Adult Registration (18+)

Last Name:	**First Name:**	**Middle Initial:**
Date of Birth:	**Social Security Number:**	**Gender:** ☐ M ☐ F
Home Phone #: _____ **OK to leave message:** ☐ Yes ☐ No	**Cell Phone #:** _____ **OK to leave message:** ☐ Yes ☐ No	**Email:** _____ **OK to enable Pt. Portal:** ☐ Yes ☐ No

I am currently a patient at (check all that apply): ☐ FMC - Heartwise ☐ FMC – Interventional Pain ☐ FMC – Behavioral Health

Mailing Address:

City:	**State:**	**Zip Code:**

Physical Address (if different from above**):**

Marital Status: ☐ Single ☐ Married **(Spouse Name:** **)** ☐ Separated ☐ Widowed ☐ Divorced

Occupation (if employed):	☐ N/A ☐ Student	**Employer:**

Type of Residence where you live: ☐ Home, own ☐ Rent ☐ Shelter ☐ Homeless ☐ Friends / Family ☐ Transitional ☐ Other: **Number of People in the household**: _____

Race: ☐ American Indian or Alaskan Native ☐ Black/African American ☐ Native Hawaiian ☐ More than one race:_____ ☐ Asian ☐ White/Caucasian ☐ Other Pacific Islander

Are you of Hispanic or Latina origin: ☐ Yes ☐ No
Language most comfortable with: ☐ English ☐ Other: (Please list)_____ **Do you need a translator?** ☐ No ☐

Are you a veteran of one of the United States Uniformed Services: ☐ Yes ☐ No

Emergency Contact Name: **Relationship to Patient:**

Emergency Phone: **Permission to speak with:** ☐ Yes ☐ No ☐ Home #: ☐ Cell #:

Preferred Pharmacy:

Responsible Party (if other than Self)**:**	**Date of Birth:**	**Social Security #:**	**Relationship to Patient:**
Mailing Address:			
Home Phone #: _____ **OK to leave message:** ☐ YES ☐ NO	**Work Phone #:** _____ **OK to leave message:** ☐ YES ☐ NO		**Cell Phone #:** _____ **OK to leave message:** ☐ YES ☐ NO
Responsible Party Occupation (if employed):	☐ N/A ☐ Student		**Employer:**

My signature here indicates the information provided above is true and correct.
My signature here also gives permission to Family Medical Clinic to communicate via the above provided phone, text, email, and voice information.

Signature *(Patient or Responsible Party)* *Date*

Print Name *(Patient or Responsible Party)* *Date*

Revised 01/2018

Adult Registration (18+)

**** We bill insurance as a courtesy. Please supply us with a copy of your insurance card(s) as well as the following information. ****

INSURANCE COVERAGE: ☐ None ☐ Alaska Medicaid ☐ Denali KidCare ☐ Medicare ☐ Private Insurance ☐Other:

Primary INSURANCE Company:	**Policy / ID #:**	**Group #**
Last Name of Insured:	**First:**	**M.I.**
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependant ☐ Other:		
Date of Birth:	**SSN:**	**Gender:** ☐ M ☐ F
Mailing Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**Work Phone:**	**Cell Phone:**
Occupation:	**Employer:**	

Secondary INSURANCE Company:	**Policy / ID #**	**Group #**
Last Name of Insured:	**First:**	**M.I.**
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependant ☐ Other:		
Date of Birth:	**SSN:**	**Gender:** ☐ M ☐ F
Physical Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**Work Phone:**	**Cell Phone:**
Occupation:	**Employer:**	

We bill insurance as a courtesy, by signing below you are authorizing FMC to perform the necessary requirements to do so.

Authorization to pay benefits to FMC: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to FMC, when they accept assignment. My signature here indicates the information provided above is true and correct.

Signature *(Patient or Responsible Party)* *Date*

Print Name *(Patient or Responsible Party)* *Date*

Service Agreement

Patient Name: _____ **Date of Birth:** _____

In order to receive treatment, you must sign below acknowledging the following terms. Please ask questions about any area of concern.

