MOOSE CREEK
Medical Clinic, LLC
211 E. Fairview Loop
Wasilla, Alaska 99654
www.MooseCreekMedical.com

PATIENT REGISTRATION FORM

Please Clearly Print Your Information

PERSONAL INFORMATION

Name:_____ Social Security#: _____
(Last) (First) (MI)

Birth Date:_____ Male ☐ Female ☐ Marital Status:_____

Race/Ethnicity:*_____ Language:*_____

[*FEDERAL GOVERNMENT REQUESTS THESE ITEMS]

Email:_____

Physical Address:_____

City:_____ State:_____ Zip:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Primary Phone *(# to call first)*:_____ Other Phone:_____

Employer:_____ Work Phone: _____

Spouses Name:_____ Social Security #:_____

Emergency Contact / Relationship:_____ / _____

Home Phone:_____ Cell Phone:_____

Referred By Physician:_____ How did you hear about us?_____

Preferred Pharmacy:_____

INSURANCE INFORMATION

Person Responsible for the Account:_____
(Last) (First) (MI)

Primary Insurance ***Please Fill In All Policy Information!***

Insurance Company:_____

Identification # *(Including Alpha Prefix if one)*:_____ Group: _____

Subscribers Name:_____ Birth Date:_____

Employed By:_____ Work Phone #:_____

Secondary Insurance ***Please Fill In All Policy Information!***

Insurance Company:_____

Identification # *(Including Alpha Prefix if one):*_____ Group:_____

Subscribers Name:_____ Birth Date:_____

Employed By:_____ Work Phone #:_____

ASSIGNMENT AND RELEASE

I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any balance due, including any collection or processing fees. I hereby authorize Moose Creek Medical Clinic, LLC to release all information necessary to secure payment of benefit and the use of this signature below on all insurance submissions.

Signature:_____ Date:_____

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CURRENT MEDICAL PROBLEMS

Please list all medical problems that you have; and anytime you were in the hospital for a medical reason.

SURGERIES

Please list any surgeries you have had in the past:

FAMILY MEDICAL HISTORY

Please list all serious medical problems in your family:

Mother: ☐ Alive ☐ Deceased Age:_____

Health Care Problems:_____

Father: ☐ Alive ☐ Deceased Age:_____

Health Care Problems:_____

Other Family:_____

ALLERGIES

Please list any medicines, foods or materials you are allergic to and your reaction:

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you live: ☐ Alone ☐ With Family ☐ Roommate(s) ☐ With spouse(name):_____

Employment: ☐ Working ☐ Home Maker ☐ Retired ☐ Unemployed ☐ Disabled

Occupation:_____ Employer:_____

What hours do you work?:

Do you Drink Alcohol: ☐ Yes ☐ No Do you currently smoke? ☐ Yes ☐ No

If you have smoked previously, what year did you quit?_____

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____ Date:_____

Patient Name:_____ DOB:_____

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Patient Medication Form

Please Clearly Print Your Information

Please give the information for all medicines that you take:
Please include: vitamins, supplements and over-the-counter medicines

Medicine:_____ Strength:_____
How Taken:_____
Medicine:_____ Strength:_____
How Taken:_____
Medicine:_____ Strength:_____
How Taken:_____
Medicine:_____ Strength:_____
How Taken:_____
Medicine:_____ Strength:_____
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How Taken:_____

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Signature:_____ Date:_____

Patient Name:_____ DOB:_____

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PRIVATE HEALTH INFORMATION DISCLOSURE

The Department of Health and Human Services has established a "Privacy Act" to help insure that personal health care information is protected for privacy. The Privacy Act was also created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient and/or to carry out treatment, payment or health care operations (TPO).

As our patient 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 responsible precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide services that are in your best interest.

I acknowledge that I have received, or had the opportunity to receive, a full copy of my full rights regarding my personal health information. I understand that I can obtain an additional copy of these rights from this office or on our website at any time.

I have reviewed and understand my rights regarding my personal healthcare information.

Signature:_____ Date:_____

Printed Name:_____ DOB:_____

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PRIVATE HEALTH INFORMATION DISCLOSURE

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 health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

Note: Use and disclosure for Treatment, Payment and Operations may be permitted without prior consent and in emergency situations.

Communication of my Private Health Information may be handled in the following manner:

- ☐ Provider may mail information to my home address.
- ☐ Provider may mail information to my work address.
- ☐ Provider may leave information on my telephone:_____
  (This may include appointment reminders or information regarding visits or study results.)
- ☐ Provider may send information to this fax number:_____
- ☐ Provider may exchange information via this email address:_____
- ☐ **Provider may send information to (name, relationship and contact information). Be advised you must provide spouses, significant others, children, etc. that you authorize information to be released to or we will not be able to discuss any information with them.**

_____

_____

Signature:_____ Date:_____

Patient Name:_____ DOB:_____

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IMPORTANT PATIENT INFORMATION

Our office will be closed on the following holidays: New Years Day, Memorial Day, 4th of July/Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Eve (Dec 24), Christmas Day (Dec 25) and the day following Christmas (Dec 26). Please plan accordingly.

In the event of bad weather or treacherous roads our office will phone you to reschedule your appointment. We live in Alaska too and the safety of our patients and staff is at upmost importance. In the event your healthcare status needs addressed urgently on these days, please rely on emergency services.

Prescription Refill Process:

1. Call your pharmacy 1st with your refill request.
2. Your pharmacy will notify us if there are no refills available and we will send in the refill accordingly.
3. We do our best to do all of the refills the same day, but have a 72 hour policy for all refill requests.

