1919 Lathrop St. Suite 222
Fairbanks, AK 99701

WELCOME TO OUR PRACTICE
Intake Form

Patient Information

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Preferred Name: _____ **Sex:** □ Female □ Male **Pronoun:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ Work**:** _____ **Ext:** _____

Preferred method for contact: □ Home □ Cell, do you prefer a Text or Voice Message? _____ □ Work

Date of Birth: _____ **SSN #:** _____-_____-_____ **Email:** _____

Primary Health Care Physician: _____ **Marital Status:** □ Married □ Single □ Other_____

Employer Name and Address: _____
Employee Status: □ Full Time □ Part Time □ Active Military □ Not Employed □ Self Employed □ Retired
Student Status: □ Full Time □ Part Time □ Not a Student

Race: □ African American □ Caucasian □ Hispanic □ Pacific Islander □ Other_____ □ Declined to report
Ethnicity: □ Hispanic □ Non-Hispanic □ Declined to report **Preferred Language:** _____

Preferred Pharmacy: _____ ☐ Consent to get prescription history

Emergency Contact

Name: _____ Relationship**:** _____

Address: _____

City: _____ State**:** _____ Zip **Code:** _____ Daytime **phone:** _____

Insurance Information

Primary Insurance: _____

Policy ID: _____ **Group #:** _____

Subscriber Name: _____ **Date of Birth:** _____ **SS#:**_____

Mailing Address/ City: _____ **State/Zip Code:** _____ **Relationship:** _____

Secondary Insurance: _____

Policy ID: _____ **Group #:** _____

Subscriber Name: _____ **Date of Birth:** _____ **SS#:**_____

Mailing Address/ City: _____ **State/Zip Code:** _____ **Relationship:** _____

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FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to our patients. The following is a statement of our financial policy, which we require that you read and agree to before any treatment.

Self-Pay Patients: Payment in full toward charges incurred at the time of service is requested. New patients need to pay a minimum of **$255.00** at the time of service.

Insured Patients: Chena Health participates in many commercial insurances. **It is your responsibility to know your insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.**

All co-pay, co-insurance, and deductibles are due at the time of service. **Any outstanding balance will be collected before your appointment.**

Please be aware that it is your responsibility to keep us updated with your correct insurance information and to supply us with a copy of your current insurance card(s). **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and submit the charges to the correct plan for reimbursement.**

Payment Options: We accept Cash, Visa, MasterCard, Debit cards, and Checks.

Out-of-State Patients: Payment in full is requested at the time of service. Upon request, information will be provided for the patient to bill their insurance.

Returned Checks: The charge for each returned check due to insufficient funds is thirty-five dollars ($35.00). **No exceptions!**

Delinquent Accounts: Chena Health is not a financial lending institution. Past-due accounts over one hundred and twenty (120) days are subject to a collection agency**. Chena Health is not liable for any consequences arising from a collections agency's effort to secure payment**.

Payment arrangements can be made with the office staff or Chena Health's billing department if a patient cannot pay their account balance. The patient will be required to provide authorization for a credit card or ACH payment (Bank account and routing number). **Chena Health is not liable for any consequences arising from overdraft fees, financial institutions' fees, or charges.**

Refunds: Refunds are subject to final insurance payment and verification.

NO SHOW/CANCELLATION: This is subject to a $25 fee if there is less than 24-hour notice or no notice is given.

Statements: To reduce paper, you will be enrolled with electronic statements. Please check your junk folder if you did not receive your statement in your email. Make sure you call our office if you do not receive the statement you expected.

I authorize Chena Health to release information to my insurance company and my insurance company to release information to Chena Health. I hereby assign benefits to be paid directly to Chena Health for this date and any future visits I may have.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Updated December 1, 2022

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Fairbanks, AK 99701

Patient's Request for Release of Information:

Authorization for Verbal Release of Protected Health Information to Designated Persons

AT THE PATIENT'S REQUEST, THIS AUTHORIZATION GRANTS PERMISSION TO CHENA HEALTH TO COMMUNICATE IN PERSON OR BY TELEPHONE WITH THE FOLLOWING PERSON(S), DESIGNATED BY THE PATIENT, TO ASSIST WITH THE PATIENT'S HEALTH SERVICES. THIS AUTHORIZATION IS APPLICABLE FOR VERBAL INFORMATION ONLY AND IS NOT VALID FOR THE RELEASE OF THE WRITTEN MEDICAL RECORD.

I AUTHORIZE Chena Health to communicate my health information to the person(s) listed below ('Designated Persons") for the following purposes: to orally confirm my appointments; to discuss results of my laboratory, radiology, or other test results; to pick up sample medications or written prescriptions for me; to discuss my health care; diagnosis, prognosis, and treatment plans; and to discuss billing and payment for medical services provided by Chena Health.

Please print the following information for each Designated Person:

Name: _____ Relationship to the Patient: _____
Address: _____ Telephone: _____
_____ Alternate Telephone: _____
_____

Name: _____ Relationship to the Patient: _____
Address: _____ Telephone: _____
_____ Alternate Telephone: _____
_____

I UNDERSTAND that this authorization applies to all departments, healthcare providers and/or employees at Chena Health.

