CHENA *Obstetrics & Gynecology*

1919 Lathrop Street, Suite 222, Fairbanks AK, 99701
Office: 907-456-8191, Fax: 907-456-8192

WELCOME TO OUR PRACTICE
INTAKE FORM

Patient Information

Last Name: _____ **First Name**: _____ **Middle Initial**: _____

Mailing Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell**: _____ **Work**: _____

Preferred method for contact: Home □ Cell/text □ Work □ **Email:** _____

Date of Birth: _____ **SSN #**: _____-_____-_____

Primary Health Care Provider: _____

Race: □ African American □ Caucasian □ Hispanic □ Pacific Islander □ Other □ Refused to report

Ethnicity: □ Hispanic □ Non-Hispanic □ Refused to report **Language:** _____
Marital Status: □ Married □ Single □ Other

Preferred Pharmacy: _____

Employee Status: □ Full □ Part-time □ Not-employed □ Self employed □ Retired

Employer Name and Address: _____
Student: □ Full time □ Part time □ Not a student

Emergency Contact

Name: _____ **Relationship**: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____ **Daytime phone**: _____

Insurance Information

Primary Insurance: _____

Policy ID: _____ **Group #**: _____

Subscriber Name: _____ **Date of Birth**: _____ **SS#:**_____

Address/ City: _____ **State/Zip Code:** _____ **Relationship:** _____

Secondary Insurance: _____

Policy ID: _____ **Group #**: _____

Subscriber Name: _____ **Date of Birth**: _____ **SS#:**_____

Address/ City: _____ **State/Zip Code:** _____ **Relationship:** _____

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FINANCIAL POLICY

Self Pay Patients: Payment in full toward charges incurred at time of service is requested. New patients need to pay a minimum of **160.00** at the time of service.

Insured Patients: Chena Ob/Gyn participates in the following health plans: Medicare, Medicaid, Alaska Blue Cross/Blue Shield (associated with Blue Card Network), City of North Pole, Aetna (Aetna affiliated), and MultiPlan (PHCS, MultiPlan, ValuePoint, BeechStreet) Network.

Co-pay and deductible are due at time of service. We will bill any other insurance carrier as a courtesy to our patients. Payment of services is due at time of service.

Please be aware that it is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**

Payment Options: We accept Visa and MasterCard. We also accept checks, cash and debit cards.

Out of State Patients: Payment in full is requested at time of service. Upon request information is provided for patient to bill their insurance.

Returned Checks: The charge for each returned check due to insufficient funds is thirty-five dollars ($35.00)

Collection Accounts: If an account has not been paid off after ninety (90) days from the day of service, the patient's account may be turned over to a collection account. Patients will not be able to make further appointments unless the account is brought current or a payment plan is set up. Accounts that cannot be solved in this manner may be turned over to an outside collection agency. Payments need to be made to the collection agency in this case. If no steps are taken to clear the balance, the practice can discharge a patient and no further appointments are made.

I hereby authorize Chena Obstetrics & Gynecology to release information to my insurance company and my insurance company to release information to Chena Obstetrics & Gynecology. I hereby assign benefits to be paid directly to Chena Obstetrics & Gynecology for this date, and any future visits I may have.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Updated July 1, 2016

CHENA *Obstetrics & Gynecology*

Patient's Request for Release of Information:

Authorization for Verbal Release of Protected Health Information to Designated Persons

AT THE PATIENT'S REQUEST, THIS AUTHORIZATION GRANTS PERMISSION TO CHENA OBSTETRICS & GYNECOLOGY TO COMMUNICATE IN PERSON OR BY TELEPHONE WITH THE FOLLOWING PERSON(S), DESIGNATED BY THE PATIENT, TO ASSIST WITH THE PATIENT'S HEALTH SERVICES. THIS AUTHORIZATION IS APPLICABLE FOR VERBAL INFORMATION ONLY AND IS NOT VALID FOR THE RELEASE OF THE WRITTEN MEDICAL RECORD.

I AUTHORIZE Chena Obstetrics & Gynecology to communicate my health information to the person(s) listed below ('Designated Persons") for the following purposes: to orally confirm my appointments; to discuss results of my laboratory, radiology, or other test results; to pick up sample medications or written prescriptions for me; to discuss my health care; diagnosis, prognosis, and treatment plans; and to discuss billing and payment for medical services provided by Chena Obstetrics & Gynecology.

Please print the following information for each Designated Person:

Name: _____ Relationship to the Patient: _____
Address: _____ Telephone: _____
_____ Alternate Telephone: _____
_____

Name: _____ Relationship to the Patient: _____
Address: _____ Telephone: _____
_____ Alternate Telephone: _____
_____

I UNDERSTAND that this authorization applies to all departments, healthcare providers and/or employees at Chena Obstetrics & Gynecology.

I UNDERSTAND that this authorization is voluntary.

I UNDERSTAND that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

I UNDERSTAND that this authorization will be effective for my lifetime, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time by sending a written statement of revocation to:

Chena Obstetrics & Gynecology
Privacy Officer
1919 Lathrop Street, Suite 222
Fairbanks, AK 99701

If I revoke the authorization, it will not have any effect on any actions taken by Chena Obstetrics & Gynecology prior to the processing of the revocation.

I UNDERSTAND that my refusal to sign this authorization will not negatively affect my health care services at Chena Obstetrics & Gynecology.

CHENA *Obstetrics & Gynecology*

BY SIGNING THIS AUTHORIZATION I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE STATEMENTS CONTAINED HEREIN. I UNDERSTAND THAT CHENA OBSTETRICS & GYNECOLOGY WILL PROVIDE ME WITH A COPY OF THIS SIGNED AUTHORIZATION FORM IF REQUESTED.

PATIENT:
Print name: _____

Signature: _____

Date: _____

Revocation of Authorization

This section is to be completed ONLY in the event the patient seeks to revoke the above authorization after signature.

By my signature below, I am revoking the authorization. I understand that this revocation will be effective when received by Chena Obstetrics and Gynecology and will not be effective to the extent that Chena Obstetrics & Gynecology has relied on my authorization prior to receiving notice of my revocation.

The designated person(s) to be revoked: _____

Patient: _____

Print Name: _____

Signature: _____

Date: _____

THIS SECTION FOR INTERNAL USE ONLY

Date revocation received: _____ Date revocation processed: _____

Name of employee processing request: _____

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Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____