ANCHORAGE NEIGHBORHOOD HEALTH CENTER

Welcome to the Anchorage Neighborhood Health Center

New Patient Packet - Medical and Dental

You need to fill out this new patient packet and return it to ANHC before we can schedule an appointment.

You can return your completed paperwork any of the following ways:

- **In person** at any ANHC front desk
- **Mail to:**
  Anchorage Neighborhood Health Center
  Attn: Patient Services
  4951 Business Park Blvd
  Anchorage, AK 99503
- **Fax to:**
  Main: 907-743-7255
  Dental: 907-743-7248
- **Online:**
  Upload at www.anhc.org. Click on "Patients" tab, then click "Submit Forms".

Submit proof of income with your packet for the sliding fee discount program.

When we have received your completed paperwork, we will call you to schedule an appointment.

If you have any questions please call us at **743-7200**.

Visit our website at **www.anhc.org.**

This health center is a Health Center Program grantee under 42 U.S.C. 245b, and a deemed Public Health Service employee under 42 U.S.C. 233(g)-(n).

Integrated care at ANHC

The Anchorage Neighborhood Health Center (ANHC) is a Patient-Centered Medical Home (PCMH), certified by The National Committee for Quality Assurance (NCQA). The patient-centered medical home is a model of care focused on patient needs, with a primary care provider coordinating medical treatment.

Patients can get high-quality, evidence-based medical and dental care for their entire family at ANHC. Care coordinators work with the patient and provider to help manage referrals. Other team members may include a nurse case manager, dietitian, behavioral health provider, pharmacist, and members of specialty disciplines including obstetrics, psychiatry, HIV/AIDS, substance use disorder, nephrology, and cardiology.

ANHC has an on-call provider available to provide urgent support 24 hours a day, 7 days a week, including weekends and holidays.

Additional information about services is available by calling the main line at 907-743-7200. Information about the organization and services is also on our website at www.anhc.org.

ANCHORAGE NEIGHBORHOOD HEALTH CENTER

4951 Business Park Blvd
Anchorage, AK 99503
907-743-7200 | anhc.org

Which type of appointment do you need? ☐ Medical ☐ Dental

Do you prefer a male or female medical provider? ☐ Male ☐ Female ☐ No preference

New Patient Registration

Social Security Number		Date of Birth	Sex

First Name	Middle	Last Name	Suffix

Preferred name if different	We have free interpreter services. What language do you need at your appointments?

Gender Identity	Sexual Orientation	Marital Status	Employment Status
☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer ☐ Other ☐ Decline	☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other ☐ Don't know ☐ Decline	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other	☐ Employed Employer Name: ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Part-time Student ☐ Full-time Student
Race ☐ Caucasian/White ☐ Asian ☐ African American/Black ☐ Pacific Islander ☐ Native Hawaiian	☐ Alaska Native ☐ American Indian ☐ Two or more races ☐ Other race: ☐ Decline	Ethnicity ☐ Latino/Hispanic ☐ Not Latino/Hispanic ☐ Decline	

We are required to ask the questions above. If you do not want to answer a question, check "decline".

Mailing Address Street	City	State/Zip

Email	Cell Phone Number	Other Phone Number

How did you hear about us?

☐ Friend/Family ☐ Website/Facebook ☐ Referral from another provider: _____

☐ TV/Radio/Newspaper ☐ Outreach/Community event ☐ Other: _____

Household information

Number of people in your household	Yearly household income $

Housing Status	Worker Status
☐ Not Homeless/Stable ☐ Homeless Shelter ☐ Street/Car/Camper ☐ Doubling Up/Couch Surfing ☐ Transitional/Halfway House	☐ Seasonal ☐ Migrant ☐ Not Seasonal/Migrant

Veteran	Disabled	Public Housing	
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	*Please turn page*

Guarantor Information (Person paying for account charges; fill out if person paying for care is not the patient)					
Social Security Number	Date of Birth		Primary Language		
Legal First Name	Middle Name	Last Name		Suffix	
Mailing Address Street	Apt/Spc #	City	State	Zip	Country
Email Address	Cell Phone Number	Other Phone Number			
Patient's Relationship to Guarantor ☐ Wife ☐ Husband ☐ Life Partner ☐ Parent ☐ Grandparent ☐ Other:					

Primary Insurance Information		
Subscriber Name (Name on Insurance Card)	Subscriber SSN	Subscriber Date of Birth
Plan Carrier (Insurance Company)	Subscriber ID Number	Group Number
Claims Address	Claims City/State	Claims Zip Code

Secondary Insurance Information		
Subscriber Name (Name on Insurance Card)	Subscriber SSN	Subscriber Date of Birth
Plan Carrier (Insurance Company)	Subscriber ID Number	Group Number
Claims Address	Claims City/State	Claims Zip Code

Emergency Contact			
Legal First Name	Middle Name	Last Name	Suffix
Relationship to Patient ☐ Wife ☐ Husband ☐ Life Partner ☐ Parent ☐ Grandparent ☐ Other:			
Cell Phone Number	Other Phone Number		

Additional Parent/Guardian (Optional)			
Legal First Name	Middle Name	Last Name	Suffix
Relationship to Patient ☐ Parent ☐ Grandparent ☐ Other:			
Cell Phone Number	Other Phone Number		

CONSENT FOR TREATMENT AND BILLING PRACTICES

Please initial each section, and sign on next page.

