Interior Women's Health

[ ] UPDATED OR [ ] NEW PATIENT REGISTRATION

Address: 1626 30th Avenue
Fairbanks, Alaska 99701
(907) 479-7701
Fax: (907) 479-7718

ACCOUNT #:_____ **PROVIDER :**_____

PATIENT INFORMATION: [ ] Patient's Photo ID [ ] Insurance Card(s) [ ] TRICARE Prime // Select // Remote // Reserve

Primary:_____ Secondary_____ Tertiary:_____

PATIENT'S LAST NAME:_____ **FIRST:**_____ **MIDDLE INITIAL:**_____

PATIENT'S MAIDEN NAME /OTHER NAMES USED — SOCIAL SECURITY NUMBER

PHYSICAL ADDRESS — CITY — STATE — ZIP CODE

MAILING ADDRESS — CITY — STATE — ZIP CODE

DATE OF BIRTH (e.g. MM/DD/YYY) — PRIMARY TELEPHONE — SECONDARY PHONE

YOUR PREFERRED SPOKEN LANGUAGE — E-MAIL

Marital Status: [ ] Married [ ] Separated [ ] Single [ ] Divorced [ ] Widowed
Race [ ] White [ ] Black [ ] Hispanic [ ] Asian [ ] Pacific Islander [ ] AK Native [ ] Other
(*The above demographic information is essential to Interior Women's Health for purposes of Clinical Quality Measures and as a provider of medical services. Thank You!)

RESPONSIBLE PERSON FOR BILLING PURPOSES: CIRCLE "SELF" IF SAME AS ABOVE

If the patient is an underage individual, who is the parent/guardian responsible for receiving and managing the billing statements? Name of Guarantor**:** _____

DATE OF BIRTH (e.g. MM/DD/YYY) — SOCIAL SECURITY # — HOME TELEPHONE

MAILING ADDRESS — CITY — STATE — ZIP

EMPLOYER — JOB TITLE

EMERGENCY OR NEXT OF KIN INFORMATION (if different than above):

EMERGENCY CONTACT(S) — TELEPHONE — RELATIONSHIP

Patient Name: _____ Chart/Account# _____

Date Of Birth: _____ Today's Date: _____

Our Insurance Effective Date: _____

*** Employer/Retiree Program provided this insurance on what effective date (approximately)?***

PRIMARY INSURANCE IN DETAIL:

INSURANCE COMPANY | **INSURED'S NAME** | PATIENT RELATIONSHIP TO INSURED

GROUP NUMBER | EMPLOYER | POLICY **#/SSN**

ADDRESS | CITY | STATE | ZIP CODE

TO VERIFY INSURANCE CALL | INSURED'S SEX | **INSURED DATE OF BIRTH (e.g. MM/DD/YYY):**

Employment Status [ ] Full Time [ ] Part-Time [ ] Unemployed [ ] Self-Employed [ ] Retired [ ] Military

** Special Note to New Expecting Mothers as needed:

MOST INSURANCE POLICIES REQUIRE THAT THE INSURED MEMBER CONTACT MEMBER SERVICES WITHIN 30-DAYS OF BIRTH TO ADD THE NEWBORN TO THE POLICY

SECONDARY INSURANCE (as applicable) IN DETAIL:

INSURANCE COMPANY | INSURED'S NAME | PATIENT RELATIONSHIP TO INSURED

GROUP NUMBER | EMPLOYER | POLICY # | DATE OF BIRTH OF INSURED (e.g. MM/DD/YYY)

ADDRESS | CITY | STATE | ZIP CODE

TO VERIFY INSURANCE CALL

Employment Status [ ] Full Time [ ] Part-Time [ ] Unemployed [ ] Self-Employed [ ]Retired [ ] Military

PATIENT REGISTRATION/GUARANTOR OR RESPONSIBLE PARTY

I AM the responsible guarantor of this account and charges incurred during this visit and I understand that full payment for treatment received is my responsibility regardless of insurance coverage. I will be responsible for paying co-pays and insurance deductibles at the time of the visit and we must inform IWH staff if we have met insurance deductibles or if there is a co-pay/co-insurance. I, hereby verify that all of the above given information is true and correct to the best of my knowledge and accept responsibility.

Account Guarantor Signature: _____Date: _____

(If the patient/client receiving services is under the age of 18 years of age a parent or legal guardian bringing the child to the appointment MUST sign this area as the responsible financial/payment party.)

In order to comply with specific rules regarding HIPAA, we ask that our patients complete and sign this privacy and security health information. **We can only speak with you, the patient, unless the sections below are completed indicating otherwise.**

Please provide the name(s) of individuals our office staff has permission to speak with regarding:
Billing & Payment information (Non Applicable N/A, Self, or Other)

_____ Relationship to me:_____

Circle: "Self" if only you can request information.

Please provide the name(s) of individuals our office staff has permission to speak with regarding:
Medication information (Not Applicable N/A, Self, or Other)

_____ Relationship to me:_____

Circle: "Self" if only you can request information.

