Patient Information

Patient Name _____ SS# _____

Date of Birth _____ Sex: Male Female

Mailing Address _____

City _____ State _____ Zip _____

Phone #'s: Home _____ Cell _____ Work _____

E-mail address: _____

Emergency (name & number) _____

Guarantor/Billing Information

Persons responsible for patient _____

Physical Address _____

City _____ State _____ Zip _____

Phone _____ Social Security # _____

Date of Birth _____

Insurance Information

Primary Insurance Company _____

Address of Insurance Company _____

Cardholder Name _____ Relationship to patient _____

Social Security # _____ Date of Birth _____ Sex: M F

ID # _____ Group # _____

Employer Name and Address _____

Secondary Insurance Company _____

Address of Insurance Company _____

Cardholder Name _____ Relationship to patient _____

Social Security # _____ Date of Birth _____ Sex: M F

ID # _____ Group # _____

Employer Name and Address _____

HIPAA PRIVACY RULE
CONSENT, INFORMATION DISCLOSURE, AND INSURANCE AUTHORIZATION

All information provided by the patient/guardian is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used as follows only with their consent. I hereby authorize Adventures in Pediatrics to furnish information to other providers, healthcare or treatment facilities, and my insurance companies for purposes of treatment, payment, and healthcare operations. I hereby assign to the physician all payments for medical services rendered to my dependent.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE

_____ _____

Guardian Signature Date

Adventures in Pediatrics
Dr. Karen Impson

HEALTH HISTORY

Date _____
Name _____ Date of Birth _____ Age _____
Who lives in the house with the child _____
Does anyone in the house smoke? _____
Any pets in the house? What kind and how many? _____
Prior Physician _____ Pharmacy used _____
How did you hear about us? _____

FAMILY HISTORY

Do any family members have any of the following conditions:

Condition	Mother	Father	Siblings	Grandparents
Asthma	_____	_____	_____	_____
Anemia	_____	_____	_____	_____
Blood disorder	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Heart attack/ disease	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____
Seizures	_____	_____	_____	_____
Depression/ anxiety	_____	_____	_____	_____
Drug/Alcohol prob.	_____	_____	_____	_____
ADD/ADHD	_____	_____	_____	_____

Anything else we should be aware of? _____

Please note age & health status. If deceased, note cause of death, if known.

Mother _____ Brothers _____
Father _____ Sisters _____

PATIENTS MEDICAL HISTORY (Please note date of onset)

Birthweight _____ Full term? yes/ no Vaginal birth? yes/ no Born where _____
Newborn problems _____
Developmental problems _____
Surgeries _____
Medical Problems _____
Injuries/Accidents _____
Hospitalizations _____
Medications (please list dose & frequency of use.)
Allergies _____
Type of Reaction _____

IMMUNIZATIONS/HEALTH SCREENING(Please note when last done, if known)

Immunizations complete Yes _____ No _____
If no, needs _____

Adventures in Pediatrics
Dr. Karen Impson

Authorization For Care of a Minor

To Whom It may Concern:

I give my permission for **Adventures in Pediatrics**, to provide any necessary medical care to my minor child whose name is _____.

This authorization expires upon the minor's 18th birthday.

In case of my absence, the following person(s) may accompany my child should health care be needed.

Name	**Relationship to patient**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____
SIGNATURE

_____
PRINT NAME

_____
RELATIONSHIP TO PATIENT

_____
DATE

Adventures in Pediatrics
Dr. Karen Impson

Adventures in Pediatrics
Financial Policy/Billing Overview

The following is a statement of our financial policy/billing overview that you are requested to read and sign prior to receiving medical treatment.

Uninsured Patients

If you have no insurance or insurance that will not cover your visit, payment in full is appreciated at the time that services are rendered. Should you not be able to make full payment, please let us know and you will be contacted by the office manager to discuss payment options on a case by case basis.

There will be a $25.00 charge for all returned or non-sufficient funds checks.