Service Agreement

- ☐ Family Medical Clinic (FMC) offers health care using a team of caregivers. These people have various training and skills which they utilize while working together as a team to help meet your health care needs. FMC has an integrated electronic health record system. Personal Health Information (PHI) is kept in your electronic health record. Your records are accessed by FMC staff members who are involved in your care. Your records may include information from any of our medical providers. It may also include reports from caregivers elsewhere, when you are referred by FMC staff to other agencies for health care services.
- ☐ All health information is kept private between you and your health care professional except in circumstances when disclosure is required or otherwise permitted by law.
- ☐ It is your responsibility to keep your scheduled appointments. If you cannot make the scheduled appointment time, you should call to reschedule your appointment in accordance with our *Appointment Policy* which is provided on the following page.

Privacy Agreement

- You have been offered a copy of FMC's *Notice of Privacy Practices*. A copy of FMC's *Notice of Privacy Practices* is posted at each service location. FMC takes seriously the protection of your Personal Health Information (PHI) and will only divulge minimum necessary information required to accomplish our purpose.
- ☐ You may register a complaint or voice a grievance without fear of reprisal.
- You have been offered a copy of FMC's *Patient Bill of Rights*.

Financial Responsibility

- All services are billed at a standard rate. **FMC bills insurance as a courtesy.** You are responsible for the balance not covered by insurance or third party payers within 120 days of your service. If you qualify, a sliding-scale discount may be applied to the unpaid balance or any "out-of-pocket" expenses. Discounts are available based on household size and household income.
- ☐ You agree to pay your fees and/or insurance co-payment and required deductible at the time of service. Any balance on your account after 120 days will be sent to Cornerstone Collections. FMC accepts assignment on Medicare and Medicaid claims.
- FMC does not operate a "free clinic." Regardless of insurance coverage or financial category, you will not be refused services because of an inability to pay, as long as you agree to demonstrate a willingness to pay. **Unwillingness to pay your account balance within 120 days will result in the balance being sent to Cornerstone Collections and may result in your dismissal as a patient**. You authorize a collections agency to contact you directly on your past balance due to Family Medical Clinic.
- ☐ If you fail to provide income verification or proof of insurance, or choose not to use your insurance, you will not be eligible to participate in a sliding discount and will be responsible for 100% of the charges for services rendered by FMC providers.
- ☐ FMC relies on the fees paid by you and your insurance company to continue to deliver services.

****I have read and agree to the above**
Service Agreement, Privacy Agreement and Financial Responsibility.**

Signature (Patient or Responsible Party): _____ Date _____

Print Name (Patient or Responsible Party): _____ Date _____

Appointment Policy

Patient Name:_____DOB: _____

We see patients on an appointment basis and your appointment is reserved exclusively for you. We respect your time and make every effort to remain on schedule; therefore we must request that you check-in on time for your appointment. Arrival time is based on appointment type and is determined by each department. Expected arrival time is communicated to you when you book your appointment.

We understand that circumstances arise that prevent patients from keeping appointments. If you are not able to keep a regular doctor appointment, please call and cancel or reschedule by 3 pm the day before your scheduled appointment. If you do not there will be a $25.00 no show/cancellation fee that will be charged to you.

If you are unable to keep a FMC – Heartwise appointment, you must call 48 hours in advance to cancel or reschedule. If you do not there is a $250 no show/cancellation fee that will be charged to you.

If you are unable to keep a FMC – Interventional Pain appointment, please call and cancel or reschedule by 3 pm the day before your scheduled appointment. If you do not there will be a $25.00 no show/cancellation fee that will be charged to you. If you are unable to keep an appointment with a Specialized Doctor, you must call 48 hours in advance to cancel or reschedule. If you do not there is a $250 no show/cancellation fee that will be charged to you.

We request these accommodations from you as it allows us to see our patients promptly as well as have time to fill cancelled appointment slots. Effective December 1, 2016 our policy states that once a second scheduled appointment is missed within a 12 month period, a notice will be sent alerting you of the consequence of missing the third scheduled appointment within a 12 month period. The consequence is that you (the patient) will only be seen on a same day appointment (if available) for the FMC – Family Practice and FMC – Heartwise. ***Due to the pain contract in FMC – Interventional Pain three missed appointments will be a termination and you will not be seen in any FMC department for 12 months.***

Patients are required to check-in at the clinic at the recommended check-in time. Patients checking-in after the recommended check-in time are considered late and will be seen only if the provider's schedule and remaining time allows for the completion of quality care.

ATTENTION PARENTS AND GUARDIANS: If your child is under 18, the policy requires that you accompany your child to all appointments and remain in the clinic during his/her appointment. Treatment will not begin until a parent or guardian is present.

I have read and understand the above appointment policy for Family Medical Clinic.

