Alaska Fracture & Orthopedic Clinic

PATIENT INFORMATION

Last Name_____ **First Name**_____ **MI** _____ **M/F**

Previous name(s) used _____

Mailing Address_____ **City** _____ **State** _____ **Zip**_____

Residence/Street _____**City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **DOB**_____ **SSN#**_____

Race _____ **Ethnicity** _____ **Language** _____ **Marital Status** _____

Employer _____ **Can we call you at work? Yes/No If yes, phone** _____

E-Mail _____

RESPONSIBLE PARTY (MINORS ONLY)

Last Name_____ **First Name**_____ **MI** _____ **M/F**

Mailing Address_____ **City** _____ **State** _____ **Zip**_____

Phone_____**DOB**_____ **SSN#**_____ **Relation to Patient**_____

INSURANCE INFORMATION

PRIMARY Insurance _____ **Policy #** _____ **Group #** _____

Insured _____**Relationship** _____**DOB**_____**Social Security #** _____

SECONDARY Insurance _____ **Policy #**_____ **Group #**_____

Insured _____ **DOB** _____ **Social Security #**_____

GENERAL INFORMATION

Person to contact if unable to reach patient (not living in your home)

Name _____ **Phone/Cell** _____**Relationship** _____

How did you hear about us? _____ **Preferred Pharmacy** _____

Primary Care Provider _____

Who do you authorize to pick up your prescriptions? _____

_____

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans, Medicaid, RR Medicare, and all other health plans to Alaska Fracture & Orthopedic Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance (including Medicaid). I hereby authorize said assignee to release all information needed to secure the payment.

Signed _____ **Date** _____

Alaska Fracture
& Orthopedic Clinic

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Alaska Fracture & Orthopedic Clinic to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Alaska Fracture & Orthopedic Clinic describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Alaska Fracture & Orthopedic Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

4100 Lake Otis Parkway, Suite 108. Anchorage, AK 99508

With this consent, Alaska Fracture & Orthopedic Clinic may call my home or other alternative location and leave a message on voice mail if needed (unless a Refusal to Voicemail form is completed) or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Alaska Fracture & Orthopedic Clinic may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Alaska Fracture & Orthopedic Clinic may e-mail any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Alaska Fracture & Orthopedic Clinic restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Alaska Fracture & Orthopedic Clinic to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Alaska Fracture & Orthopedic Clinic may decline to provide treatment to me.

_____	_____
Print Patient's Name	Signature of Patient or Legal Guardian
_____	_____
Date	Print Name of Legal Guardian, if applicable

ALASKA FRACTURE & ORTHOPEDIC CLINIC
FINANCIAL POLICIES

PLEASE REVIEW AND INITIAL

PATIENT NAME _____ DATE _____

- If proof of insurance/eligibility cannot be provided, payment will be due in full. _____
- Alaska Fracture & Orthopedic Clinic will collect any deductibles, copay, or coinsurance on the date of service. _____
- Medical insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, etc. _____
- Balances on your account must be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel. If you are in need of an arrangement, please contact the billing department in a timely manner as any claim over 90 days will be due in full or reviewed for collections. _____
- Statements are not generated for an amount due to less than $2.50; please watch your insurance explanations to see if you owe a balance. _____
- Please be aware you may receive a separate charge from an outside lab (i.e., LapCorp) for specialized lab tests. _____
- Alaska Fracture & Orthopedic Clinic is in network with the following insurances: Aetna, Blue Cross, Cigna, Medicaid, Medicare, Moda/ODS, Multiplan, Tricare, United Health Care, and the VA. If your insurance is not one of these, please be aware your claim(s) will be processed as "out of network". _____
- Delinquent account (>90 days) is subject to collections processes which may include the account being transferred to Cornerstone Credit Services (CCS). You will be responsible for any fees and/or commission charged to Alaska Fracture & Orthopedic Clinic by CCS. Patients whose accounts have been sent to CCS will be reviewed for possible discharge from the clinic. _____
- Alaska Fracture & Orthopedic Clinic will charge a fee of $30.00 for any checks returned as NSF. The patient's account be flagged that only cash or credit card payments will be accepted due to the NSF. _____
- Any appointment cancelled less than 24 hours prior to the scheduled appointment time will be documented as a missed appointment on the account. Missed appointments are subject to a $50 fee. After two missed appointments an account may be reviewed for discharge from the practice. _____
- It is important to clarify the reason for your visit(s). Please do this at the time of your visit as it is Alaska Fracture & Orthopedic Clinic policy to not change the diagnosis code ***after*** the visit. Do feel free to clarify/ confirm what diagnosis will be used with your provider before you leave the office. _____

Alaska Fracture & Orthopedic Clinic

Authorization to Discuss PHI

I, _____ (print patient name), authorize Alaska Fracture & Orthopedic Clinic to ***verbally*** discuss my medical records with:

☐ ADD ☐ REMOVE

1. _____
2. _____
3. _____

By signing this authorization form, I understand that:

- Some records may contain extremely confidential information. This may include alcohol/substance abuse/testing, mental health conditions/psychotherapy notes and psychological evaluations, HIV testing, status or care and treatment for AIDS, sexually transmitted disease/testing, and genetic records.
- Once the office discloses health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.
- I may revoke this authorization in writing. If revoked, it would not affect any actions already taken by Alaska Fracture & Orthopedic Clinic based upon this authorization. Two ways to revoke this authorization are: Fill out a revocation form (available from the office) *or* write a letter to the office.
- This is not an authorization to release printed medical records.

_____ _____

Patient or Parent/Guardian name (print) Patient Date of Birth

_____ _____

Signature of patient or Parent/Guardian Date

Alaska Fracture & Orthopedic Clinic

Telemedicine Consent Form

I, _____, understand and agree that by participating in telemedicine services with Alaska Fracture & Orthopedic Clinic, I am agreeing to the following terms and conditions:

1. I understand that telemedicine involves the use of electronic communications to enable healthcare providers at Alaska Fracture & Orthopedic Clinic to provide healthcare services remotely.

2. I understand that telemedicine may involve the use of videoconferencing, secure messaging, or other electronic communications technologies to diagnose, consult, treat, and educate me.

3. I understand that telemedicine services may not be as complete as in-person services, and that there may be limitations to the diagnosis or treatment that can be provided via telemedicine.

4. I understand that Alaska Fracture & Orthopedic Clinic will use commercially reasonable efforts to ensure the security and confidentiality of all telemedicine sessions, but that there may be some risks associated with electronic communications, including interception or unauthorized access.

5. I understand that I may need to be physically present at a healthcare facility or other location for certain tests, exams, or treatments that cannot be performed via telemedicine.

6. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time.

7. I understand that my healthcare provider at Alaska Fracture & Orthopedic Clinic may determine that telemedicine services are not appropriate for my care and may terminate telemedicine services at any time.

8. I understand that I may be responsible for payment of any fees associated with telemedicine services that are not covered by my insurance.

By signing below, I acknowledge that I have read and understand the terms of this consent form, and that I consent to the use of telemedicine services as described above. This consent is valid for one year from the date of signature.

_____ _____

Patient or Parent/Guardian name (print) Patient Date of Birth

_____ _____

Signature of patient or Parent/Guardian Date