There will be times when an Urgent Care or Emergency Room evaluation is recommended. If this is the case, it is for the benefit of you as a patient.

I have reviewed and understand the information on this page.

Signature:_____ Date:_____

Printed Name:_____ DOB:_____

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PATIENT RIGHTS & RESPONSIBILITIES

Patient Rights:

1. Respect for the privacy of your personal health information (PHI).
2. Be treated with respect.
3. Participation in all medical decisions and treatment options.
4. Receive prompt and appropriate referral for needed services.
5. Be provided with awareness of possible complications and side effects of recommended treatments.

Patient Responsibilities:

1. Keep and be on time (or early) for appointments. Take note of the cancellation policy.
2. Treat all staff members with respect.
3. Follow treatment recommendations and treatment plans.
4. Immediately report any complications from treatments or if you decide to stop any medications.
5. Seek attention at an Urgent Care/Emergency Room if you are having healthcare issues that need addressed and our office is closed.
6. Follow recommendations for referrals/diagnostics.
7. Complete necessary forms for compliance with privacy regulations, Moose Creek Medical Clinic LLC Patient Policies, and Release of Information.
8. Bring a list of all of your medications (strength and dosages) to every single office visit, or bring all of your medications with you to your appointment.

I have read and understand my rights and responsibilities and agree to comply with them.

Signature:_____ Date:_____

Printed Name:_____ DOB:_____

Patient Name:_____ DOB:_____

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PATIENT POLICIES

Co-Pays, Deductibles, and Fees:

1. All Co-Pays and deductibles are due at time of service.
2. A $25 late fee will be added to accounts not paid in full on a monthly basis.
3. All accounts not paid in full within 90 days will be sent to collections and will have additional fees attached.
4. If you are having difficulty paying your bill, we will work with you and invite you to contact our office to set up a payment plan. If you set up a payment plan and your payment is declined, your account will be deferred to collections.

Medical Records:

1. We will make every effort to fulfill requests for medical records within 3 business days.
2. If you have already received a copy of your records and you request an additional copy, a $25 service fee will be charged.
3. A signed ROI (Release of Information form) is necessary to share your medical records with other healthcare providers.

Missed Appointments/No Show Fees:

1. If you fail to keep your appointment or do not cancel >24 hours in advance, a $60-100 fee will be charged to you, not to your insurance company. This fee must be paid in full prior to any further appointments being scheduled or prescriptions being filled.
2. Failing to keep your appointment or not cancelling >24 in advance may be grounds for termination.
3. There will not be a cancellation fee assessed to you if your appointment is cancelled by Moose Creek Medical Clinic LLC due to inclement weather, natural disasters, or provider illnesses.
4. It is extremely important for you to be punctual for your appointment. We reserve the right to reschedule your appointment if you show up >10 minutes after your scheduled time. We also reserve the right to assess a fee similar to our No Show Fee if you are >10 minutes late.

Respect for Moose Creek Medical Clinic LLC Staff:

It is understood that there may be times when you are not feeling well and it becomes easy to be aggresive, angry, or frustrated, however, disrespect to any staff member at any time will not be tolerated and is grounds for patient termination from Moose Creek Medical Clinic LLC.

I have read and understand these policies and agree to comply with them.

Signature:_____ Date:_____

Printed Name:_____ DOB:_____

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HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Moose Creek Medical Clinic LLC to use and disclose my protected health information (PHI) to carry out:

•Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
•Obtaining payment from third party payers;
•The day-to-day healthcare operations of Moose Creek Medical Clinic LLC.

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I hereby acknowledge that I have reviewed the HIPPA Notice of Privacy Practice document

Signature:_____ Date:_____

Printed Name:_____ DOB:_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ DOB:_____

Social Security Number:_____ Phone (home):_____ Phone (cell):_____

Address:_____

City, State, Zip:_____

The above listed patient authorizes the following healthcare facility to make record disclosure:

To/From:

Moose Creek Medical Clinic LLC

211 E. Fairview Loop

Wasilla, Alaska 99654

Phone: (907) 373-3335

Fax: (907) 373-3331

To/From:

Facility Name:_____

Facility Address:_____

City/State/Zip:_____

Phone:_____

Fax:_____

The purpose of the disclosure is:

- ☐ Ongoing Medical Treatment
- ☐ Personal/Legal/Administration
- ☐ Insurance Request
- ☐ Other

Information to be released:

- ☐ Medical Records
- ☐ Hospital records from the following dates: start_____ finish _____
- ☐ Labwork
- ☐ Radiology Results

Restrictions: Only medical records generated in this healthcare facility will be copied unless otherwise requested. This authorization is only valid for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand I may revoke this authorization at any time. I must do so in writing and present my written revocation to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand the Chemical Dependency clients/patients records are protected by Federal Law (42CFR, part 2) and can not be disclosed without this written consent unless otherwise provided in federal regulations.

If I have questions about disclosure of my health information, I may contact Moose Creek Medical Clinic LLC.

I have read the above Authorization fro Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

I understand that there will be a fee assessed with copying records. (see below)

This authorization shall remain in effect for 1 year following the date signed. A photocopy is as valid as the original.

Signature of Patient/Parent/Guardian/Authorized Representative:_____ Date:_____

Printed Name of Authorized Representative:_____

Relationship/Capacity to Patient:_____

Fees for Record Copying:
Personal Request: No charge for a one time courtesy copy of current records up to 25 pages.
Insurance/Administration: First 50 pages, $50, each additional page $0.50.
Provider Request: No charge for copies of records required for specified ongoing care.
Requests for copies of all records without regard to specific illness or time frame, first 25 pages, $25.
Legal Request: First 50 pages, $65.00, then each additional page $0.60.