Alpine URGENT CARE & SPORTS MEDICINE

New Patient Information Form

Demographics

First Name: _____ Middle Initial: _____ Last name: _____

Date of birth: _____ Sex: ☐M ☐F Social security #: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Home phone #: _____ Cell phone #: _____ Work phone #:_____

May we leave a message on your phone? ☐ Yes ☐ No If yes, which one(s)? ☐ Home ☐ Cell ☐ Work

Message can be: ☐ Detailed **or** ☐ Name and number only **Would you like a call following up on your visit?** ☐ Yes ☐ No

Email (optional): _____ May we send account statements by email? ☐ Yes ☐ No

Employer: _____ Occupation: _____

Work status: ☐ Full time ☐ Part time ☐ Seasonal Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

For minor patients: Responsible party name: _____ DOB: _____ Relation: _____

Health Insurance Information

Primary Insurance Company: _____ Employer: _____

Insurance policy holder name: _____ Social security #: _____

Insured date of birth: _____ Patient relation to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Company: _____ Employer: _____

Insurance policy holder name: _____ Social security #: _____

Insured date of birth: _____ Patient relation to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Workers Compensation & Motor Vehicle Accident Information - Only applicable if injury related to work or auto accident

Is your visit related to a work injury? ☐ Yes ☐ No Date of injury: _____ Date reported: _____

Employer: _____ Manager/HR contact: _____ Phone#: _____

Work Comp Insurance Coverage Provider: _____ Your claim #: _____

★★★★★ WE DO NOT BILL THIRD PARTY CLAIMS - PLEASE PROVIDE YOUR PERSONAL CLAIM INFORMATION ★★★★★

Is your visit related to a motor vehicle accident? ☐ Yes ☐ No Date of MVA: _____ Date reported: _____

Your auto insurance carrier: _____ Policy #: _____ Phone #: _____

Your claim #: _____ MedPay available? ☐ Yes ☐ No How much? _____

Medicare Policy & Patient Acknowledgement

The providers of Alpine Urgent Care & Sports Medicine are in no way contracted with Medicare and therefore are not enrolled or able to submit claims to Medicare for consideration and reimbursement of treatment provided to Medicare beneficiaries. Due to legislation outlined in Section 1848 of the Social Security Act, the providers of Alpine Urgent Care & Sports Medicine may not treat any qualified Medicare benificiary regardless of the benificiary's other health insurance coverage or willingness to pay. We sincerely apologize for any inconvinience this may cause you.

Please initial_____ I certify that I am not a Medicare benificiary and am not enrolled in either Part A or Part B of Medicare.

_____ PATIENT/GUARDIAN SIGNATURE

_____ DATE

FOR CLINIC STAFF USE ONLY:

Patient Chart Number: _____

Staff Reviewer 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
□	□	□	Weight loss or gain
□	□	□	Fatigue
□	□	□	Fever or chills
□	□	□	Weakness
□	□	□	Trouble Sleeping

No	In last month	Now	Skin
□	□	□	Rashes
□	□	□	Lumps
□	□	□	Itching
□	□	□	Dryness
□	□	□	Hair/nail changes

No	In last month	Now	Throat/Mouth
□	□	□	Bleeding
□	□	□	Dry mouth
□	□	□	Sore throat
□	□	□	Hoarseness
□	□	□	Non-healing sores

			Respiratory
□	□	□	Cough
□	□	□	Sputum
□	□	□	Coughing up blood
□	□	□	Shortness of breath
□	□	□	Wheezing
□	□	□	Painful breathing

			Nose
□	□	□	Stuffiness
□	□	□	Discharge
□	□	□	Itching
□	□	□	Hay fever
□	□	□	Nosebleeds
□	□	□	Sinus Pain

			Urinary
□	□	□	Frequency
□	□	□	Urgency
□	□	□	Burning or pain
□	□	□	Blood in urine
□	□	□	Incontinence
□	□	□	Change in urinary strength

			Head
□	□	□	Headache
□	□	□	Head injury

			Psychiatric
□	□	□	Stress
□	□	□	Depression

			Hematologic
□	□	□	Ease of bruising
□	□	□	Ease of bleeding

			Ears
□	□	□	Decreased hearing
□	□	□	Ringing
□	□	□	Earache
□	□	□	Drainage

			Neck
□	□	□	Lumps
□	□	□	Swollen glands
□	□	□	Pain
□	□	□	Stiffness

			Endocrine
□	□	□	Heat or cold intolerance
□	□	□	Sweating
□	□	□	Excessive thirst
□	□	□	Change in appetite

			Gastrointestinal
□	□	□	Difficulty swallowing
□	□	□	Heartburn
□	□	□	Change in appetite
□	□	□	Nausea/vomiting
□	□	□	Change in bowel habits
□	□	□	Rectal bleeding
□	□	□	Constipation
□	□	□	Diarrhea

			Eyes
□	□	□	Vision loss/changes
□	□	□	Glasses/contacts
□	□	□	Pain
□	□	□	Redness
□	□	□	Blurry/double vision
□	□	□	Flashing lights
□	□	□	Glaucoma/cataracts
□	□	□	Specks

			Neurologic
□	□	□	Dizziness
□	□	□	Fainting
□	□	□	Seizures
□	□	□	Weakness
□	□	□	Numbness
□	□	□	Tingling
□	□	□	Tremor

			Musculoskeletal
□	□	□	Muscle/joint pain
□	□	□	Stiffness
□	□	□	Back pain
□	□	□	Redness of joints
□	□	□	Swelling of joints
□	□	□	Trauma