Medicaid

A Medicaid coupon is required for each office visit at the time of service. A $3.00 co-pay is required for all patients over 18 years of age who are not enrolled in the Denali Kid Care Program. This payment will be required at the time of service. You will be expected to pay for any service denied by Medicaid as Non-Covered i.e. any routine services for anyone over 18.

Insurance Patients

We will accept assignment of benefits for most insurance companies if:

1) You provide this office with all the billing information for your particular insurance coverage,
2) You agree to pay your co-payment at the time that services are rendered. If you do not know what portion you are expected to pay, we will expect 20% of your total charges. We will then bill your carrier and you will receive a bill for any portion due once your carrier has paid. Full payment of these portions is due immediately upon notification.
3) You have met your deductible and are being seen for a covered service,
4) You have a good credit record with this office and have not previously misstated insurance coverage, deductibles, or co-pays

Insurance is a contract between you and your insurance company. Our agreement to file your claim is a courtesy and you are ultimately responsible for all charges.

Usual and Customary Rates

We are committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any arbitrary determination of usual and customary rates by your insurance company.

_____
Patient Name

_____ _____
Responsible Party Signature Printed Name

_____
Responsible Party SSN & date of birth (required)

_____
Date

Consent to Privacy Practices

Adventures in Pediatrics
Dr. Karen Impson
3719 E. Meridian Loop Suite D
Wasilla Alaska 99654

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my medical care and follow-up among any health care provider who may be involved either directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that from time to time this office has the right to change its *Notice* and that I may contact this office at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private health information is used and disclosed. I also understand you are not required to agree to my requested restriction but that if you do agree, you are bound to abide by such restrictions .

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____

Signature of responsible party _____

Printed Name _____

Relationship to the patient _____

Date _____

ADVENTURES IN PEDIATRICS
3719 E MERIDIAN LOOP, SUITE D
WASILLA AK, 99654
PHONE (907) 373-7337
FAX (907) 357-9029

HIPPA COMPLIANT

MEDICAL RECORDS RELEASE OF INFORMATION AUTHORIZATION

PATIENT NAME_____ DOB_____ SSN_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____
PARENT NAME (S)_____
PHONE_____ CELL_____ WORK_____

I REQUEST MEDICAL INFORMATION FROM:

HOSPITAL/PHYSICIAN_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____
PHONE_____ FAX_____

I AUTHORIZE THIS INFORMATION TO BE DISCLOSED TO:

ADVENTURES IN PEDIATRICS
3719 E MERIDIAN LOOP, SUITE D
WASILLA AK, 99654
PHONE (907) 373-7337 FAX (907) 357-9029

I AUTHORIZE THE FOLLOWING INFORMATION TO BE RELEASED FROM MY RECORD (S)

_____ENTIRE MEDICAL RECORD _____LABORATORY REPORTS _____CONSULTATION
_____HISTORY & PHYSICAL _____OPERATIVE NOTES
_____ER REPORT _____DISCHARGE SUMMARY
_____OTHER_____

BY INITIALING THE SPACE BELOW, I SPECIFICALLY AUTHORIZE THE USE AND/OR DISCLOSURE FOR THE FOLLOWING HEALTH INFORMATION AND/OR MEDICAL RECORDS, IF SUCH INFORMATION AND/OR RECORDS EXIST:

_____INFORMATION RELATING TO MENTAL HEALTH CONDITIONS _____(INITIALS)
_____INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE _____(INITIALS)
_____INFORMATION RELATING TO HIV TESTING, INFECTION STATUS, OR CARE AND TREATMENT

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES. THE FEDERAL RULES PROHIBIT MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS TO OR AUTHORIZED REPRESENTAITVE. THIS AUTHORIZATION WILL EXPIRE 180 DAYS FROM THE DATE OF SIGNING. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME AND DO NOT HOLD LIABLE THE PHYSICIAN/HOSPITAL FOR RECORDS RELEASED PRIOR TO THE DATE OF REVOCATION.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE:_____
(If other than patient)

RELATIONSHIP TO PATIENT:_____ DATE:_____