES OF THOSE PEOPLE THAT WE MAY SHARE INFORMATION WITH.

WITHOUT YOUR WRITTEN CONSENT, THIS INFORMATION WILL NOT BE RELEASED.

_____**PHONE**_____

_____**PHONE**_____

_____**PHONE**_____

_____**PHONE**_____

PATIENT'S SIGNATURE_____

DATE _____

4048 Laurel St. Suite 306 Anchorage, AK 99508 ph (907) 770-7800 fax (907) 929-4660 www.akimp.com

IMPORTANT NOTICE

Patient's of Alaska Internal Medicine and Pediatrics:

Please be aware that we require a 24 hour notice for cancelled appointments. Any appointments that are missed or cancelled with less than 24 hours notice will be charged a 50.00 -100.00 fee. The amount is at our discretion and is determined by the length of the appointment cancelled or the number of previous missed or cancelled appointments.

Thank you for your cooperation in this matter.

Alaska Internal Medicine & Pediatrics

Patient's Signature _____

Date _____

Alaska Internal Medicine & Pediatrics
ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received Alaska Internal Medicine & Pediatrics' Notice of Privacy Practices and Client Rights, and that I understand and have had an opportunity to ask questions about the Notice.

_____
Name

_____
Signature

_____
Date

_____
Name of Parent/Guardian/Personal Representative

_____
Signature of Parent/Guardian/Personal Representative

_____
Date

This acknowledgement page should be retained in the patient's record.
If acknowledgment could not be obtained from patient,
the reasons must be documented below.

_____

_____

_____

_____

_____

ALASKA INTERNAL MEDICINE & PEDIATRICS

SHARING OF MEDICAL RECORDS BETWEEN THE PATIENT AND AKIMP

AKIMP will send correspondence, such as bills, records, etc. to your mailing address. If you would prefer to use another type of correspondence, you will need to choose and initial the options below.

*****You will need to cross off any type of communication that you do not want to use, and sign for any type of communication that you prefer to use.**

Email Address _____

Email is not a secure way to share medical records. It can get rerouted and end up in someone else's possession by mistake. It can be hacked. It puts your information on an internet based platform.

If I choose this method of record sharing and correspondence, I recognize the risks involved and take full responsibility for those risks. Initial_____

Text Phone Number_____

Text can be seen in some circumstances by others and is not a secure way to share records or correspondence. If I choose this method of record sharing and correspondence, I recognize the risks involved and take full responsibility for those risks. Initial_____

A Fax can be sent to a number of your choosing upon request

Please be aware that numbers can be transposed by the person giving it or sending it and can end up in the wrong hands. If your information is delivered to a public or private fax, it can be seen by bystanders and anyone who accepts the fax. If I choose this method of record sharing and correspondence, I recognize the risks involved and take full responsibility for those risks. Initial_____

Telehealth "Video visit with the doctor"

Both parties must be in the state of Alaska during the visit. There are limits to what can be accomplished during this type of visit. ie, diagnotic tests, hands on evaluation, technical difficulties, unauthorized access or loss of information due to technology issues, etc.

I will not hold AKIMP responsible for any failures due to issues related to telehealth. Initial_____

Other _____ Initial_____

Any inherent risks with regards to the sharing of records and communication through unsecure means is the responsibility of the patient if chosen by the patient. Initial_____

Patient Signature_____ Date _____

Alaska Internal Medicine & Pediatrics
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the medical information practices of Alaska Internal Medicine & Pediatrics. Alaska Internal Medicine & Pediatrics is considered a covered entity, and therefore we are required by law to maintain the privacy of personal health information and to provide you with notice of our legal duties and privacy practices with respect to personal health information. All Alaska Internal Medicine & Pediatrics departments or programs are covered by this Notice and your personal health information may be shared among these divisions.

Our Pledge Regarding Medical Information

We understand that medical information about your health is personal. We will not disclose your personal health information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. This Notice applies to all of the medical records we maintain. It describes the ways in which we may use and disclose medical information, and describes our obligations with regard to such information. .

We are required by law to:
- Keep your protected health information private;
- Provide notice of our legal duties and privacy practices with respect to protected health information;
- Notify affected individuals following a breach of unsecured protected health information;
- Give you this Notice of Privacy Practices; and
- Follow the terms of the Notice of Privacy Practices currently in effect.

We have the right to change our practices regarding the personal health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling the Privacy Officer at [INSERT NUMBER], or stopping by the Privacy Officer's office at [INSERT ADDRESS] (the "Privacy Officer").

How We May Use/Disclose Your Medical Information

The following are some of the different ways that we may use and disclose your personal health information:

For Treatment. We may use or disclose medical information about you to facilitate treatment, rehabilitation or treatment through services provided by Alaska Internal Medicine & Pediatrics. For example, we may disclose medical information to other healthcare providers who are involved in taking care of you.

For Payment. We may use and disclose medical information about you to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies (either directly or through a third party billing company), medical necessity determinations and reviews, and collection of outstanding accounts.

For Health Care Operations. We may use and disclose medical information about you for other Alaska

Internal Medicine & Pediatrics health care operations necessary to run Alaska Internal Medicine & Pediatrics. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; licensing; personnel training programs; fraud and abuse detection programs; and general Alaska Internal Medicine & Pediatrics administrative activities.

To Business Associates. There are some services provided to Alaska Internal Medicine & Pediatrics through contracts with business associates. Examples include accounting, legal, training, and consulting services. Information shall be made available to business associates consistent with their need to know for purposes of providing services.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Other Uses and Disclosures

We may also use and disclose your health information in the following circumstances, when permitted by law, and with only the minimum necessary information being disclosed:

- Appointment reminders
- Language interpreters
- Information about available treatments or products
- Funeral Directors/Coroners/State Medical Examiners
- Workers' Compensation
- Correctional Institutions (if you are in jail or prison)
- Law Enforcement
- Tissue and organ donation
- Disaster relief
- Military and Veterans (if you are an armed forces member)
- Responses to legally compliant court orders
- National security

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. This includes the use or disclosure of psychotherapy notes, the use or disclosure of PHI for marketing, or the sale of PHI, which will require your express written authorization.

Your Rights Regarding Personal Health Information

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to, or copies of, this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. If your records are

held in electronic format, you may also obtain an electronic copy if it is reasonably available. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must provide a supporting reason, be made in writing, and be submitted to the Privacy Officer. If we agree to amend the information, we will generally amend your information within 60 days of your request and will notify you when we have amended the information

  We may deny your request for an amendment if does not meet the requirements listed above. In addition, we may deny your request if you ask us to amend information that: is not kept by or for Alaska Internal Medicine & Pediatrics; 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 information which you would be permitted to inspect and copy; or is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request a list of disclosures, where such disclosure was made for any purpose other than treatment, payment or health care operations. We are not required to give you an accounting of information we have shared with our business associates or for which you have given us a written authorization.

  To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years or before April 14, 2003. Your request should indicate in what form you want the list (i.e. paper or electronic). The first list you request within a 12-month period will be free, and you may be charged for the cost of any additional lists. We will notify you of the cost and you may choose to withdraw or modify your request before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a transport or treatment we provided. We are not required to agree to your request unless the disclosure is to a health plan for purposes of carrying out payment or health care operations (not treatment purposes) and the information pertains solely to an item or service paid for fully out of pocket.

  To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must describe: (1) what information you want to limit; (2) whether you want to limit use, disclosure or both; and (3) to whom the limits shall apply, for example, your spouse.

- **Right to Request Confidential Communications.** You can request that we communicate confidentially with you about medical matters. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will accommodate reasonable requests. Your request must specify how you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You may request a paper copy at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy.

Right to Revoke Authorization/Permissions

If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. Your substance abuse records received by a person or entity pursuant to your written authorization may not be re-disclosed without your written consent.

Questions/Exercising Rights

If you have any questions about this Notice or would like to exercise any of the rights contained herein, please contact: Alaska Internal Medicine & Pediatrics Privacy Officer, Cerena Warner at, 907-929-4606 or the main office number, 907-770-7800.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Alaska Internal Medicine & Pediatrics or with the Secretary of the Department of Health and Human Services. To file a complaint with Alaska Internal Medicine & Pediatrics, contact the Privacy Officer. All complaints must be submitted in writing. You will not be retaliated against or penalized for filing a complaint. The Secretary of DHHS can be reached at:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue. S.W.
Room 509F, HHH Building
Washington, D.C. 20201