Fairbanks Family Wellness
3550 Airport Way, #4, Fairbanks, AK 99709
Phone: 907-479-2331 Fax: 907-479-0164
FairbanksFamilyWellness.com

New Patient Intake Form

Name: _____ Date: _____
Last First Middle
Mailing Address: _____
Street/PO Box City State Zip
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: ____-_____-____ Date of Birth: _____

Email Address: _____

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____ Occupation: _____

Referring Physician: _____ Family Physician: _____

Reason for visit: _____

Patient younger than 18 list parent(s)/Legal Guardian(s): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information: Please Give Your Cards to Receptionist for Copying
Primary Insurance: _____
Insured's Name: _____ Relationship to Patient: _____Date of Birth: _____
ID Number: _____ Group Number: _____
Secondary Insurance: _____
Insured's Name: _____ Relationship to Patient: _____ Date of Birth: _____
ID Number: _____ Group Number: _____

Worker's Compensation/Motor Vehicle Accident
Date of Injury: _____ Injury due by ☐ Worker Compensation ☐ Auto Accident
Insurance Company (Worker's Comp or Auto Ins.): _____
Address: _____
Claim Number: _____

Please tell us how you learned of our services or who we can thank:

☐ Yellow Pages Advertisement ☐ I was a Former Patient ☐ Family/Friend ☐ TV Advertisement

☐ Newspaper Advertisement ☐ Doctor Recommendation ☐ TV Advertisement ☐ Other _____

X_____ _____
Signature Patient or Parent/Legal Guardian if Patient is under 18 Date

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Office Policy

The staff at the office of Fairbanks Family Wellness, welcomes you and also thanks you for choosing our office to support you in better health. We want to make your visit with us both beneficial and pleasant.

Our policy is that payment is due at the time that services are rendered. We accept all major credit cards. We do not accept out of state checks. Returned checks are subject to a fee of $30.00. Deductible and Co-payment (your percentage) are also expected at each visit.

We will gladly discuss your proposed treatment and answer any question relating to your insurance. You must realize however, that:

1. Your insurance is a contract between you, your employer and Insurance company; **we are not part of that contract.**

2. Our fees are per service and fall within most but not all insurance guidelines for "usual and customary, and/or reasonable fee." Insurance policies base their payments on UCR fees. Charges more than UCR fee are not considered for payment by insurance but **are the responsibility of the patient.**

3. Not all services are covered under all policies; some insurance companies ARBITRARILY select certain serves they will not cover.

4. We do not automatically file pre-authorization or call your insurance to verify your benefits. Please contact your employer regarding insurance questions and available benefits.

The filing of insurance claims is a courtesy that we extend to our patients. **All charges are your responsibility from the date of service.** We will attempt to get payment from the insurance company for up to 60 days after the date of treatment. After 90 days, it will become your responsibility to pay the balance in full, regardless of pending action by your insurance company.

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Please Initial on Each Line.

_____ As a courtesy to you, we will call, text or email you 24 hours prior to your appointment. We require that you confirm your appointment. If your appointment is not confirmed, we reserve the right to offer your time slot to someone else.

_____ For established patients: Cancellations without 24 hours notice will be subject to a service charge of $50.00. We now require a credit card to be kept on file for missed or no show/no call appointment to be charged.

_____ For new patients: We require a credit card to keep on file which will be charged $50.00 missed or no call/no show appointments.

_____ After 3 no show appointments at Fairbanks Family Wellness, you will need to call and see if provider has any opening or that day. We will no longer be able to schedule you out for appointments.

I have read and understand the above office policy.

X _____ _____
Signature Patient or Parent/Legal Guardian if Patient is under 18 Date

X _____ _____
Printed Name of Patient or Parent/Legal Guardian if Patient is under 18 Date

Credit Card Holder Name: _____

Credit Card Number: _____

Expiration Date: _____/_____

CCV: _____

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Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

☐ I authorize the release of Information including the diagnosis records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number: _____
if unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (day) _____ between (time) _____

Notice of HIPAA Privacy Practice: I have received and reviewed the HIPAA Privacy Practice of Fairbanks Family Wellness.

Signed: _____ Date: _____

Witness: _____ Date: _____