

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: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Birth: _____ SSN #: _____

Preferred Pharmacy: _____

Marital Status: Married Single Other

Employee Status

Full Part-time Not employed Self employed Retired

Employer Name: _____

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 or Alaska, Blue Cross/Blue Shield (associated with Blue Card Network).

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.

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 twenty-five dollars (\$25.00)

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 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 July 11, 2007

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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.