			Vascular
□	□	□	Calf pain w/ walking
□	□	□	Leg cramping

			Breasts
□	□	□	Lumps
□	□	□	Pain
□	□	□	Discharge

			Cardiovascular
□	□	□	Chest pain/discomfort
□	□	□	Tightness
□	□	□	Palpitations
□	□	□	Shortness of breath w/ activity
□	□	□	Difficulty breathing lying down
□	□	□	Swelling

Form completed by: _____ Relationship to patient: _____

Patient/Guardian signature: _____ Date: _____

Staff Reviewer initials: _____

Date: _____

Staff Use Only
Acct #: _____

Alpine URGENT CARE & SPORTS MEDICINE

Thank you for choosing **Alpine Urgent Care & Sports Medicine** for your medical needs. We strive to deliver excellence in care with each visit. Your patronage is vital to the success and continuation of our clinic.

Please understand that a mutual financial understanding is an important part of our relationship. We require payment in full at the time of service for all costs determined as patient responsibility. It is our policy to collect any deductible, co-insurance, co-pays or other patient costs at the time services are rendered. We attempt to make this process as easy as possible for you. As a courtesy we bill most commercial health insurance plans when complete and accurate insurance information is provided at the time of service. Our educated front desk staff will verify your insurance benefits and explain the details of your financial responsibility prior to your visit with your provider. The information provided at the time of benefit confirmation is only an estimate and is not a guarantee; actual benefits will be determined at the time the claim is processed based on all coverage requirements outlined in your plan benefit booklet.

For patients not covered by insurance that are able to pay their bill in full by cash or credit card on the date of service we may be able to offer discounted rates on office visits, diagnostic testing and durable medical equipment. Our office requires a down payment of $100.00 made by cash or credit card prior to seeing the provider and the balance due in full at the time of checkout.

Ultimately, all charges are patient responsibility. As insurance is billed as a courtesy, it is the patient's responsibility to ensure timely payment of all insurance claims. At times, insurance companies will put a hold on the processing of claims and request information from the subscriber. It is the patient's responsibility to make sure requested information is completed and returned to the insurance company immediately. In the event that a claim is pended for more than 30 days, the account balance will be transferred to patient responsibility and a statement sent out for payment in full.

Our practice is committed to providing the best care for our patients and our charges are set at usual and customary for our area. For our patient's convenience have contracted with the following PPO networks:

★Blue Cross Blue Shield ★Aetna ★Multiplan ★PHCS ★Beechstreet

All contracted discounts determined by the above networks will be honored. For all other insurance plans and networks the patient is directly responsible for any balance left after insurance has made payment.

Accepted forms of payment are: cash, cashiers checks & credit cards. Personal checks are not accepted.

Worker's Compensation

We are able to bill your employers workers compensation insurance company for injuries occurring while on the job in Alaska when the patient provides the front desk with a copy of the Report of Injury filed with their employer as well as the appropriate contact information for the employer and all claim information the patient has at that time. Ultimately it is the patient's responsibility to ensure we have complete information to bill in a timely manner. Unfortunately, we are unable to bill Federal Worker's Compensation. Any patient injured while working for the federal government is covered under Federal Worker's Compensation and will need to seek treatment elsewhere.

Automobile Accidents

We are able to submit medical claims to personal auto insurance carriers for patient's recently injured in a motor vehicle accident that have an open claim with MedPay available for treatment. The patient is required to provide the front desk with complete claim and billing information when checking in for an appointment. We do not deal with Third Party claims. In the instance that a patient seeks care for injuries sustained in a motor vehicle accident and does not have a personal policy with MedPay available, payment is due in full at the time of service.

SIGNED: _____ DATE: _____

FOR CLINIC STAFF USE ONLY:

Patient Account Number: _____

Alpine URGENT CARE & SPORTS MEDICINE

Patient Name: _____

Please initial next to each statement below:

_____ I understand that I am financially responsible for all charges incurred by my dependent or myself. I agree to pay all amounts determined as patient responsibility as well as any fees associated with services rendered, including collections costs.

_____ I authorize my insurance company(s) to pay Alpine Urgent Care & Sports Medicine for those charges that are filed by the clinic on my behalf.

_____ In the event that payment is issued to me by my insurance company for treatment/services received at Alpine Urgent Care & Sports Medicine any amount up to the balance on my account will be immediately remitted to Alpine Urgent Care & Sports Medicine.

_____ I authorize Alpine Urgent Care & Sports Medicine to release any medical information required by my insurance company, worker's compensation or auto insurance carrier for the processing of any medical claims on my behalf.

_____ I have read and signed the Alpine Urgent Care & Sports Medicine Financial Policy.

_____ I acknowledge that I have been provided a copy of Alpine Urgent Care & Sports Medicine's Notice of Privacy Practices which describes how my medical information may be used and disclosed.

_____ I give Alpine Urgent Care & Sports Medicine permission to speak with and provide information to the following people regarding my medical and/or billing information:

_____

_____

Please list name(s) and relationships on the lines provided above.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

GUARDIAN PRINTED NAME DATE

_____ _____

GUARDIAN SIGNATURE DATE

FOR CLINIC STAFF USE ONLY:

Patient Account Number: _____

Alpine URGENT CARE & SPORTS MEDICINE
1310 E. Dimond Blvd., Suite 1
Anchorage, AK 99515
P: (907) 344-2400

HIPAA Notice of Privacy Practices

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.

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HIPAA Notice of Privacy Practices continued…

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.

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HIPAA Notice of Privacy Practices continued…

YOUR RIGHTS continued…

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 initial & 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.