561 S Denali Street, Suite E
Palmer, AK 99645

TFHCPalmer@Outlook.com
Phone (907) 745-1777
Fax (907) 745-0226

NEW PATIENT REGISTRATION FORM

Date: _____/_____/_____

Email Address: **Text Message Number:**

Preferred Provider:

Patient Information

Last Name: First Name: MI:

Date of Birth: Age: SSN:

MAILING Address:

City: State: Zip Code:

Please check primary phone Home Phone ☐ Cell Phone ☐ Work Phone ☐

Martial Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Gender: ☐Male ☐Female

Spouse's Name: (☐ N/A) Race:

Occupation: Employer:

Primary Insurance Information

☐*Check if same as patient*

Primary Insurance Name:

Name of Policy Holder: DOB: SSN:

Relationship to the patient: Employer:

Policy #: Group #:

Secondary Insurance Information (Only if Applicable)

Secondary Insurance Name:

Name of Policy Holder: DOB: SSN:

Relationship to the patient: Employer:

Policy #: Group #:

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IN CASE OF EMERGENCY

Name of friend or relative:	
Relationship to patient:	
Home Phone #:	Cell Phone #:

The information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Family Health Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Parent/Guardian Signature *Today's Date*

* Please note: Although you have selected a Preferred Provider at TFHC, there may be circumstances in which he/she is not available for appointment as desired. However, TFHC has multiple providers who are willing to provide you care if this provider is not available.

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Release Authorization Form

(COMPLETE TOP OR BOTTOM)

I, _____ authorize the release of my private health
Patient's Name
information to _____ _____
Name *Relationship*

I understand this information may include test results, referral information, scheduling, cancelation, or confirming appointments, as well as any other medical information pertinent to my care.

I acknowledge that this authorization is valid throughout my relationship with **The Family Health Center** I understand that I may revoke this agreement at any time by submitting a request in writing.

OR

I, _____ **DO NOT** want my private health
Patient's Name
information released to anyone at this time. Should I choose to designate someone at a later date, I will submit that request in writing.

SIGN BELOW

_____ _____
Patient's Signature *Today's Date*

the Family Health Center

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General Provisions

BILLING

Patients must pay co-pay at time of visit. Any retuned check will be subject to a $30.00 charge. After three billing statements without payment, the account will go to collections. We are happy to make payment arrangements with you.

Our goal is to provide you with the best medical care possible. Annual physical exams give us a chance to address your overall physical and emotional health. The **preventative** care we provide during a physical may also include *an assessment of dietary and exercise habits, review of vaccinations, discussion of screening tests, lifestyle behaviors, etc.* We often look in on chronic stable problems such as high blood pressure, arthritis, and/or other ongoing controlled medical conditions.

Regular office visits differ from the **preventative** and wellness care provided at a physical because they focus on *other new ongoing or poorly controlled medical concerns.* **These types of problems need to be addressed in an appointment separate from a preventative or physical exam. If, however, we adequately cover required preventative and wellness care during the physical, sometimes we will have time to discuss new problems identified by you or the physician.**

We would like to correct a misperception that is occurring regarding "double charges". Please note that the insurance companies do allow providers to address additional complaints beyond a physical examination. If new problems are found or poorly controlled problems are addressed, an additional office evaluation code will be generated *in addition* to a preventative physical examination code. Essentially, part of the visit is preventative, but part of the visit is not part of a wellness exam.

Therefore, this generates another charge to the insurance company which in turn may require you to pay your copayment, coinsurance or deductible charge.

INITIAL _____

APPOINTMENTS

Once an appointment has been made, please respect the time that has been reserved in our office schedule for you. **There will be a $100.00 charge for missed appointments and appointments NOT canceled within 24 hours.** We make every attempt to give our patients a courtesy call reminding you of you appointment time, but it is your responsibility to know when your appointment time is and to communicate with us if you will not make it in a timely fashion. This charge is voluntary, a patient will not be sent to collections over it. HOWEVER, if you do not value that a provider must be compensated for the visit even though you did not make it to your scheduled appointment, you will be discharged from the clinic.

INITIAL _____

LAB SERVICES

Our preferred laboratory is **Quest**, we are able to draw and collect specimens for this, but you maybe subject to a co-payment and/or a deductible. Please note that you are fully responsible for any and all charges.

INITIAL _____

REFERRALS

Your insurance company, not this office, establishes referral policies. **Please note that referrals require up to 72 hours to process.** We will automatically send it via facsimile or electronically to your specialist. Same day referrals are limited to medical emergencies. **WE DO NOT BACK DATE REFERRALS**, per your insurance and our office policies. If you are unsure whether your insurance plan requires referrals, please call your insurance company.

INITIAL _____

PRESCRIPTION REFILLS

In order to provide quality healthcare, please ensure an adequate supply of medication to last you until your next appointment. Your provider will give you enough refills to last until the next office visit. For example, blood pressure and cholesterol medication necessitate an office visit at least every 6 months. If you running out of medication please inform our medical assistant so that we may arrange for a one-time 30 day supply. In addition, we do not refill controlled substances without seeing the patient, ever. For instance, Percocet, Vicodin, Tylenol #3, or the generics of any of those medications will not be refilled over the phone so please do not ask. Antibiotics are frequently over prescribed, we will only prescribe an antibiotic if we see you for your illness, and then only at the providers discretion. Coming in is not a guarantee you will receive antibiotics. Refill requests may take as long as **3 business days** to complete, so make sure to request refills in a timely fashion before your prescriptions run out.

INITIAL _____

LAB RESULTS

If your results are of concern due to being abnormal, we will make every effort to promptly contact you. Please be sure this office has your correct telephone numbers on file. If you are contacted regarding abnormal results, you may be asked to schedule a follow up appointment with your provider. If you wish to obtain an actual copy of your report, you may do so by making prior arrangements with the medical assistant to pick up a copy, which we will leave at the front desk.

INITIAL _____

PRIOR AUTHORIZATION

Your insurance company, not this office, sets medication formularies. We make every effort to adhere to these formularies, which frequently change. If the medication prescribed to you is not covered by your insurance, we will be happy to change the medication to an alternative on your formulary-preferred list.

INITIAL _____

ADVANCE DIRECTIVES

Advance Directives are available at the front desk. If you would like one to fill out please ask the receptionist. Once completed please return it to any of the staff here in the office so that it can be scanned into your chart.

By signing below, I certify that I have read and completely understand the office policies of The Family Health Center

_____ _____

Signature *Date*

_____

Print Name

the Family Health Center

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Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize The Family Health Center and it's providers to view my external prescription history via eClinicalworks EHR system. I understand that this includes but is not limited to prescription history from other unaffiliated medical providers, insurance companies, and/or pharmacy benefit managers may be viewable by provider and staff at The Family Health Center. This also may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE CONSENT TO OBTAIN EXTERNAL PRESCIPRTION HISTORY

Patient Signature _____ Date _____

Done!