Informed Consent for Treatment

I consent (agree) to health care including routine diagnostic procedures, medical and dental treatment, and other health services provided by the Anchorage Neighborhood Health Center (ANHC) and its authorized personnel and agents.

I understand that:

- The practice of medicine, dentistry, and surgery are not exact sciences, and that diagnosis and treatment involve risks of injury and sometimes death. I acknowledge that there are no guarantees about the results of the examinations, treatments, or other health services provided by ANHC.
- Except in emergency or extraordinary circumstances, no substantial procedures are performed upon a patient unless, and until, he/she has had an opportunity to discuss them with a physician, dentist, or other health professional to the patient's satisfaction.
- Each patient has the right to consent or refuse to any proposed procedure or treatment plan.
- No patient will be involved in any research or experimental procedure without his/her full knowledge and consent.

_____ Patient Initials

Notice of Privacy Practices

I acknowledge and agree that I have reviewed a copy of ANHC's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of the notice at any time.

_____ Patient Initials

Statement for Release of Information for Audit Purposes

The process of checking business records and policies is called an audit. Auditors are officials that check patient financial applications to make sure ANHC is following grant rules. Auditors will only use your information to check that ANHC is processing applications and payments correctly.

- I consent to the release of any of my financial records that may be considered necessary for review by any auditor for any assistance program that I am eligible for, or participating in.
- Audited programs may include but are not limited to sliding fee scale, grant-funded programs, and pharmacy assistance programs.
- Financial records that may be deemed necessary for review include, but are not limited to: sliding fee scale application and supporting documents, patient information, insurance information, and any other types of information contained within my electronic health and/or dental records.

_____ Patient Initials

Continue on next page

Release, Assignment, and Statement of Responsibility

I authorize (give permission for) the release of any information necessary to process my insurance claims and assign and request payment directly to the Anchorage Neighborhood Health Center, Inc. (ANHC).
I understand that I may revoke (withdraw) this consent at any time in writing to this office.

I understand that:

- I am responsible for payment for all services and products provided to me, or any patient for which I am the guarantor of payment.
- I agree, whether I sign as legal guardian, guarantor, or patient, to pay that account in accordance with the regular rates and terms of ANHC.
- If the account is referred to an attorney or collection agency for collection, I will pay actual attorney's fees and the collection expense. If your account is 30 days past due, you may be charged interest at the legal rate.

_____ Patient Initials

Patient Notice of Billing Practice and Office Policy

Payment for services provided by ANHC is due at the time of service. We accept: cash, Visa, MasterCard, Discover Credit Cards, debit cards, and personal checks. Payment plan options are reviewed individually.

Health Insurance: If you have health insurance, we will send the bill to your insurance company for you.

- If you are not sure if your provider is in-network or preferred with your insurance plan, please ask us before your appointment.
- We expect you to pay at the time of service for any estimated patient responsibility portion, including co-pays, deductibles, coinsurance, and/or charges for non-covered services.
- We allow a 90-day grace period for your insurance to respond to our claims. If the insurance company does not respond to our claims within 90 days, you will be responsible for paying the full balance.

Sliding Fee Discount Program: ANHC is a non-profit community health center. We have a sliding fee discount for patients whose household income is below 200% of Alaska's Federal Poverty Level. This discount is available to qualified uninsured and under-insured patients.

- The Sliding Fee Discount can be used for co-pays, deductibles, and coinsurance.
- If your income or household size changes, you must update your sliding fee application.
- You must update your application at least every 12 months to qualify for the sliding fee scale discount.

_____ Patient Initials

I have read the statements above. I understand my rights as a patient and financial responsibility to the Anchorage Neighborhood Health Center. If I have additional questions, I will speak to a staff member before my appointment.

Signature: _____ Date: _____

ANCHORAGE NEIGHBORHOOD HEALTH CENTER

4951 Business Park Blvd
Anchorage AK 99503
907-743-7200 | anhc.org

APPOINTMENT POLICIES

If you need to cancel or reschedule your appointment, please call before 5pm the day before your appointment. If you cancel the same day of your appointment, it will be considered a "no show".

