## PATIENT INFORMATION

**Full legal name ______________________________________________________ Date of Birth______/______/_______**

**Social Security # _______________________________Sex _____Age____________ Today's Date_________________**

**Home Phone _____________________Cell Phone ______________________Work Phone _______________________**

**Mailing Address _____________________________________City________________State________Zip___________**

**Email _________________________________________Preferred Pharmacy __________________________________**

**IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING:**

Parent/Guardian_______________________________________________________ Date of Birth______/______/______

Relationship to Patient: _______________________Phone (If different from above) _______________________________

Address (If different from above) _______________________________________________________________________

Primary party to contact for billing (circle one) Yes No

Parent/Guardian_____________________________________________________ Date of Birth______/______/________

Relationship to Patient: _______________________Phone (If different from above) _______________________________

Address (If different from above) _______________________________________________________________________

Primary part to contact for billing (circle one) Yes No

**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:**

Primary Insurance _________________________________Insurance ID#________________________________________

Name of Policy Holder___________________________ DOB _________________ Relation to Patient _______________

Secondary Insurance _______________________________Insurance ID#________________________________________

Name of Policy Holder___________________________ DOB _________________ Relation to Patient _______________

## PRIVATE HEALTH INFORMATION

As our client we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take precautions to protect your private health information. When it is appropriate and necessary, we will provide the minimum information to only those we feel are in need of your health care information for treatment, payment or health care operations.

I acknowledge that I have received, or had the opportunity to receive, a full copy of our Notice of Private Policies. I understand that I can obtain an additional copy of these rights from this office any time.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule gives individuals the right to request a restriction on uses of Private Health Information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternate means, such as sending correspondence to the individual's home, work or fax number. The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure for PHI to the minimum necessary to accomplish the intended purpose.

These provisions do not apply to uses made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to disclose my PHI. I also authorize my healthcare provider to communicate my PHI in the following manner:

Provider may mail my information to my mailing address Yes No

Provider may leave a voicemail on my home phone Yes No

Provider may leave a voicemail on my cell phone Yes No

Provider may send information to email provided on page one Yes No

Provider may release information to me and the following individuals:

| | Name | DOB | Relationship | Phone Number |
|---|---|---|---|---|
| 1. | ____________ | ____________ | ____________ | ____________ |
| 2. | ____________ | ____________ | ____________ | ____________ |
| 3. | ____________ | ____________ | ____________ | ____________ |

Signature______________________________ Date ______________

## 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 ______________