_____ _____

Signature (Patient or Responsible Party) Date

Revised 01/2018

Adult Patient History Form

Patient Name: _____ **DOB:** _____

Provider: _____ **Date:** _____

PRESCRIPTION MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION ("Over-the-counter" medications such as aspirin, ibuprofen, vitamins, etc.)

Non-Prescription Medications	Dose	How often taken
Herbal Preparation	**Dose**	**How often taken**

ALLERGIES OR DRUG REACTIONS? Please list drug and type of reaction

Allergy/Drug Name	Reaction

Dentist: Name_____Phone Number_____

Eye Doctor: Name_____Phone Number_____

Adult Patient History Form

Please check known diseases/illnesses (heart, lung, etc.):

PAST MEDICALHISTORY					
	Abnormal heart rhythm		Anxiety		Gout
	Atrial fibrillation or flutter		Arthritis		Headaches
	Heart attack		Asthma		Hepatitis
	Stroke or TIA		Blood disorder		Kidney disease
	Congestive heart failure		Cancer		Kidney stones
	Heart valve disease		Cataracts		Liver disease
	Heart murmur		Chronic Lung Disease (COPD)		Prostate problems
	High cholesterol		Convulsions (seizures)		Rheumatic fever
	Clotting disorders		Depression		Sleep Apnea
	Aneurysm		Diabetes (insulin dependent)		TB or positive skin test
	High blood pressure		Diabetes (no insulin)		Thyroid disease
	Acid reflux/ heart burn		Gallstones		Ulcers
	AIDS or HIV		Gastrointestinal Disease		Mental illness

Other:_____

_____

❒Prostate Screen: Date_____Result:_____

❒Bone Density Test: Date_____Result:_____

PAST SURGICAL HISTORY					
	Coronary bypass		Hip replacement		Tonsillectomy
	Breast surgery		Knee replacement		Pacemaker or Defibrilator
	Gallblader removal		Other orthopedic surgery		Hysterectomy
	Hernia repair		Cardiac Cath		Splenectomy
	Gastric bypass		Cardiac Stent		

Other: _____

_____

HOSPITALIZATION:

Date:_____Reason_____

Date:_____Reason_____

Date:_____Reason_____

FAMILY MEDICAL CLINIC
BECAUSE YOUR HEALTH WON'T WAIT

Adult Patient History Form

FAMILY HISTORY					
(S) Please Specify Type	Father	Mother	Brother	Sister	Grandparent
Auto Immune **(S)**					
Blood Clotting Disorder **(S)**					
Seizures					
COPD					
Asthma					
Heart disease					
Heart attack					
Heart bypass					
High blood pressure					
Congestive heart failure					
Heart rhythm problems					
High Cholesterol					
Cancer **(S)**					
Diabetes **(S)**					
Stroke					
Thyroid disorders **(S)**					
Mental illness **(S)**					
Addiction **(S)**					
Colon Cancer					

Social History:		
Alcohol Use in Past 12 Months:	❒ yes ❒ no	
If Yes:	How Often?	❒ Never ❒ Monthly or less ❒ 2-4 times a month ❒2-3 times a week ❒ 4 or more times a week
	How Many?	❒ 1 or 2 ❒ 3 or 4 ❒ 5 or 6 ❒ 7 to 9 ❒ 10 or more
	How often 6 or more on one occasion?	❒ Never ❒ Less than monthly ❒ Monthly ❒ Weekly ❒ Daily or almost daily
Tobacco Use:		❒ Current ❒ Former year quit_____❒ Never
If Current Smoker:	How Often?	❒ Every Day ❒ Some Days
	How Many?	❒ 5 or Less ❒ 6-10 ❒ 11-20 ❒ 21-30 ❒ 31+
	How soon after waking up?	❒ Within 5 minutes ❒ 6-30 min ❒31-60 min ❒> 60 min
	Interested in Quitting?	❒ Ready to quit ❒ Thinking about quitting ❒ Not ready to quit

Adult Patient History Form

Second Hand Smoke	❒ yes ❒ no	How often:
Caffeine:	❒ yes ❒ no	Amount: Frequency:
Do you follow a special diet?	❒ yes ❒ no	Type:
Have you ever used drugs other than for medical reasons?	❒ yes ❒ no	
Education:	❒ yes ❒ no	
Exercise:	❒ yes ❒ no	Frequency:
Home Carbon Monoxide detector use:	❒ yes ❒ no	
Who lives at home?		
What is your primary language?		
Legal problems:	❒ yes ❒ no	
Marital Status:	❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed	
Employment:		
Smoke detector in house:	❒ yes ❒ no	
Travel outside US within past:	❒ 2 weeks ❒ 3 months ❒ year ❒ none	
Do you feel safe at home?	❒ yes ❒ no	Location:

