ARCTIC SKYE FAMILY MEDICINE
2851 East Palmer Wasilla Highway Suite 3
Wasilla , AK 99654

Rebecca White, M.D.
Kristine Jakiemiec, PA-C
Phone: 907-357-7944 Fax: 907-357-7991

Patient Information

Name________________________ Date of Birth____________ Social Security Number____________

Physical Address ________________________ City____________ State________ Zip________

Mailing Address ________________________ City____________ State________ Zip________

Home phone Number______________ Cell Phone Number______________ Work Phone Number______________

Gender: ☐ Male ☐ Female ☐ Other 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 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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Phone: 907-357-7944 Fax: 907-357-7991 Printed name: ______________________________

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. This authorization will remain in effect until revoked in writing by the patient or the patient transfers care to another provider.

______________________________ ______________
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:______________

FINANCIAL POLICY

Patient Name (Printed) ____

Arctic Skye Family Medicine is committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from Arctic Skye Family Medicine including those covered by my insurance. As a convenience, Arctic Skye Family Medicine will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if Arctic Skye Family Medicine determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.

3. If my insurance company requests information from me it is my responsibility to respond promptly. Claims pended for this reason will be transferred to me and remain my responsibility. The details of what is covered or not covered by my insurance company and my policy is also my responsibility and Arctic Skye Family Medicine is not liable for disputes in regard to this issue. If Arctic Skye Family Medicine is not a "Preferred Provider" for my insurance, I understand that non-allowed amounts will not be written off and I will be billed for any of these amounts.

4. Uninsured Patients: Payment is due in full at the time of service. I will receive a 10% discount on my charges.

5. Arctic Skye Family Medicine may deny service or reschedule my appointment for failure to pay bills in a timely manner. If my account is delinquent after 90 days, my account will be turned over to an outside collection agency and I will be dismissed as a patient of Arctic Skye Family Medicine.

6. It is my responsibility to provide my current address, telephone number, email address, and insurance information and update this if there are any changes.

7. I have the option to provide Arctic Skye Family Medicine with my debit/credit card or ACH information which will be kept on file. If I choose to do this, I authorize Arctic Skye Family Medicine to apply charges to my payment card and/or ACH account for all amounts owed to Arctic Skye Family Medicine for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), or (iv) amounts not covered by insurance. I can designate the maximum (not to exceed) amount of such payment.

8. If I agree to keep my payment information on file (as per #7 above), I understand that my signature and payment information will be maintained on file digitally for future use by Arctic Skye Family Medicine. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.

9. If I agree to set up a payment plan for large amounts owed, Arctic Skye Family Medicine can offer the option of paying my share of costs via an automated payment plan. I understand that I will be charged the agreed upon amount on a specified date by debit/credit card or ACH information. I will receive email notification three days before my debit/credit card is charged or amount withdrawn via ACH.

10. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I will receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date.

11. Transaction receipts will be maintained in the patient file, will be emailed to me if I provide and maintain a valid email address or will be printed and mailed if I request a paper receipt.

12. I understand that I must provide 24 hour notice to cancel or change an appointment. Missed appointments inconvenience others who need access to medical care. Failure to cancel an appointment in advance with an adequate reason will be documented in the schedule as a "No Show." Three "No Shows" in one year may result in termination from Arctic Skye Family Medicine.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Patient Name (Printed) ______________________________ Date ________________

Patient (or Guardian) Signature ____

E-Prescribe Program

E-prescribing is defined as a way for doctors to electronically send an accurate, error free and understandable prescription directly to a pharmacy from your providers office. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances safety. The Medicare Modernization Act of 2003 listed the standards that have to be included in the e-prescribing program. These include:

Formulary and benefit Transactions- Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transaction- Provides the health care provider with information about your current and past prescriptions. This allows your health care provider to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens; therapeutic interventions; drug to drug and drug allergy interactions, adverse drug reactions; and duplication therapy.

Fill Status Notification- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patients prescription has been picked up, not picked up or partially filled.

By signing the consent form, you are agreeing that Arctic Skye Family Medicines Providers and designated staff can request and use your prescription medication history from other healthcare providers and / or third-party pharmacy benefit payors for the treatment purposes.

Understanding all the above, I hereby provide informed consent to Arctic Skye Family Medicine to enroll me in the e-prescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Consent

Patient Signature____ Date_______________

Parent/Guardian Signature__________________________________ Date_____________