FAIRBANKS FAMILY WELLNESS

We Have the Knowledge to Nurture.

Patient Intake ***PLEASE USE PRINT***

Name: _____ Date: _____
Last First MI

Mailing Address: _____
Street/PO Box City State Zip

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

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

Email Address: _____

Gender: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____ Occupation: _____

Referring Physician: _____ Family Physician: _____

Reason for Visit: _____

Patient younger than 18 list parent(s)/legal guardian(s): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information: *Please Give your Cards to Receptionist for Scanning*

Primary Insurance: _____

Insured's Name: _____

Relationship to Patient: _____ Date of Birth: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____

Insured's Name: _____

Relationship to Patient: _____ Date of Birth: _____

ID Number: _____ Group Number: _____

Signature of Patient or Responsible Party: _____

Printed Name: _____

Relationship to Patient: _____ Date: _____

3550 Airport Way, Suite 4
Fairbanks, AK 99709
Phone: (907) 479-2331
Fax: (866) 834-0164

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Office Policy PLEASE USE PRINT

Patient Name: _____

The staff at the office of Fairbanks Family Wellness, welcomes you and also thanks you for choosing our office to support you in better health. We want to make your visit with us both beneficial and pleasant.

Our policy is that payment is due at the time that services are rendered. We accept all major credit cards. We do not accept out of state checks. Returned checks are subject to a fee of $30.00. Deductible and Co-payment (your percentage) are also expected at each visit.

1. Your insurance is a contract between you, your employer, and your insurance company. ***We are not part of that contract***. Please contact your employer or the number on the back of your insurance card for any questions and to verify benefits, deductibles, co-pay, and/or co-insurance.

2. We do not automatically file pre-authorization or call your insurance to verify your benefits. Not all services are covered under all policies; insurance companies select certain services they will not cover. It is your responsibility to contact your insurance company to verify coverage.

3. Our fees are per service and fall within most but not all insurance guidelines for “usual and customary, and/or reasonable fee”. Insurance policies base their payments on UCR fees. Charges more than UCR fee are not considered for payment by insurance ***but are the responsibility of the patient.***

The filing of insurance claims is a courtesy that we extend to our patients. ***All charges are your responsibility from the date of service.*** We will attempt to get payment from the insurance company for up to 60 days after the date of service. After 90 days, it will become your responsibility to pay the balance in full, regardless of pending action by your insurance company.

Signature of Patient or Responsible Party: _____

Printed Name: _____

Relationship to Patient: _____ Date: _____

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Financial Contract PLEASE USE PRINT

Please Initial Each Line **Patient Name:** _____

_____ As a courtesy to you, we will call, text, or email you 24 hours prior to your appointment. We require that you confirm your appointment.

_____ We now ***require a credit card*** to be kept ***on file*** to charge for cancellations without 24 hours notice, no show, no call appointments. Cancellations without 24 hours notice, no show, no call appointments will be automatically charged a service fee of $50.00.

_____ After 3 no show appointments at Fairbanks Family Wellness, you will need to call for a same day appointment. This will be based on your provider's availability. We will no longer be able to schedule you out for appointments.

_____ Your deductible and/or co-pays will be automatically charged to your credit card after each Telemedicine appointment.

_____ For TSD (Time of Service Discount) the agreed upon amount will be automatically charged to your credit card after each visit.

Credit Card Information

Name as it appears on your credit card: _____

Credit Card Number: _____

Expiration Date: _____ CCV: _____

By signing below you authorize FFW to automatically charge your card for the items listed above.

Authorized Signature: _____

Date: _____

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HIPAA: Medical Release Form ***PLEASE USE PRINT***

Patient Name: _____ Date of Birth: _____

Release of Information

☐ I authorize the release of Information including the diagnosis records, examinations rendered, and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____

☐ Information is ***NOT*** to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ☐ My Home ☐ My Work ☐ My Cell

Contact Number: _____

If Unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Other: _____

The best time of day to reach me is between (times): _____and_____

I was offered a copy of the HIPAA Privacy Practice of Fairbanks Family Wellness.

Signature of Patient or Responsible Party: _____

Printed Name: _____

Relationship to Patient: _____ Date: _____

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Informed Consent for Telemedicine ***PLEASE USE PRINT***

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with the following providers:

Amy Williamson, ND, Sara Wood, LPC, Suzette Mailloux, ND, Sara Evans, APRN, Tamela Edwards, LPC, Emily Low, LPC, Haley Evens, APRN, FNP-BC, Meeka Lockert, FNP-BC, Stephanie Gottschalck, L.Ac, Olivia Foote, LPC, Anne Sterle, LCMHC, Lia Aitken, LPC, Robin Baise, LPC, Adiella Callahan, LPC, Melodee Morris, LPC, Ed, Stacie Braband, Amanda Forsting

1. ***Purpose and Benefits:*** The purpose of this consent is to use telemedicine to enable patients to receive care during the COVID19 pandemic and afterwards as needed.

2. ***Nature of Telemedicine Consultation During the Consultation:*** Any details talked about during your appointment will be discussed through the use of HIPAA compliant interactive video, audio and telecommunications technology.

3. ***Medical Information and Records:*** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4. ***Confidentiality:*** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Alaska State law apply to information disclosed during this telemedicine consultation.

5. ***Risks and Consequences:*** The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. Following the telemedicine consultation, your practitioner may recommend an in person visit or a visit to another provider.

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6. ***Rights:*** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits, to which you would otherwise be entitled.

7. ***Financial Agreement:*** This telemedicine consultation will be billed to your insurance company and any deductibles and/or co-pays will be charged after your appointment. If you have TSD or an Election to Self Pay your card will be charged automatically after each appointment.

I have been advised of all the potential risks, consequences, and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Patient's Name: _____

Signature of Patient or Responsible Party: _____

Printed Name: _____

Relationship to Patient: _____

Date: _____

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