PATIENT BILL OF RIGHTS & RESPONSIBILITIES

Our patients have the right to…

1. receive service without regard to age, race, color, sexual orientation, religion, marital status, gender, national origin or sponsor;

2. be treated with consideration, respect and dignity including privacy in treatment;

3. be informed of the services available and the name and function of person providing health care services;

4. receive from your health care provider information necessary to give informed consent prior to the start of any non-emergency procedure or treatment or both. An informed consent shall include, at a minimum:
   - information concerning the procedure or treatment or both;
   - the reasonably foreseeable risks;
   - alternatives for care or treatment, if any, as a reasonable provider under similar circumstances would disclose;

5. be informed of off-hour emergency coverage;

6. be informed of the charges for services, assistance in determining eligibility for third-party reimbursements and, when applicable, informed of the availability of discounted cost care;

7. receive an itemized copy of your bill upon request;

8. obtain from your health care provider, or their delegate, complete and current information concerning your diagnosis, treatment and prognosis in terms you can be reasonably expected to understand;

9. voice grievances and recommend changes in policies and services to FMC staff, administration, and the Alaska State Department of Health without fear of reprisal;

10. express complaints about the care and services provided and to have such complaints investigated. FMC is responsible for providing a written response within 30 days, if requested, indicating the findings of the investigation. FMC is also responsible for notifying you or your designee that if you are not satisfied with the response, you may register a complaint to the Alaska State Department of Health & Human Services Office, by phone (907)465-4722 or at www.hss.state.ak.us,

11. appoint someone you trust to decide about your treatment, if you lose the ability to decide for yourself;

12. receive care in an environment where pain and/or suffering can be expressed with comfort and dignity;

13. access or amend your health record as allowed by privacy laws;

14. privacy and confidentiality of all information and records pertaining to your treatment;

15. approve or refuse the release or disclosure of contents of your health record except as required or allowed by law.

PATIENT BILL OF RIGHTS & RESPONSIBILITIES

The patient or their legally designated representative is responsible…

1. to actively participate in their care to the fullest extent possible;

2. to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to their health;

3. to make it known whether they clearly understand a suggested course of action and what is expected of them;

4. to follow the treatment plan recommended by the health care provider. This may include following the instructions of health care personnel as they carry out the coordinated plan of care and implement the health care providers orders;

5. to report unexpected changes in their condition to their provider;

6. to keep appointments and, when unable to do so for any reason, to follow the terms of the appointment policy;

7. for their actions if they refuse treatment or do not follow provider instructions. If the patient cannot follow through with the treatment, they are responsible for informing the health care provider;

8. for assuring that the financial obligations of their health care are fulfilled as promptly as possible. You are responsible for providing information needed by FMC to secure payment;

9. for following clinic rules and regulations affecting patient care and conduct;

10. for being considerate of the rights of other patients and personnel;

11. for being respectful of the property of FMC and others;

12. for recognizing the effect of lifestyle on your health which depends not just on the care you receive but on the decisions you make in your daily life;

13. for assuring that children brought into a FMC facility by you are supervised at all times.

FMC – Family Practice
(907) 262-7566

FMC – Heartwise
(907) 262-7566

FMC – Interventional Pain
(907) 260-1619

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Family Medical Clinic. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.
Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you. Individual Rights
You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Family Medical Clinic Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting a receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints or Contact Person
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our Clinic Operations Manager:

FMC-COM
Family Medical Clinic
206 West Rockwell Ave, Suite 100
Soldotna, AK 99669
Phone: (907) 262-7566

If you believe your privacy rights have been violated, you may file a complaint with our Clinic Operations Manager at the above listed number and/or with the Secretary of the Department of Health and Human Services at: Office for Civil Rights Region X U.S. Department of Health & Human Services 2201 Sixth Avenue, M/S: RX11 Seattle, WA 98121-1831 You will not be penalized for filing a complaint.

_____ _____
Patient/Guardian Signature Date

_____ _____
Print Patient Name Patient Date of Birth