MNA

MEDICAL NETWORK OF ALASKA

Fax or Email completed form

Fax: (907) 357-1110
reception@alpenglowak.com

PATIENT INFORMATION

Last Name_____ First Name_____ MI _____ M/F

Previous name(s) used _____

Mailing Address_____ City _____ State _____ Zip_____

Residence/Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ DOB_____ SSN#_____

Race _____ Ethnicity _____ Language _____ Marital Status _____

Employer _____ Can we call you at work? Yes/No If yes, phone _____

E-Mail _____

RESPONSIBLE PARTY (MINORS ONLY)

Last Name_____ First Name_____ MI _____ M/F

Mailing Address_____ City _____ State _____ Zip_____

Phone_____DOB_____ SSN#_____ Relation to Patient_____

INSURANCE INFORMATION

PRIMARY Insurance _____ Policy # _____ Group # _____

Insured _____Relationship _____DOB_____Social Security # _____

SECONDARY Insurance _____ Policy #_____ Group #_____

Insured _____ DOB _____ Social Security #_____

EMERGENCY CONTACT

Person to contact if unable to reach patient (not living in your home)

Name _____ Phone/Cell _____Relationship _____

How did you hear about us? _____ Preferred Pharmacy _____

Primary Care Provider _____

Who do you authorize to pick up your prescriptions? _____

_____

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans, Medicaid, RR Medicare, and all other health plans to Medical Network of Alaska. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance (including Medicaid). I hereby authorize said assignee to release all information needed to secure the payment.

Signed _____ Date _____

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Medical Network of Alaska to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Medical Network of Alaska describes such uses and disclosures more completely.)

I acknowledge that Medical Network of Alaska is a network of medical practices to include but not limited to, Capstone Family Medicine, Capstone Urgent Care, Capstone Diabetes and Endocrinology, Alpenglow Women's Health, and Alaska Fracture and Orthopedic Clinic. My personal health information will be accessible across the network when appropriate for the continuity of my care.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Medical Network of Alaska reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

3331 E. Meridian Park Loop
Wasilla, AK 99654

With this consent, Medical Network of Alaska may call my home or other alternative location and leave a message on voice mail if needed (unless a Refusal to Voicemail form is completed) or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Medical Network of Alaska may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Medical Network of Alaska may e-mail any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Medical Network of Alaska restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Medical Network of Alaska to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Medical Network of Alaska may decline to provide treatment to me.

_____	_____
Print Patient's Name	Signature of Patient or Legal Guardian
_____	_____
Date	Print Name of Legal Guardian, if applicable

MEDICAL NETWORK OF ALASKA FINANCIAL POLICIES

PLEASE REVIEW AND INITIAL

PATIENT NAME _____ DATE _____

- If proof of insurance/eligibility cannot be provided, payment will be due in full. _____
- Medical Network of Alaska will collect any deductibles, copay, or coinsurance on the date of service. _____
- Medical insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, etc. _____
- Please be advised if you are here for a preventative visit/physical and have health problems you want to discuss with your provider during your well visit, this could result in an additional charge, which may or may not be covered by your insurance. For clarification or to update the reason for your visit, please see the front desk. _____
- Balances on your account must be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel. If you are in need of an arrangement, please contact the billing department in a timely manner as any claim over 90 days will be due in full or reviewed for collections. _____
- Statements are not generated for an amount due to less than $2.50; please watch your insurance explanations to see if you owe a balance. _____
- Please be aware you may receive a separate charge from an outside lab (i.e., Quest Diagnostics) for specialized lab tests. _____
- Medical Network of Alaska is in network with the following insurances: Aetna, Blue Cross, Cigna, Medicaid, Medicare, Moda/ODS, Multiplan, Tricare, United Health Care, and the VA. If your insurance is not one of these, please be aware your claim(s) will be processed as "out of network". _____
- Delinquent account (>90 days) is subject to collections processes which may include the account being transferred to Cornerstone Credit Services (CCS). You will be responsible for any fees and/or commission charged to Medical Network of Alaska by CCS. Patients whose accounts have been sent to CCS will be reviewed for possible discharge from the clinic. _____
- Medical Network of Alaska will charge a fee of $30.00 for any checks returned as NSF. The patient's account be flagged that only cash or credit card payments will be accepted due to the NSF. _____
- Any appointment cancelled less than 24 hours prior to the scheduled appointment time will be documented as a missed appointment on the account. Missed appointments are subject to a possible $50 - $100 fee, depending on the provider. After two missed appointments an account may be reviewed for discharge from the practice. _____
- It is important to clarify the reason for your visit(s). Please do this at the time of your visit as it is Medical Network of Alaska policy to not change the diagnosis code ***after*** the visit. Do feel free to clarify/confirm what diagnosis will be used with your provider before you leave the office. _____

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CONSENT TO DISCUSS WITH NON-MEDICAL PERSONS

I, _____ (print patient name), authorize Medical Network of Alaska to ***verbally*** discuss my medical records with:

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

By signing this authorization form, I understand that:

- Some records may contain extremely confidential information. This may include alcohol/substance abuse/testing, mental health conditions/psychotherapy notes and psychological evaluations, HIV testing, status or care and treatment for AIDS, sexually transmitted disease/testing, and genetic records.
- Once the office discloses health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.
- I may revoke this authorization in writing. If revoked, it would not affect any actions already taken by Medical Network of Alaska based upon this authorization. Two ways to revoke this authorization are: Fill out a revocation form (available from the office) *or* write a letter to the office.
- This is not an authorization to release printed medical records.

