ARCTIC SKYE FAMILY MEDICINE
561 S. DENALI Suite E
Palmer, AK 99645

Phone: 907-745-7944 Fax: 907-745-7918

Rebecca White, M.D.
Kristine Jakiemiec, PA-C

Patient Information

Name:_____ Date of Birth:_____ Social Security Number:_____

Mailing Address:_____ City_____ State_____ Zip_____

Home phone Number_____ Cell Phone Number_____ Work Phone Number_____

Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Decline to answer ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/AK Native ☐ Asian ☐ Black/African American ☐ Nat. Hawaiian/Pacific Islander
☐ White ☐ Other Race ☐ Unknown ☐ Decline to Answer

Preferred Pharmacy:_____

Emergency Contact:_____ Phone Number:_____

Do you allow voice messages: ☐ Yes ☐ No If yes, where? ☐ Home ☐ Work ☐ Cell

Do you allow Email: ☐ Yes ☐ No

Email Address:_____

Responsible Party Information

Name:_____ Date of Birth:_____ Social Security Number_____

Address:_____ City_____ State_____ Zip_____

Relation to Patient:_____ Employer:_____

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

Insurance Information

Primary Insurance:_____ Policy#_____ Group#_____

Subscriber's Name:_____ Date of Birth:_____ Relation to Patient:_____

Secondary Insurance:_____ Policy#_____ Group#_____

Subscriber's Name:_____ Date of Birth:_____ Relation to patient:_____

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Consent to Treat

By signing below, I, (or my authorized representative on my behalf) authorize Arctic Skye Family Medicine and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care provider. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____ _____

Patient/Guardian Signature Date

Benefit Assignment /Release of Information

I authorize Arctic Skye Family Medicine to release and receive information concerning my injury/illness/mental illness/addiction/HIV (AIDs Virus) STD's and /or treatment to medical providers, guarantors or insurance carriers. I assign Arctic Skye Family medicine all payments for services rendered.

_____ _____

Patient/Guardian Signature Date

Receipt of Notice of Privacy Practices

Please sign to show you have been provided the opportunity to review the Privacy Practices as required by HIPAA. A copy will be made for you at your request.

_____ _____

Patient/Guardian Signature Date

Permission to Disclose Health Information

Please use the following area to designate persons you would like to have access to your medical information:

Name:_____ Relation to You:_____ Contact Number:_____

Name:_____ Relation to You:_____ Contact Number:_____

I authorize Arctic Skye Family Medicine to release my health information to the above individual.(s)

Signature:_____ Date:_____

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Financial Policy

Payment for services rendered is the responsibility of the person receiving the services or his/her guardian regardless of insurance or third party liability.

Insured Patients

We bill insurance as a courtesy. Deductibles and copay amounts are due at the time of service. If your insurance has not sent payment within 45 days, all charges will be transferred to you directly. If your insurance company sends payment to you, please contact our office.

Your insurance company may request information from you. Please respond promptly. Claims pended for information requested from you are transferred to and remain your direct responsibility. However, sending the requested information immediately should allow your carrier to process and pay for your services before they become past due. Insurance is a contract between you and your insurance carrier. We are not party to your contract and will not become involved in any dispute between you and your carrier regarding eligibility, deductibles, co-payments, secondary insurance or "usual and customary "allowances. Charges in excess of what your carrier allows is your responsibility. It is also your responsibility to know if your insurance requires you to see a "preferred provider".

Medicaid

Persons covered by Medicaid must present insurance card and pay the required co-pay at the time of service. If you do not have proof of coverage, your appointment will be rescheduled.

Uninsured Patients

Payment is due in full at the time of service. You will receive a 10% discount on your charges.

Overdue Accounts

Arctic Skye makes every attempt to help you stay current on your account, but we are a small practice and cannot carry balances for longer than 6 months. If your account is 120 days past due, your account will be turned over to a collection agency. If your account is sent to a collection agency, you will be dismissed as a patient of Arctic Skye Family Medicine.

Missed Appointments

We require a 24 hour notice to cancel or change an appointment. Missed appointments inconvenience those individuals who need access to medical care. We reserve the right to dismiss a patient who routinely misses their appointments. Failure to cancel an appointment in advance without an adequate reason missing your appointment will be documented in our schedule as a "No Show". Three "No Shows" in one year will result in termination from Arctic Skye Family Medicine.

Patient Printed Name_____ Date:_____

Patient Signature:_____