2925 Debarr Road Suite 230
Anchorage, Alaska 99508
907.777.1800
www.akpeds.com

Patient Information

* some of this information is requested by the US government*

First Name:	Middle:	Last:	Suffix:
Address:	City:	State:	Zip:
Date of Birth: _____ / _____ / _____	Sex: ☐ M / ☐ F	Ethnicity:	☐ Hispanic or Latin ☐ Not Hispanic or Unknown
Primary Care Provider (PCP):		Race:	☐ African American ☐ Asian ☐ Hispanic ☐ Native Alaskan/Indian ☐ Native Hawaiian ☐ White ☐ Other
Primary Language:	Birth Order(1st, 2nd child):		
Primary Pharmacy (include location):		School Name:	Grade:

Are you transferring to ACP from another Provider? ☐No ☐ Yes – Clinic Name: ____

How did you find out about ACP? ☐ friend or referral - please list: ____
☐ internet search ☐ advertisement ☐ insurance company ☐ yellow pages

Responsible Party Information

* please note that text and email is not a secure communication method*

First Name:	Middle:	Last:	Suffix:
Address:	City:	State:	Zip:
Date of Birth: _____ / _____ / _____	Sex: M / F	Relationship to Patient:	
Mobile Phone:	Home Phone:	Work Phone:	
Email:	Employer:		

Primary Phone: ☐ mobile ☐ home Health Reminders (annual exams, immunizations, etc): ☐ text ☐ email ☐ phone call

Additional Parent / Guardian Information

First Name:	Middle:	Last:	Suffix:
Address:	City:	State:	Zip:
Date of Birth: _____ / _____ / _____	Sex: M / F	Relationship to Patient:	
Primary Phone:	Work Phone:		
Email:	Employer:		

Primary Insurance (Please provide your ID card)

Insurance Company:	Subscriber ID:	Group ID:
Insured/Relation to Patient:	Date of Birth: _____ / _____ / _____	

Secondary Insurance (Please provide your ID card)

Insurance Company:	Subscriber ID:	Group ID:
Insured/Relation to Patient:	Date of Birth: _____ / _____ / _____	

Alaska Center for Pediatrics
BIRTH THROUGH ADOLESCENT CARE

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Emergency Contact Info

If I am unable to attend my child's appointment, the following adults may attend in my stead, sign for medical care and make medical decisions for my child. I understand that when I designate another person to authorize treatment decisions for my child, ACP may offer protected health information relative to that decision to the designated person.

Name:	Phone:	Relationship to Patient:
Name:	Phone:	Relationship to Patient:

ACP Policy Acknowledgement

***Families that are separated, divorced or unmarried-we do not allow more than one responsible party. Parents/Guardians are expected to make arrangements between themselves if they plan to split the charges for the patients' medical care. (e.g. we cannot collect half of the current charges and bill the remainder to the other parent/guardian)**

I understand that the primary guarantor listed is financially responsible for all charges regardless of who holds the insurance policy (deductibles, co-payment and/or co-insurance amounts at the time of service), whether or not paid by insurance, and for all services rendered on my behalf or my dependents. After the current balance has been paid by insurance claim(s), it is the policy holder's responsibility to submit to any secondary or tertiary insurance companies on a zero balance.

***HIPAA Privacy Rule (Consent, Information Disclosures and Authorization)**

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used only with patient consent. I hereby authorize Alaska Center for Pediatrics, P.C. to furnish information to other providers, healthcare or treatment facilities. I understand that the information to be released MAY include material that is protected by Federal Law. My initials below authorize release of the following type of information. However, if you elect not to provide consent, please mark N/A (not applicable).

Drug/Alcohol abuse _____ (Initials)   Mental Health _____ (Initials)   HIV/AIDS ____ (Initials)

***Prescription History Consent**

For safe, effective medication prescribing, our Electronic Health Record enables us to identify all of your current medications electronically. Please indicate your consent for our practice to obtain external prescription information from pharmacies.

YES _____ (Initials)   NO _____ (Initials)

***Custody Arrangements**

☐ **Check this box if you have <u>court ordered</u> custody arrangements.**
(if you checked this box - initial to the right)

Court ordered custody arrangements must be presented as applicable. Failure to supply these documents may leave you and your child unprotected in custody matters. Only completed and finalized documents will be accepted. **<u>Changes must be updated with ACP as they occur</u>**.

Court Ordered Documents Provided? YES _____ (Initials)   NO _____ (Initials)

***Receipt of Privacy Practices and Financial Policy Written Acknowledgement**

I, ______________________________________ have reviewed and been offered copies of Alaska Center for Pediatrics Notice of Privacy Practices and Financial Policy on behalf of my child listed above.

***Check-in Policies** - in our effort to provide excellent care and service to our patients, we request that you observe the following policies:

- Patient contact information and identification (when appropriate) will be verified at each visit
- Insurance information will be verified and if a copy of the card is not on file, one will be obtained
- No cell phone use in exam rooms
- All patients are expected to check out with the front desk after each visit
- Co-payments and co-insurances or applicable deductible amounts are due at the time of service
- If you have a school physical form completed, please give it to the front desk to stamp/scan into your child's records
- Unless otherwise specified all messages left on primary phone may include health information

As the responsible party for this patient, I have read and understand all of the office policies listed above and agree to their terms.

***Signature ____Date: __________________________**

ACP staff initials:	Date:	ACP staff initials:	Date:

Revised: 4/10/17