Interior Women's Health
Child/Adolescent Registration

Patient Information: ☐ Male ☐ Female

Last Name: _____ First Name: _____ M.I._____

DOB: _____ Age: _____ Primary Phone: _____E-mail: _____

Address: _____ City: _____State:_____ Zip: _____

Guarantor: (Parent/Guardian bringing in the child not necessarily the policy holder)

Last Name: _____ First Name: _____ M.I._____

SSN: _____DOB: _____ Relationship to Patient: ☐ Mother ☐ Father ☐ Other: _____

Address: _____ City: _____State:_____ Zip: _____

Primary Phone: _____ Secondary Phone: _____ Work Phone: _____

E-mail: _____Occupation: _____ Employer: _____

The information listed below is essential to IWH for purposes of Clinical Quality Measures and as a provider of medical services. This information is optional. As it pertains to the child:

Race: ☐ American Indian/AK Native ☐ Hawaiian/Pacific Islander ☐ Black/African American ☐ Hispanic ☐ Other ☐ Chose not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Chose not to disclose

Insurance Information:

This information is required even with a copy of your card on file

Primary
Insurance: _____

ID#:_____Grp #:_____

Policy Holder: _____

Date of Birth: _____ Employer/Union: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary
Insurance: _____

ID#:_____Grp #:_____

Policy Holder: _____

Date of Birth: _____ Employer/Union: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Emergency Contacts:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Authorization:

I hereby authorize my insurance companies to make payment directly to Interior Women's Health. This assignment will remain in effect until revoked by me in writing.

I authorize the release of any medical information necessary to process my insurance claims. I understand I am financially responsible for all charges related to my care at Interior Women's Health regardless of whether or not paid by my insurance company including any cost assigned by a collection agency and/or attorney fees.

I understand all patient cost-shares (deductible, co-insurance and/or co-pays) will be collected at the time of service.

Parent/Guardian Signature: _____**Date**: _____

Interior Women's Health
Consent/Authorization

Consent to Leave Messages

Interior Women's Health may need to contact you about your child's test results, appointments, referrals, or billing/insurance information. To protect your child's privacy and follow federal guidelines we require written permission to do so.

Name of Child: _____ Date of Birth: _____

□ **I DO NOT** give IWH permission to leave messages on any of my phone numbers

□ I give permission for messages to be left on my phone number(s) below:

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

Regarding the following: (**check all that apply**)

□ Appointment Reminders/Changes □ Account Payment/Balances □ Cost Estimates □ Insurance/Billing

□ Test Results □ Medication □ Needed/Completed Treatment □ All General Healthcare Information

Consent to Share Information with Family & Friends

Many patients allow family members such as spouses, partners, parents or children to call and request information pertaining to treatment, test results and financial matters. Under HIPAA we are not allowed to release this information to anyone without patient consent. If you would like our office to release information to a family member on your chi behalf please complete the following information.

IWH may release information on behalf to the following person(s):

1. Name: _____ Phone: _____ Relationship: _____

□ Appointment Reminders/Changes □ Account Payment/Balances □ Cost Estimates □ Insurance/Billing

□ Test Results □ Medication □ Needed/Completed Treatment □ All General Healthcare Information

2. Name: _____ Phone: _____ Relationship: _____

□ Appointment Reminders/Changes □ Account Payment/Balances □ Cost Estimates □ Insurance/Billing

□ Test Results □ Medication □ Needed/Completed Treatment □ All General Healthcare Information

3. Name: _____ Phone: _____ Relationship: _____

□ Appointment Reminders/Changes □ Account Payment/Balances □ Cost Estimates □ Insurance/Billing

□ Test Results □ Medication □ Needed/Completed Treatment □ All General Healthcare Information

Authorized Signature:

I understand it is my responsibility to keep this information up to date and any change in consent must be done so in writing including revoking this information.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Patient Name **Relationship to Patient**

Interior Women's Health
HIPPAA Privacy Practices

Uses and Disclosures

I give IWH my consent and the medical facility is permitted to use and disclose my protected health information (any individual identifiable information, treatment, or payment for health care) for the following purposes, without further notification or authorization from me: treatment, continued treatment, health insurance carriers for payment, refunds or adjustments, and or related healthcare operations while observing and respecting the spirit of HIPAA privacy laws.

I have been informed that I may review Interior Women's Health Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. It is the practice of all medical facilities to make patients aware of their right to privacy and confidentiality.

