PATIENT INFORMATION

Full legal name _____ **Date of Birth**_____/___/_____

Social Security # _____**Sex** ____**Age**_____ **Today's Date**_____

Mailing Address_____

City_____ **State**_____ **Zip code**_____ **Occupation** _____

Phone (H)_____**(C)**_____**Marital Status**_____

Ethnicity (optional)_____**Primary Language**_____

Email _____

Preferred Pharmacy _____

If patient is a minor please complete the following:

Mother's Name_____ Date of Birth_____/___/_____

Phone (H)_____(C)_____

Occupation_____ Employer Name_____

Primary party to contact for billing (circle) Yes No

Address (If different from minor): _____

City_____ State_____ Zip code_____

Father's Name_____ Date of Birth_____/___/_____

Phone (H)_____(C)_____

Occupation_____ Employer Name_____

Primary party to contact for billing (circle) Yes No

Address (If different from minor): _____

City_____ State_____ Zip code _____

INSURANCE INFORMATION

Billing preference (circle one):

*Insurance * Medicaid (includes Denali KidCare) *Medicare *Self Pay

Please present photo ID and insurance information to front desk to be copied in addition to completing the following:

Name of Primary Insurance company:_____

Name of Policy Holder/Insured:_____

Relation to you (if NOT yourself)_____Insured Date of Birth_____

Insured SSN_____ Insured Employer name and location_____

Who may we thank for referring you to us today?_____

CONSENT FOR TREATMENT

I authorize the collective health care providers at Mat-Su Midwifery & Family Health to render mutually agreed upon services as necessary for my care and/or my family.

Signature_____Date_____

FINANCIAL AGREEMENT

I understand that I am responsible for all fees regardless of insurance. I understand that fees will be generated for all services rendered if paying with insurance; I am responsible for furnishing the insurance information correctly to the office prior to treatment unless other arrangements have been made in advance. I hereby authorize Mat-Su Midwifery & Family Health to furnish information to insurance carriers concerning my illness/injury and treatment and hereby assign all payments for medical services rendered to myself and my dependents. I understand that Mat-Su Midwifery & Family Health uses Larsen Billing Service as their outsourced billing company and may be contacted by them for payment or additional billing related information.

Signature_____Date_____

Mat-Su Midwifery and Family Health, Inc.
Notice of Privacy Policies

This notice describes how information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.

Introduction:

Mat-Su Midwifery and Family Health, Inc. is committed to treating and using protected health information about you responsibly. This notice describes what health information we collect, and how and when it is used or disclosed. It also describes your rights as they relate to your protected health information. This notice is effective April 1, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information:

With each visit to Mat-Su Midwifery and Family Health, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your health or medical record, serves as: a basis for planning your care and treatment, a means of communication among the healthcare professionals who contribute to your care, legal documentation describing the care you received, a means by which you or a third-party payer can verify that services billed were provided, a tool in training healthcare professionals, a source of data for medical research, a source of information for public health officials charged with improving the health of this state and the nation, a source of data for our planning and marketing, and a tool with which we can assess and continually work to improve the care we render and outcomes we achieve. Understanding what is in your record and how your health information is used helps you ensure its accuracy, and who, what, when, where, and why others may access your health information, which helps you make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of Mat-Su Midwifery and Family Health, INC., the information belongs to you. You have the right to:

-Obtain a paper copy of this notice of information practices upon request.
-Inspect and copy your health record as provided for in 45 CFR 164.524.
-Amend your health record as provided in 45 CFR 164.528.
-Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
-Request communications of your health information by alternative means or at alternate locations.
-Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 1264.522.
-Revoke your authorization to use or disclose health information except to the extent action has already been taken.

