

# CHENA *Obstetrics & Gynecology*

1919 Lathrop Street, Suite 217, Fairbanks AK, 99701  
Office: 907-456-8191, Fax: 907-456-8192

## WELCOME TO OUR PRACTICE INTAKE FORM

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Ok to leave message: home  cell  work  email address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Race:  African American  Caucasian  Hispanic  Pacific Islander  Other  Refused to report

Ethnicity:  Hispanic  Non-Hispanic  Refused to report

Marital Status:  Married  Single  Other

Preferred Pharmacy: \_\_\_\_\_

Employee Status:  Full  Part-time  Not-employed  Self employed  Retired

Employer Name and Address: \_\_\_\_\_

Student:  Full time  Part time  Not a student

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

### Insurance Information

Primary Insurance: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_

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## FINANCIAL POLICY

**Self Pay Patients:** Payment in full toward charges incurred at time of service are requested.

**Insured Patients:** Chena Ob/Gyn participates in the following health plans: Medicare, Medicaid, Alaska Blue Cross/Blue Shield (associated with Blue Card Network), and Aetna.

Co-pay and deductible are due at time of service. We will bill any other insurance carrier as a courtesy to our patients. Payment of services is due at time of service.

Please be aware that it is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**

**Payment Options:** We accept Visa and MasterCard. We also accept checks, cash and debit cards.

**Out of State Patients:** Payment in full is requested at time of service. Upon request information is provided for patient to bill their insurance.

**Returned Checks:** The charge for each returned check due to insufficient funds is thirty-five dollars (\$35.00)

**Collection Accounts:** If an account has not been paid off after ninety (90) days from the day of service, the patient's account may be turned over to a collection agency. A thirty-five percent (35%) collection fee is added to the outstanding balance. Payments need to be made to the collection agency in this case. If no steps are taken to clear the balance, the practice can discharge a patient and no further appointments are made.

I hereby authorize Chena Obstetrics & Gynecology to release information to my insurance company and my insurance company to release information to Chena Obstetrics & Gynecology. I hereby assign benefits to be paid directly to Chena Obstetrics & Gynecology for this date, and any future visits I may have.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Updated May 3, 2011

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Acknowledgement of Receipt of HIPAA Notice of  
Privacy Practices

I have reviewed the Chena Obstetrics & Gynecology Notice of Privacy Practices. A copy will be provided to me if I request.

**Signature:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

- I authorize Chena Obstetrics & Gynecology to disclose my health information to an individual other than myself, should I not be available:

**Name of individual:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

- I do not authorize the release of my health information except as noted in the Notice of Privacy Practices.