PATIENT **REGISTRATION** INFORMATION
35911 Kenai Spur Hwy # 6, Soldotna AK 99669 907-260-7729

HEALTH NORTH FAMILY MEDICINE llc EIN: 264206114
4050 Lake Otis Pkwy # 111, Anchorage AK 99508 907-561-1195

PATIENT INFORMATION:

Patient Name: _____ Male / Female
Married Single Divorced Other / Employed Student Retired Other
SS #_____Employer_____
Date of Birth_____
Address: _____City_____ State_____ Zip_____
Daytime Phone_____ **OK leave message? Yes / No**
Cell Phone _____ OK **leave a message? Yes / No**
Email: _____
Please Note: Your email is used for clinic communication only, such as appointment reminders and will never be sold.

HOW DID YOU HEAR ABOUT US? Friend / Family / TV Commercial / Radio _____ / Internet / Drove by Insurance Co. /Previous Patient / Fish Hook Sign / Flyer / Tourist Book / Magazine Other: _____

Would you like your billing statement to be: Mailed or Email

Name of Personal Representative: _____
(Optional): This person may act in place of you, for purposes of authorizing use and disclosure of protected health info.
Emergency Contact: _____Phone:_____

RESPONSIBLE PARTY (if other than PATIENT): ☐ **CHECK HERE IF SELF (over 18yrs old)** ☐ **CHECK HERE IF address is the SAME**
Name:_____ Date of Birth_____
SS # _____ Relationship to patient_____
Phone_____ OK leave a message? Yes / No
Address: _____ City_____ State_____ Zip _____

INSURANCE INFORMATION: If no Insurance, ☐ **Check here (SELF PAY)** and turn page over to review & sign

PRIMARY Insurance:
Name of Insurance Company: _____
Insurance ID # _____ Group# _____
Employer: _____
_____Check if YOU are the insured person, IF NOT, PLEASE FILL OUT THE FOLLOWING:
Name of Insured person, if not self _____Male / Female
Date of Birth_____ SS#_____
Relationship to Patient: Spouse / Parent / Other: _____

Secondary Insurance:
Name of Insurance Company: _____
Insurance ID # _____ Group# _____
Employer: _____

_____Check if YOU are the insured person, IF NOT PLEASE FILL OUT THE FOLLOWING:
Name of Insured person, if not self-_____Male / Female
Date of Birth_____ SS#_____

TURN OVER TO REVIEW AND SIGN:

PATIENT NAME: _____Date of Birth: _____

Order to receive treatment, you must agree to the following terms. Please feel free to ask questions about any area of concern. Service Agreement: I understand that Health North Family Medicine (HNFM) offers health care using a team of caregivers. These people have various training and skills. They work together as a team to help me meet my health care needs and too coordinate my care. Protected health information (PHI) about my health, and the care they provide, is kept in my medial health record. My record is accessed by staff members at HNFM who are involved in my care. This record may include information from medical providers and laboratories. It also includes reports from caregivers elsewhere, when I have been referred by HNFM staff to other places for health care services. All health information is kept private between me and my health care professional except in circumstances when disclosure is required or otherwise permitted by law. I understand that it is my responsibility to keep my scheduled appointment. If I cannot make my scheduled appointment and do not call to cancel or reschedule before the time of the appointment,

I understand that I will be charged a $50.00 no show fee.

Privacy Agreement: I acknowledge that I have been offered a copy of HNFM's Notice of Privacy Practices. An additional copy of HNFM's Notice of Privacy Practices is available to me at any time upon my request. I understand that HNFM takes seriously the protection of my protected health information (PHI) entrusted to them and will only divulge minimum necessary information required to accomplish their purpose. I understand that I may register a complaint or voice a grievance without fear of reprisal. I acknowledge that I have been offered a copy of HNFM's privacy policy.

Financial Responsibility: I understand that HNFM relies on the fees paid by me and my insurance company to continue to deliver services. I understand that HNFM will only bill my insurance as a courtesy for me on family practice visits, and that after 45 days from the date of billing, I am responsible for all charges including balances not covered by insurance or any non-covered or "out of pocket" expense. I understand that my care at HNFM is a partnership between myself and the HNFM staff. This partnership is defined in the privacy policy and a copy is available to me at my request. I agree to pay my copayment at the time of service. I understand that I may request a payment plan which will be determined on a case by case basis by HNFM staff. I understand that if I am put on a payment plan I am responsible for the entire amount and must make payments until the balance is paid in full. I understand that HNFM does not operate a "free clinic." I will not be refused services because of an inability to pay as long as I agree to demonstrate a willingness to pay. (i.e. payment plan) I understand that if I do not demonstrate a willingness to pay OR I miss an agreed upon payment in my payment plan, I may be dismissed as a patient and my account may be turned over to a collection agency. ***** We bill insurance as a courtesy, by signing below you are authorizing HEALTH NORTH FAMILY MEDICINE to perform the necessary requirements to do so.** Authorization to pay benefits to HEALTH NORTH FAMILY MEDICINE: I authorize HEALTH NORTH FAMILY MEDICINE to release medical or other necessary information to my insurance company in order to process my health insurance claims. **We do not accept MEDICARE OR MEDICAID.** I also request payment of my benefits to be released to HEALTH NORTH FAMILY MEDICINE. My signature here indicates the information provided above is true and correct.

CONSENT FOR MEDICAL TREATMENT: The undersigned consents to the procedures which may be performed at Health North Family Medicine, including but not limited to: laboratory procedures, x-ray examination, medical and/or surgical treatment and/or clinic service rendered to the patient under the general and special instructions of the patient's physician. S/he understands that it is customary, except in emergent or unusual circumstances, that major procedures are not carried out on a patient until s/he has discussed them with the physician or other health care professional and has agreed to the procedure(s); that each patient has the right to refuse any proposed procedure(s); and that no guarantee has been made as to the result or cures that may be obtained from examination or treatment in this clinic.

THE hCG weight loss program, If I have chosen to participate, please review and sign below for the following waiver: The HCG program for weight loss, which includes diet, behavior changes and HCG administration: I am aware that results may vary and are not guaranteed. With HCG, there are possible risks of fatigue, mild headaches, bruising or swelling at the injection site or possible allergic reaction, etc. ** I agree that I have been counseled on a specific weight loss program for me with diet and HCG Injections **to attain my targeted weight loss. I must follow the program to achieve the desired results. ** I have been counseled on self-injection and assume full responsibility for myself. ** I also will dispose of used syringes properly. Patients who have been found to have submitted fraudulent material will be terminated from the program. ** Any medication is strictly for the use of the patient and not to be transferred or distributed, modified or used by any other party. . I understand and agree that any monies paid for the HCG diet program or medication are non-refundable and if not all used, may ONLY be issued as a credit for future appointments. No refunds will be given. HCG medication is not able to be returned once it leaves the clinic.

***** I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES. ***** (Extra copies in the waiting room for your convenience)

SIGNATURE: _____ Date: _____

(Patient, Parent or Legal guardian)