Our Responsibilities:

Mat-Su Midwifery and Family Health, INC. is required to:

-Maintain the privacy of your health information.
-Provide you with this notice of our legal duties and privacy practices with respect to information we collect and maintain about you.
-Abide by the terms of this notice.
-Notify you if we are unable to agree to a requested restriction.
-Accommodate reasonable requests you may have to communicate health information by alternate means or at alternate locations.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised policies in our front office and notify you by mail. We will not use or disclose your health information without your authorization except as described in this notice. We will discontinue use or disclosure of your health information after we have received a written revocation of authorization.

For More Information or To Report a Problem:

If you have questions or would like additional information, you may contact the practice's privacy officer at (907) 357-0820. If you believe your privacy rights have been violated, you may file a complaint with the practice's privacy officer, or with the Office for Civil Rights, U.S Department of Health and Social Services. There will be no retaliation for filing a complaint with either the privacy officer or the Office of Civil Rights. The address for the OCR is:

Office for Civil Rights
U.S. Dept. of Health and Social Services
200 Independence Ave., SW
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment, and Health Operations:

We will use your health information for treatment:

For example: Information obtained by a nurse, physician, or other member of your healthcare team may be entered in your record and used to determine the best course of treatment for you. The physician will also document his/her expectations of the other members of your healthcare team, who will then record their actions and observations. In this way, the physician will

know how you are responding to treatment. We will also provide other physicians or subsequent healthcare providers with copies of medical records and various reports that should assist him/her in treating you, once we have set up an appointment with them.

We will use your health information for payment:

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations:

For example: Members of the medical staff, as well as the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so he/she can perform the job we've asked him/her to do and bill you or your third-party payer for services rendered. To protect your health information, we require our business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or other individual responsible for your care of your care at our location and general condition.

Communication with Family: Healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to preserve the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organization or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about alternative treatment or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health and legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makers provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

I have read and understand, and agree to the terms of this policy.

Patient Name_____ Signature_____ Date_____
Parent/Guardian Signature_____ Date_____

PEDIATRIC QUESTIONNAIRE

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

Name of Primary Care Provider: _____

DIAGNOSIS

Please describe your child's main medical diagnoses or problem(s) that you would like addressed today:_____

_____

_____

What factors or events, if any, do you believe may have triggered your child's problem/illness?_____

_____

_____

What are your goals of treatment for your child?_____

_____

_____

CURRENT SYMPTOMS AND HEALTH CONCERNS: circle all that apply

*Abdominal Pain	*Allergies	*Attention Problems
*Behavioral Difficulties	*Constipation	*Developmental Delay
*Diarrhea	*Eczema	*Energy Problems
*Environmental Issues	*Frequent Infections	*Medications/Therapies
*Nutrition	*Obsessions/Compulsions	*Seizures
*Sensory Issues	*Sleep Issues	*Tics

*Other Neurologic Issues (please describe):_____

* Other (please describe):_____

Please circle those that apply:

Alaska Native	African American	Hispanic	Mediterranean
Native American	Caucasian	Other: _____	

Please list any hospitalizations, emergency room visits, or surgeries:

1._____ 4._____

2._____ 5._____

3._____ 6._____

PAST MEDICAL HISTORY

*Abdominal Pain	*Allergies	*Attention Problems
*Behavioral Difficulties	*Constipation	*Developmental Delay
*Diarrhea	*Eczema	*Energy Problems
*Environmental Issues	*Frequent Infections	*Medications/Therapies
*Nutrition	* Obsessions/Compulsions	* Seizures
*Sleep Issues	*Tics	* Vaccinations

*Other (please describe):_____

Please list any medications or supplements that your child has taken in the past, including antibiotics and steroids:

1._____ 4._____
2._____ 5._____
3._____ 6._____

Please list all current medications, vitamins, nutritional supplements, herbs, homeopathic remedies, etc.
Supplement/Medication Dose Frequency How long?