_____ _____

Patient or Parent/Guardian name (print) Patient Date of Birth

_____ _____

Signature of patient or Parent/Guardian Date

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MEDICAL NETWORK OF ALASKA

Telemedicine Consent Form

I, _____, understand and agree that by participating in telemedicine services with Medical Network of Alaska, I am agreeing to the following terms and conditions:

1. I understand that telemedicine involves the use of electronic communications to enable healthcare providers at Medical Network of Alaska to provide healthcare services remotely.

2. I understand that telemedicine may involve the use of videoconferencing, secure messaging, or other electronic communications technologies to diagnose, consult, treat, and educate me.

3. I understand that telemedicine services may not be as complete as in-person services, and that there may be limitations to the diagnosis or treatment that can be provided via telemedicine.

4. I understand that Medical Network of Alaska will use commercially reasonable efforts to ensure the security and confidentiality of all telemedicine sessions, but that there may be some risks associated with electronic communications, including interception or unauthorized access.

5. I understand that I may need to be physically present at a healthcare facility or other location for certain tests, exams, or treatments that cannot be performed via telemedicine.

6. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time.

7. I understand that my healthcare provider at Medical Network of Alaska may determine that telemedicine services are not appropriate for my care and may terminate telemedicine services at any time.

8. I understand that I may be responsible for payment of any fees associated with telemedicine services that are not covered by my insurance.

By signing below, I acknowledge that I have read and understand the terms of this consent form, and that I consent to the use of telemedicine services as described above. This consent is valid for one year from the date of signature.

_____ _____

Patient or Parent/Guardian name (print) Patient Date of Birth

_____ _____

Signature of patient or Parent/Guardian Date

ALPENGLOW WOMEN'S HEALTH

Patient Information

Name _____ D.O.B _____

Pronouns ○He/Him ○She/Her ○They/Them ○_____

Gender Identity ○Male ○Female ○FTM ○MTF ○Other

Current Care Team

Provider _____ Specialty _____

Provider _____ Specialty _____

Today's Date _____

Current Medications *(including over the counter)*:

Name of Drug	Dose (include strength and number of pills per day)	Prescribed by

Preferred Pharmacy

Gynecologic History

Date of last Pap smear _____ Abnormal Pap smear _____ Date of LMP _____

Flow _____ Duration of flow (days) _____ Frequency of cycle (Q days) _____ Age at 1st period _____

If post-menopausal, age at menopause _____ HPV vaccine _____ Sexually active _____ STIs/STDs _____

Age at first child _____ Current birth control method _____ Desired birth control method _____

History of sterilization/partner vasectomy _____ Date of last colonoscopy _____ Date of last mammogram _____

Most recent bone density _____ Post menopausal bleeding _____ Hormone replacement therapy _____

Obstetric History

Total	Full Term	Premature	Terminated	Miscarriage	Ectopic	Multiple births living
_____	_____	_____	_____	_____	_____	_____

Delivery Date	Delivery Type (Vaginal, Cesarean, Miscarriage, Termination)	Gestational weeks of Delivery	Sex	Name	Weight	Delivery Location	Complications

ALPENGLOW WOMEN'S HEALTH

Family History	Circle One	Age of Death	Health issues / Cause of death if deceased
Father	☐ Alive / Deceased ☐		
Mother	☐ Alive / Deceased ☐		
Paternal Grandfather	☐ Alive / Deceased ☐		
Paternal Grandmother	☐ Alive / Deceased ☐		
Maternal Grandfather	☐ Alive / Deceased ☐		
Maternal Grandmother	☐ Alive / Deceased ☐		

How many siblings? _____ Brothers _____ Sisters _____ Sons _____ Daughters

Social History

Education and Occupation

Are you currently employed? ☐ Y / N ☐

Occupation _____

What is the highest grade or level of school you have completed or the highest degree you have received?

_____

Marriage and Sexuality

What is your relationship status? _____

Do you use protection against STDs? ☐ Y / N ☐

Substance Use

Do you or have you ever smoked tobacco? ☐ Y / N ☐

Years smoked _____ Packs per day _____

Do you or have you ever used any other forms of tobacco or nicotine? ☐ Y / N ☐

Type _____

Do you use any illicit or recreational drugs? ☐ Y / N ☐

Type _____

What is your level of alcohol consumption? _____

Surgical History *(include date of surgery)*	Hospitalizations *(include dates and reason)*

Medical History *(Do you have now or have you ever had):*

- ☐ Diabetes (type) _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Heart Murmur
- ☐ Heart problems
- ☐ Pneumonia
- ☐ Stroke
- ☐ Asthma
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Stomach Ulcer
- ☐ Gallstones
- ☐ Migraines
- ☐ Anxiety
- ☐ Depression
- ☐ Skin Disorders
- ☐ Eating Disorder
- ☐ Rheumatic Fever
- ☐ Other: _____

Allergies

Type of Allergen *(i.e. penicillin or nickel)*	Reaction *(i.e. anaphylaxis, swelling, rash, other*