Please provide the name(s) of individuals our office staff has permission to speak with regarding:
ALL General Healthcare information (Not Applicable N/A, Self, or Other)

_____ Relationship to me:_____

Circle: "Self" if only you can request information.

EXCEPTIONS
IWH's office staff has permission to speak to the individuals above this form about my care EXCEPT:
Patient Informs IWH of the following restrictions:
_____

_____ _____
Patient Printed name Date

_____ _____
Patient Signature IWH Patient Registration Staff Member

Disclaimer: Patient's Consent to Discuss Health Care or Health Care Services i.e. billing, payment, medications, all general health care, let it be known that this assignment will remain in effect until revoked by me in writing or a new consent form is signed. A scanned copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

INTERIOR WOMEN'S HEALTH NOTICE OF PRIVACY PRACTICES

HIPAA PRIVACY NOTICE AND CONSENT FORM

USES AND DISCLOSURES

I give IWH my consent and the medical facility is permitted to use and disclose my protected health information (any individual identifiable information, treatment, or payment for health care) for each of the following purposes, without further notification or authorization from me: treatment, continued treatment, health insurance carriers for payment, refunds or adjustments, and or related healthcare operations while observing and respecting the spirit of HIPAA privacy laws.

I have been informed that I may review Interior Women's Health Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. It is the practice of all medical facilities to make patients aware of their right to privacy and confidentiality.

I understand that Interior Women's Health has the right to change their privacy practices and or adhere to changes of the law and that I may obtain any revised notices upon request.

I understand that I have the right to request a restriction of how my protected health information is used. I also understand that Interior Women's Health is not required to agree to the request. If Interior Women's Health agrees to my requested restriction, the facility must follow the restriction(s) as indicated by me as the patient.

I understand that I may revoke this consent at any time, simply by making a request in writing, except for information already used or disclosed prior to my request.

COMPLAINTS

If you believe your privacy rights have been violated you may complain to Interior Women's Health, and to the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Interior Women's Health directly, please call the Office Coordinator, Privacy Contact at (907) 479-7701 or write to 1626 30th Avenue, Fairbanks, AK 99701. You will not be retaliated against if you file a complaint and we will appreciate the opportunity to resolve your concern and help us make quality improvements in our services provided to our patients.

EFFECTIVE DATE

This Notice has been revised from September 1, 2015 and it goes into effect immediately.

ACKNOWLEDGEMENT OF NOTICE

I hereby acknowledge receipt of Interior Women's Health **Notice of Privacy** practice and protocol.

_____ _____

Patient's Name Date

_____

Patient's Signature

_____

Patient Support Representative, Print Name

_____

State Relationship to Patient if the Patient is Under 18

INTERIOR WOMEN'S HEALTH
FINANCIAL AGREEMENT

Thank you for choosing Interior Women's Health as your health care provider. The following is our Financial and Appointment Policies. If you have any questions or concerns regarding our policies, please do not hesitate to speak with the Office Coordinator.

We ask that all patients read and sign our Financial Agreement prior to being seen by a provider.

ACCEPTABLE METHODS OF PAYMENT:

- **Cash Patients –** Please refer to the "Cash-Patient**"** policy**.** In addition, you are hereby informed that payment for services are due at the time services are rendered, unless you have made alternative arrangements with the Billing Department prior to the appointment.
- **Insured Patients -** Interior Women's Health offers the courtesy of filing your insurance claim for you, but **we do require that co-pays, deductibles and remaining balances be paid at the time services are rendered.** Insured patients are required to sign the **Assignment of Benefits** portion for us to receive payment from insurance agencies.
- **Payment Plans –** Payment plans are available for those who meet the criteria for extensive treatments, surgery and obstetrical care. Such payment arrangements are to be made prior to the date of service and a payment agreement must be signed by the guarantor of the account.
- **We accept cash, checks, Master-card, Visa, and Discover credit/debit cards for your convenience.** A $25.00 charge will be assessed on all returned checks.

DELINQUENT ACCOUNTS

Any account that has not been paid upon within 30-days of receiving payment by the patient's insurance company will be considered delinquent. Any account sent to collections or attorney's fee incurred due to delinquency will be the sole responsibility of the Guarantor. Appointments will not be scheduled for patients who have accounts in collections until the balance has been paid in full.

APPOINTMENT POLICY

If you are **15-minutes late** you will need to reschedule your appointment. We ask that you give the practice at least a 24 hour notice of appointment cancellation. If at least a 24 hour notice is not given this appointment will be considered a "no-show" and will activate the "No-Show and Cancellation" policy in effect. T**he first no-show there will be no charge; thereafter, there will be a $25 fee for the 2nd no-show that must be paid prior to being seen.** Please refer to the Practice's policies and procedures.

ASSIGNMENT OF BENEFITS

I hereby guarantee payment of all charges incurred at Interior Women's Health. I hereby assign and direct insurance payments and all benefits for medical services under this claim be directed to Interior Women's Health. I hereby authorize the release of any medical information requested by the insurance company with the above assignment.

_____ _____

Patient/Guardian Signature Date

Thank you for choosing us as your health care provider. We appreciate the opportunity to serve you.