_____
_____
_____
_____
_____
_____

BIRTH HISOTRY

PRENATAL/PREGNANCY HISTORY:
Illnesses during pregnancy: _____
_____
_____
Medications during pregnancy (rhogam, antibiotics, vaccines, herbs, supplements):_____
_____
_____

DELIVERY HISTORY

Mode of delivery: Vaginal delivery C-section Gestation: Preterm Full Term

Birth Weight: _____ Maternal Group B strep: Positive Negative

Complications:_____
_____
_____

POSTPARTUM HISTORY

Please describe any postpartum complications:_____

Did you or your child receive any medications after delivery? Yes No If yes, please explain:_____
_____

Did you suffer from postpartum blues/depression? Yes No

DEVELOPMENTAL HISTORY

Has your child's development been normal? Yes No

If no, please describe the development problems and at what age the problems began to appear. _____

_____

_____

ALLERGIES/SENSITIVITES

Please list any medications or supplements your child has had a reaction to. Describe the reaction.

_____

_____

_____

_____

ENVIRONMENTAL HISTORY

Does your home have a lot of: Dust Mold

Is your child exposed to cigarette smoke? Yes No

Please list any other exposures your child may have had in the past and present:

_____

_____

DIGESTIVE HISTORY

How often does your child have a bowel movement? _____

What is your child's stool like? (check all that apply)

Well-formed Mucousy Loose, falls apart Watery Small, hard Greasy/floats
Thin, long ribbons Bloody Foul-smelling Painful Lots of undigested food particles

Does your child have heartburn or reflux? Yes No

Does your child have frequent gas or belly bloating? Yes No

Does your child have any abdominal pain? Yes No

DIET HISTORY

Was your child breast fed? Yes No If yes, for how long? _____

Was your child bottle-fed? Yes No Brand of formula: _____

Do you have any concerns about your child's current diet? Yes No

Does your child eat refined sugar? Yes No Does your child eat fast food? Yes No

Please describe your child's current diet:_____

_____

Please describe your child's typical breakfast:_____

_____

Please describe your child's typical lunch:_____

_____

Please describe your child's typical dinner:_____

_____

Please describe your child's typical snacks:_____

_____

What does your child drink throughout the day?_____

SCHOOL HISTORY

School Name:_____ **Grade:** _____

Does your child have an Individualized Education Plan (IEP)? Yes No

Do you have any concerns regarding your child's school progress (academic, social, teacher, peer relationships)?
Yes No If yes, please explain: _____

_____

SOCIAL HISTORY

List the family and household members:
Relationship: Age: Occupation:

_____

_____

_____

_____

_____

_____

Are your child's parents: Married Unmarried Separated Divorced: When? _____

Child care situation: Parents Others:_____

Concerns about your child: Alcohol use Tobacco Sexual activity Aggressive behavior

Is violence at home a concern? Yes No Are there guns in the home? Yes No

Are there pets in the home? Yes No Do any family members smoke? Yes No

Please describe any recent stressful events: _____

_____

_____

How does your child interact with other children?_____

_____

_____

How does your child interact with adults?_____

_____

_____

FAMILY MEDICAL HISTORY

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Alcoholism								
Anemia								
Asthma								
Autism								
Autoimmune Disorder								
Birth Defect/Congenital Anomaly								
Bleeding Problem								
Cancer: Breast								
Cancer: Type_____								
Cancer: Type_____								
Depression								
Developmental Delay								
Diabetes								
Eczema (Atopic Dermatitis)								
Food Allergy								
Genetic Disorder								
Hay Fever (Allergic Rhinitis)								
Hearing Disorder								
Heart Attack/Coronary Artery Disease								
High Cholesterol (Hyperlipidemia)								
High Blood Pressure								
Immune Disorder								
Inflammatory Bowel Disorder (Crohns/UC)								
Kidney Disease								
Migraine Headaches								
Psychiatric/Mental Illness								
Scoliosis								
Stroke								
Substance Abuse								
Thyroid Disorders								
Tobacco Use								
Tuberculosis								
Death before age 56								
Other:								