Patient Information

First Name:______________________M.I.________ Last Name:______________________

Birthday:______________________ Sex: M ❑ F ❑ Social Security #:______________________

Mailing Address:____

City: ______________________State:________ Zip:______________________

Home phone:____________Cell:____________Work:____________Ext:____________

Employer:______________________________Occupation:______________________

Work Status: ❑ Full Time ❑ Part Time ❑ Seasonal Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Is Patient a minor? ❑ Yes ❑ No **Responsible Party Name:** ____________Relation:____________DOB:________

May we leave a message on your phone? ❑ Yes ❑ No If yes, which one(s)?______________________

Message can be: ❑ Detailed or ❑ Only name and number only **Would you like a follow up call on your visit?** ❑ Yes ❑ No

Email(optional)______________________May we send account statements to this address? ❑ Yes ❑ No

Primary Insurance Name:______________________Employer:______________________

Insurance policy holder name:______________________DOB:______________________

Relation to patient:______________________ Co-pay/Co-ins:$___/___% Deductible met? Yes No Not Sure

Secondary Insurance Name:______________________Employer:______________________

Insurance policy holder name:______________________DOB:______________________

Relation to patient:______________________ Co-pay/Co-ins:$___/___% Deductible met? Yes No Not Sure

Is your visit today related to a motor vehicle or work accident? ❑ No ❑ Yes If yes: ❑ Work ❑ Motor vehicle

Insurance Name:______________________________Policy/Claim #:______________

Employer:______________________Phone:______________Manager:______________

Release of Information:

I hereby authorize Alpine Urgent Care to release relevant personal medical documents to the necessary parties involved in my active treatment plan, and that changes to this authorization must be made in writing and delivered to Alpine Urgent Care 1310 E. Dimond Blvd., Ste. 1, Anchorage, AK 99515(Please initial)__________

(Please initial) __________ I authorize Alpine Urgent Care to release medical information to (Name and relation to patient):

____

Acknowledgement of Medicare Benefits

(Please initial)______ I certify that I do not receive Medicare benefits of any kind, part A or B. I also certify that Medicare is not secondary to any other insurance plan for me. Alpine Urgent Care is not legally able to see and charge patients with Medicare, and patients are not able to submit receipts to Medicare for reimbursement.

Financial Policy Acknowledgement

Responsible party is accountable for payment at time of service. Alpine Urgent Care will bill patient's insurance for services rendered, provided we have all correct and current insurance information. It is understood that the insurance company may assist in paying medical costs, but that I am financially responsible for all medical services rendered, and if necessary, I agree to pay all fees associated with services rendered including collection costs. I must pay the copay, and any unmet deductible at the time of service.
(Please initial)__________

I understand that if a check I write is returned to Alpine Urgent Care due to insufficient funds, I will be invoiced for the original amount of the returned check and an additional $30.00(thirty dollar) NSF bank charge. (Please initial)________

Patient Name:______________________________Date:______________________

Responsible Party Name (if different from patient):______________________

Responsible Party Signature:____

Staff Initials:______

Patient Name: ____

How would you like to be addressed? ____________________________________

How did you hear about our office? ❑ Magnet Mailer ❑ Google Ad ❑ Internet Search ❑ Press Ad

❑ Drive by/Saw Sign ❑ Premera BCBS ❑ Aetna ❑ Know staff ❑ Hotel______________

❑ Friend/Family_______________________ ❑ Insurance Co. _______________

❑Referred by clinic__________________________ ❑ Other____________

Do you have a Primary Care Doctor? If 'yes' who?______________________

Emergency Contact Name: ______________Phone #:____________Relation:_______

Purpose of visit (be brief)____

____

Personal Medical History: Do you have any medical problems? ____________________

____

Have you had any surgeries before? (Date/type) ______________________________

____

Are you currently pregnant or breastfeeding? ❑ No ❑ Yes Weeks & Due Date:____________

Are you allergic to any medications? Please list and describe the kind of reaction you have: _____

____

____

Please list your **current medications** (*including over the counter and herbal supplements*):

Name	Dose	Frequency
1.		
2		
3.		
4.		
5.		

Family History: Any family history of medical problems? ______________________

____

Social History:

Are you (check one): ❑ Employed ❑ Student ❑ Not working ❑ Retired ❑ A minor

Do you use, or have you ever used tobacco products? ❑ Yes ❑ No

Please specify product used ❑ Cigarettes ❑ Chew ❑ Other________________________

How long? _______ How many packs per day?______Are you interested in quitting? _______

If you've quit tobacco products please specify year ________

Do you drink alcohol?________ How many drinks per week do you have? ________

Do you use any recreational drugs? ________ If yes, what? __________________

Continued on the back side

Have you experienced any of the following? (please address each item):

No	In last month	Now	General	No	In last month	Now	Skin	No	In last month	Now	Throat/Mouth
☐	☐	☐	Weight loss or gain	☐	☐	☐	Rashes	☐	☐	☐	Bleeding
☐	☐	☐	Fatigue	☐	☐	☐	Lumps	☐	☐	☐	Dry mouth
☐	☐	☐	Fever or chills	☐	☐	☐	Itching	☐	☐	☐	Sore throat
☐	☐	☐	Weakness	☐	☐	☐	Dryness	☐	☐	☐	Hoarseness
☐	☐	☐	Trouble Sleeping	☐	☐	☐	Hair/nail changes	☐	☐	☐	Non-healing sores
			Respiratory				**Nose**				**Urinary**
☐	☐	☐	Cough	☐	☐	☐	Stuffiness	☐	☐	☐	Frequency
☐	☐	☐	Sputum	☐	☐	☐	Discharge	☐	☐	☐	Urgency
☐	☐	☐	Coughing up blood	☐	☐	☐	Itching	☐	☐	☐	Burning or pain
☐	☐	☐	Shortness of breath	☐	☐	☐	Hay fever	☐	☐	☐	Blood in urine
☐	☐	☐	Wheezing	☐	☐	☐	Nosebleeds	☐	☐	☐	Incontinence
☐	☐	☐	Painful breathing	☐	☐	☐	Sinus Pain	☐	☐	☐	Change in urinary strength
			Head				**Psychiatric**				**Hematologic**
☐	☐	☐	Headache	☐	☐	☐	Stress	☐	☐	☐	Ease of bruising
☐	☐	☐	Head injury	☐	☐	☐	Depression	☐	☐	☐	Ease of bleeding
			Ears				**Neck**				**Endocrine**
☐	☐	☐	Decreased hearing	☐	☐	☐	Lumps	☐	☐	☐	Heat or cold intolerance
☐	☐	☐	Ringing	☐	☐	☐	Swollen glands	☐	☐	☐	Sweating
☐	☐	☐	Earache	☐	☐	☐	Pain	☐	☐	☐	Excessive thirst
☐	☐	☐	Drainage	☐	☐	☐	Stiffness	☐	☐	☐	Change in appetite
			Gastrointestinal				**Eyes**				**Neurologic**
☐	☐	☐	Difficulty swallowing	☐	☐	☐	Vision loss/changes	☐	☐	☐	Dizziness
☐	☐	☐	Heartburn	☐	☐	☐	Glasses/contacts	☐	☐	☐	Fainting
☐	☐	☐	Change in appetite	☐	☐	☐	Pain	☐	☐	☐	Seizures
☐	☐	☐	Nausea/vomiting	☐	☐	☐	Redness	☐	☐	☐	Weakness
☐	☐	☐	Change in bowel habits	☐	☐	☐	Blurry/double vision	☐	☐	☐	Numbness
☐	☐	☐	Rectal bleeding	☐	☐	☐	Flashing lights	☐	☐	☐	Tingling
☐	☐	☐	Constipation	☐	☐	☐	Glaucoma/cataracts	☐	☐	☐	Tremor
☐	☐	☐	Diarrhea	☐	☐	☐	Specks				
			Musculoskeletal				**Vascular**				**Cardiovascular**
☐	☐	☐	Muscle/joint pain	☐	☐	☐	Calf pain w/ walking	☐	☐	☐	Chest pain/discomfort
☐	☐	☐	Stiffness	☐	☐	☐	Leg cramping	☐	☐	☐	Tightness
☐	☐	☐	Back pain				**Breasts**	☐	☐	☐	Palpitations
☐	☐	☐	Redness of joints	☐	☐	☐	Lumps	☐	☐	☐	Shortness of breath w/ activity
☐	☐	☐	Swelling of joints	☐	☐	☐	Pain	☐	☐	☐	Difficulty breathing lying down
☐	☐	☐	Trauma	☐	☐	☐	Discharge	☐	☐	☐	Swelling

Form completed by: ____________________ Relationship to patient: ____________________

Patient/Guardian signature: ____________________ Date: ____________________

Staff Reviewer initials: ____________________

Date: ____________________

Staff Use Only
Acct #: ____________________

HIPAA Notice of Privacy Practices

Alpine Urgent Care & Sports Medicine
1310 E. Dimond Blvd., Suite 1
Anchorage, AK 99515
P: 907-344-2400

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and abide by the same HIPAA Privacy standards as outlined in this Notice of Privacy Practice.

Other Permitted Uses and Disclosures Requiring Your Written Authorization

Unless noted above in our Use and Disclosures, all other permitted uses and disclosures of your protected health information will be made only with your consent, authorization or opportunity to object unless required by law. This includes:

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure for marketing purposes
- Disclosures that constitute a sale of your protected health information.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to receive a Breach Notification. You have the right to receive a notification upon a breach of any of your unsecured Protected Health Information.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Notice of Privacy Practices Acknowledgment

Alpine Urgent Care & Sports Medicine

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:______________________________________