I UNDERSTAND that this authorization is voluntary.

I UNDERSTAND that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

I UNDERSTAND that this authorization will be effective for my lifetime, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time by sending a written statement of revocation to:

Chena Health
Privacy Officer
1919 Lathrop Street, Suite 222
Fairbanks, AK 99701

If I revoke the authorization, it will not have any effect on any actions taken by Chena Health prior to the processing of the revocation.

I UNDERSTAND that my refusal to sign this authorization will not negatively affect my health care services at Chena Health.

1919 Lathrop St. Suite 222
Fairbanks, AK 99701

BY SIGNING THIS AUTHORIZATION I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE STATEMENTS CONTAINED HEREIN. I UNDERSTAND THAT CHENA HEALTH WILL PROVIDE ME WITH A COPY OF THIS SIGNED AUTHORIZATION FORM IF REQUESTED.

PATIENT:
Print name: _____

Signature: _____

Date: _____

Revocation of Authorization

This section is to be completed ONLY in the event the patient seeks to revoke the above authorization after signature.

By my signature below, I am revoking the authorization. I understand that this revocation will be effective when received by Chena Health and will not be effective to the extent that Chena Health has relied on my authorization prior to receiving notice of my revocation.

The designated person(s) to be revoked: _____

Patient: _____

Print Name: _____

Signature: _____

Date: _____

THIS SECTION FOR INTERNAL USE ONLY

Date revocation received: _____ Date revocation processed: _____

Name of employee processing request: _____

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Fairbanks, AK 99701

HIPAA email consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website
  - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Chena Health to send me personal health information via unencrypted email

_____ _____ _____ _____

Signature **Date** **Printed name** **Please print email address (parent or guardian if patient is a minor)**

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email

_____ _____ _____

Signature **Date** **Printed name (parent or guardian if patient is a minor)**

Please bring completed form to your visit

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Fairbanks, AK 99701

Chena Health 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.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for one medical condition and need to contact another of your doctors to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or attorney for audit purposes.

In addition, unless you object, we may use your health information to send you appointment reminders, information about treatment alternatives, or other health-related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about you to those people We may also share medical information with these people to notify them about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice (such as for marketing purposes) or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Privacy Officer. Specifically, you have the following rights:

- You have the right to ask that we limit how we use or disclose your medical information. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid out of pocket. You have the right to ask that we send you information at an alternative address or by an alternative means. We will consider your request, but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so. To request confidential communications, you must make your request in writing to Nancy Bergen, CPC, CPPM. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.
- In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you, for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which

we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- You have a right to receive a paper copy of this Notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

IV. Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office. We will provide the mailing address at your request.

We will take no retaliatory action against you if you make any complaints, whether to us or to the Department of Health and Human Services. We support your right to the privacy of your health information.

If you have questions about this Notice or any complaints about our privacy practices, please contact our Privacy Officer, either by phone or in writing at:

Chena Health
1919 Lathrop Street, Suite 222
Fairbanks, AK 99701-5942
Phone: (907)456-8197

V. Effective Date: This Notice was effective on **10/17/2017** .

1919 Lathrop St. Suite 222
Fairbanks, AK 99701

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name:_____

Date of Birth: _____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we will try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

[ ] I have received the Notice of Privacy Practices effective date 10/17/2017.

_____ _____
Patient's (or Legal Representative's) Signature) Date

_____
Relationship of Legal Representative

For office use only

To be completed only if Acknowledgement is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices?
[ ] Yes [ ] No

2) Please explain why the patient was unable to sign this Acknowledgement and our efforts to try to obtain the patient's signature:

_____
_____
_____
_____
_____

_____ _____
Name/Title Date

1919 Lathrop St. Suite 222
Fairbanks, AK 99701

Chena Health

HIPAA AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION, CONSENT TO RECEIVE TEXT MESSAGES

Chena Health respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. To ensure that Chena Health is acting according to your wishes, using your personal information with your authorization, and communicating with you in a manner you authorize, we ask you to fill out and sign this form. Chena Health will keep a copy of your written permission on file. I specifically authorize text messaging communication with Chena Health. The phone number I want text communications sent to is _____. I understand that text message communications may be unsecured. I understand that a risk of unsecured text messages is the potential that a third party could read the communication. I understand my mobile provider's standard rates for sending and receiving text messages will apply.

I am not required to sign this authorization. Chena Health does not condition treatment, payment, benefit eligibility, or enrollment activities on signing this form. I can request a copy of this authorization be mailed to me. I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send a written notice to the Chena Health Privacy Officer at 1919 Lathrop St., Ste. 222, Fairbanks, AK 99701. I understand that Chena Health, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Chena Health's control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date signed.

Patient Name: _____ (first) (m. initial) (last)

Signature: _____ Date: _____

Address: _____

(street address) _____

(city) (state) (zip code)_____

Phone: (area code) (home or mobile number) _____

For personal representatives, please provide the following: I, _____,

represent that I am the health care agent/ guardian/ surrogate/ parent of the patient above. Personal

Representative Signature: _____

Address: _____ Phone: _____

*If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient.