



### 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 # \_\_\_\_\_

### GENERAL INFORMATION

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 \_\_\_\_\_



## 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 Physicians, Capstone Urgent Care, Capstone Diabetes and Endocrinology, and Alpenglow Women's Health. 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:

3122 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. \_\_\_\_\_
- Statements are not generated for an amount due of 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: Medicare, Medicaid, Blue Cross, Tricare, Cigna, Aetna, Moda/ODS, and Multiplan. 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 until the debt has been repaid. \_\_\_\_\_
- Any appointment cancelled less than 24 hours prior to the scheduled appointment time will be documented as a missed appointment on the account. After four 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 a diagnosis code *after* the visit. Do feel free to clarify/confirm what diagnosis will be used with your provider before you leave the office. \_\_\_\_\_



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

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 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

# 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 <small>(Vaginal, Cesarean, Miscarriage, Termination)</small>	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)
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## Medical History (Do you have now or have you ever had):

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

## Allergies

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