I understand that Interior Women's Health has the right to change their privacy practices and or adhere to changes of the law and that I may obtain any revised notices upon request.

I understand that I have the right to request a restriction of how my protected health information is used. I also understand that Interior Women's Health is not required to agree to the request. If Interior Women's Health agrees to my requested restriction the facility must follow the restriction(s) as indicated by me as the patient.

I understand I may revoke this consent at any time, simply by making a request in writing, except for information already used or disclosed prior to my request.

Complaints

If you believe your privacy rights have been violated you may complain to Interior Women's Health and to the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Interior Women's Health directly, please call the Office Coordinator, Privacy Contact at (907)479-7701 or write to 1626 30th Ave, Fairbanks, Alaska 99701. You will not be retaliated against if you file a complaint and we will appreciate the opportunity to resolve your concern and help us make quality improvements in our services provided to our patients.

Effective Date

This Notice has been revised from September 1, 2015 and goes into effect immediately.

Acknowledgement of Notice

I hereby acknowledge receipt of Interior Women's Health **Notice of Privacy** practices and protocol.

_____ _____

Patient's Name **Date of Birth**

_____ _____

Parent/Guardian Signature **Today's Date**

Interior Women's Health
Financial Policy/No Show Policy

Thank you for choosing Interior Women's Health as your health care provider. We understand and appreciate the complicated nature of insurance reimbursement. Whenever possible, our staff strives to provide clear and transparent payment expectations from both our patients and their insurance companies.

The following information is provided, in advance, to avoid any misunderstandings or disagreements concerning payment of services. If you have questions regarding our financial policy please do not hesitate to speak to one of our Patient Coordinators or Billing Specialist.

Financial Expectations:

1. Provide current and accurate insurance information (including insurance cards) at each visit.
2. Payment is ***DUE AT THE TIME OF SERVICE,*** including outstanding deductibles, co-pays and co-insurance. Please be prepared to pay your bill on the day of your appointment.
3. Interior Women's Health accepts the following methods of payment: cash, check, credit card and Care Credit. A $25.00 NSF fee will be charged on any returned check.
4. IWH is in network with Blue Cross Blue Shield, Aetna, Tricare, Medicaid and Medicare. All other insurance plans are considered out of network. Higher cost shares may apply to out of network plans.
5. If the patient is a minor child (18 years or younger) the parent or guardian bringing the child in is responsible for payment (not necessarily the policy holder). Payment is due at the time of service.
6. ***Outstanding balances will need to be paid prior to scheduling new appointments*** unless arrangements have been made in advance with the billing department.
7. Under certain circumstances IWH may be able to set up a payment plan for those patients who qualify. Please ask to speak to a Billing Specialist about payment plan availability and payment plan expectations. Payment plans will require a down payment of at least 30% of billed charges.
8. Accounts with delinquent balances may be referred to Cornerstone Credit Services after 60 consecutive days without payment. Accounts referred to Cornerstone Credit will be closed until all fees, including penalties and interest, are paid in full at Cornerstone Credit Service.
9. Your insurance plan is a contract between you and your insurance company. Any disputes or questions concerning payment and benefits must be directed at your insurance company. IWH strongly encourages all patients to contact their insurance company for plan details and benefits prior to receiving care.
10. It is the patient's responsibility to return any requested information from their insurance company. This includes Coordination of Benefit questionnaires as well as accident questionnaires. Failure to return this information to your insurance plan will result in the balance being immediately transferred to you and payable by you.

Late/No Show Fees

If you are 15 minutes late for your appointment you will need to reschedule your appointment. You are asked to provide at least 24-hour notice for appointment cancellations. Failure to provide adequate cancellation notice will result in the appointment being assigned as a "No Show" appointment.

We understand there are sometimes unforeseen events that occur that may prevent you from being able to provide a 24-hour cancellation notice. As a courtesy to our patients, the first "No Show" appointment will be given a one-time courtesy excuse. However, the second "No Show" appointment will be assigned a fee of $50.00. This fee will need to be paid prior to new appointments being scheduled. In the event there is a third "No Show" appointment a fee of $100.00 will be assessed. After the third no show fee you may be discharged from the practice for non-compliance of appointments.

If you are current OB patient (pregnancy to 6 weeks post-partum) your second and subsequent "No Show" fee will be assessed at $25.00 each. If you are unable to pay your no-show fee by your next appointment you will need to speak to our billing department for payment arrangements. After your 6-week postpartum period the non ob IWH no show policy will take effect.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Patient Printed Name **Relationship to patient**