Wendell Street Psychiatric Services LLC
225 Wendell Street Suite B
Fairbanks AK 99701
907.455.4135 fx 907.455.4115

Mikki King Barker DO
Jennifer Cross MA, LCP
Yolanda Easaw-Favor MSW. CDC1

Last Name First Middle	☐ Male ☐ Female	Work Phone:	
Mailing Address	City	State	Zip
Street Address if different from mailing:			
Home phone:	Cell phone:	Date of Birth:	Social Security Number:
In case of emergency notify Name (day phone, evening phone)	E-mail:		
Referred by:	Primary Physician:	Preferred Pharmacy:	
(if minor) Parent /// Spouse Name:	Date of Birth:	SSN:	
Mailing address (if different from child):			
Home phone:	Employer:	Work phone:	
(If minor) Parent Name:	Date of Birth:	SSN:	
Mailing address (if different from child):			
Home phone:	Employer:	Work phone:	
Guardian/ Other parent Name:	Date of Birth:	SSN:	
Mailing address if different from child:			
Home phone:	Employer:	Work phone:	
1. Insurance Name Address			
Group/ Plan number:	ID number:	Insurance Phone:	
Insured person:	Insured Date of birth:	Relation to patient:	
Employer of insured (If applicable)			
2. Insurance Name Address			
Group/ Plan number:	ID number:	Insurance Phone:	
Insured person:	Insured Date of birth:	Relation to patient:	
Employer of insured (If applicable)			

I authorize treatment for myself or for my minor child. I understand that I am financially responsible, regardless of insurance, for payment. Initial : ______

I authorize the release of information (required to process a claim) to my insurance company. I authorize payment of insurance benefits to Mikki K Barker DO. Jennifer Cross, MA, LPC, Yolanda Easaw-Favor MSW
This authorization shall expire in one year or upon my written notice. Initial : ______

I acknowledge I have received or read a copy of Wendell Street Psychiatric Services LLC Notice of Privacy Practices and I have been given an opportunity to ask any questions regarding these practices. I understand I have a right to a copy of this Notice upon my request. Initial : _____

Signature of patient, parent or legal guardian: ________________________________ Date:____________________

Signature of patient, parent or legal guardian: ________________________________ Date:____________________

Witness: ____ Date: ____________________

Wendell Street Psychiatric Services LLC
225 Wendell Street Suite B
Fairbanks AK 99701
907.455.4135 fx 907.455.4115

Authorization to Release Information

I _____ hereby authorize Wendell Street Psychiatric Services LLC,
(Client print name)
225 Wendell Street Suite B, Fairbanks AK 99701 to release to and/or from:

_____

Address: _____

For the information below regarding services received for the time period

From: _____
(Specified date)

To: _____ 20_____
MO/DAY

Information may be furnished in **written** or **oral** form. (circle one or both)
I am releasing this information for the following purpose(s). (check all that apply)

☐ Continued Care ☐ Referral Source

☐ Insurance Request ☐ Other: _____

Information to be furnished (this section must be completed)

Check (V)	Initial	
		Psychiatric/Psychological History and Evaluation
		Psychological Testing Report
		Clinician's Progress Notes and/or Discharge Summary
		Consultation/Laboratory Reports
		Diagnosis
		Attendance in Counseling
		Participation in Counseling
		Letter/Medical Statement
		Other Specified Information:

I understand that my records are protected under both State Law and Federal Confidentiality Regulation (CRR 42, Part2) and cannot be disclosed without my written consent unless otherwise provided for in legal and judicial decisions. I certify that this consent has been given freely and voluntarily. I understand that services are not contingent upon my consent for release of information. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken upon this release.

This release will automatically expire 1 year (365 days) after the date signed.

_____ _____
Client (Parent if Minor) Signature Provider

_____ _____
Date Witness

Wendell Street Psychiatric Services LLC
225 Wendell Street Suite B
Fairbanks AK 99701
907.455.4135 fx 907.455.4115

Policy for Payment of Services

A clear understanding of the financial responsibility for your care is fundamental to assuring a healthy and professional relationship with my billing staff and myself. Please read this form carefully and have your questions answered by calling *Golden Heart Medical Billing* at **459-8200.**

Payment: I accept cash, credit cards or checks. In extenuating circumstances, I am willing to work with you on a reasonable payment plan. Please call *Golden Heart Medical Billing* at **459-8200.**

Insurance: Remember that you are ultimately responsible for your bill. If you have private insurance, as a courtesy we will bill your carrier for services. We will need a copy – front and back – of your insurance card to provide proof of insurance, to bill for you.

- All new patients will be expected to pay balance in full at time of your initial visit. We will file your insurance and refund to you any overpayment.
- All patients are expected to pay the full amount of your visits at the beginning of the insurance deductible year. You will then be asked to continue in paying your co-pays for the remainder of the insurance year.
- You will be sent a monthly statement of all balances due. Please compare it to the explanation of benefit you will receive from your insurance company. Feel free to call *Golden Heart Medical Billing* at **459-8200** with any questions.
- Please keep in mind that Insurance is a contract between you and your insurer. We will be happy to assist you in any way we can. However, will not become involved in disputes concerning deductibles, co-pays, secondary insurance, or so-called “usual and customary” reductions.
- **Medicare patients**: remember that you do have a deductible/co-payment and we request that you pay this once you have received your statement from Golden Heart Medical Billing.
- **Medicaid** patients are asked to pay their co-payment of **$3.00** at the time of service.
- **Veteran’s Administration** patients are required to get all pre-authorizations done before each visit, and have that authorization in your hand or faxed to our office if you would like the VA to pay. Otherwise you will be expected to pay for services rendered. The same rules apply to all **Tricare, and ChampVA**.

Past Due/Delinquent Accounts: You are expected to pay your balance in 15 days of receipt of your statement from *Golden Heart Medical Billing*. Past due accounts will be referred for collection if necessary. We will not be liable for any consequences that may result from a collection agency’s effort to secure payment.

I have read and understand the above terms and agree to this policy for payment of services.

_____ _____

Printed Name Date

_____

Signature