If you arrive later than your check in time, you are considered late, and we may reschedule your appointment. If you arrive 10 minutes late it will be considered a "no show" for the appointment.

If you have 3 "no-shows" (late cancellations, late arrivals, and/or missed appointments) in 1 year, you may be unable to schedule appointments for up to 12 months. You will only be able to see a provider in our "Alternate Access Clinic", and may have a long wait time.

Medical Appointments: 743-7201
Dental Appointments: 743-7202

If you have questions about scheduling appointments, please call us.

I have read and understand ANHC's appointment policies as described above.

Signature:_____ **Date:**_____

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ANCHORAGE NEIGHBORHOOD HEALTH CENTER

MEDICAL HEALTH HISTORY

Name: _____ DOB: ____/____/_____ Today's Date: ____/____/_____

Reason for visit: _____

Previous Medical Provider(s): _____ Date of last physical: ____/____/_____

Please check if you have ever had any of the following:

☐ Measles	☐ Hemorrhoids	☐ Osteoporosis	☐ High/Low Blood Pressure
☐ Mumps	☐ IBS / Diverticulitis	☐ Hives	☐ Anemia
☐ Chicken Pox	☐ Crohn's Disease	☐ Eczema	☐ Blood/Plasma Transfusion
☐ Diphtheria	☐ Ulcer	☐ Bladder Infections	☐ Bruising
☐ Smallpox	☐ Glaucoma	☐ Kidney Disease	☐ Infectious Mono
☐ Polio	☐ Epilepsy	☐ Thyroid Disease	☐ Epstein Barr Virus
☐ Rheumatic Fever	☐ Diabetes	☐ Hernia	☐ HIV / AIDS
☐ Whooping Cough	☐ Cancer	☐ Back Trouble	☐ STD
☐ Tuberculosis	☐ Stroke	☐ Migraine Headache	☐ Hepatitis ☐A ☐B ☐C
☐ Pneumonia	☐ Heart Disease	☐ Head Injury	☐ Other Disease (List):
☐ Bronchitis	☐ Mitral Valve Prolapse	☐ Chronic Fatigue	
☐ Asthma	☐ Arthritis	☐ Fibromyalgia	
☐ Respiratory Disease			

Previous Hospitalizations, Surgeries, Serious Illnesses, or Traumatic Events	Date

Lifestyle Questions

Substance	Currently use?	Previously used?	Type(s)	Amount
Caffeine	☐ Yes ☐ No	☐ Yes ☐ No	☐ Coffee ☐ Soda ☐ Energy Drink	_____ drinks per day
Tobacco	☐ Yes ☐ No	☐ Yes ☐ No	☐ Cigarettes ☐ Chew ☐ Vape	_____ packs per day
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No	☐ Beer ☐ Wine ☐ Liquor	_____ drinks per week
Recreational/ Street Drugs	☐ Yes ☐ No	☐ Yes ☐ No	_____	_____

What is your occupation? (janitor, teacher, taxi driver, etc) _____

How many hours per day do you use TV, computers, and smartphones? _____ hours per day

Do you exercise? ☐ Yes ☐ No
If yes, what kind of exercise? _____ How often? _____

Relationship/Marital Status: ☐ Single ☐ Married ☐ Living w/partner ☐ Separated/Divorced ☐ Widowed

Are you sexually active? ☐ Yes ☐ No

Family Medical History	Relationship to you				
☐ Diabetes	☐ Grandparent	☐ Father	☐ Mother	☐ Sibling	☐ Child
☐ Cancer	☐ Grandparent	☐ Father	☐ Mother	☐ Sibling	☐ Child
☐ Heart Disease	☐ Grandparent	☐ Father	☐ Mother	☐ Sibling	☐ Child
☐ High Blood Pressure	☐ Grandparent	☐ Father	☐ Mother	☐ Sibling	☐ Child
☐ Death Before Age 50	☐ Grandparent	☐ Father	☐ Mother	☐ Sibling	☐ Child
☐ Depression	☐ Grandparent	☐ Father	☐ Mother	☐ Sibling	☐ Child

Name: _____ DOB: ____/____/_____ Today's Date: ____/____/_____

Current Medications (Including inhalers, herbs, supplements, and over-the-counter)

Medication Name	Dose (mg, ml)	Frequency (how often?)

Allergies (medicine, food, environmental)

☐ No known allergies

Recent Medical Symptoms

General Symptoms
- ☐ No problems with weight change/fever/fatigue
- ☐ Recent weight change:
- ☐ Fever
- ☐ Fatigue/Poor Energy

Eyes
- ☐ No problems with eyes
- ☐ Eye disease or injury
- ☐ Wear glasses
- ☐ Wear contact lenses
- ☐ Blurred vision

Ear/Nose/Throat/Mouth
- ☐ No problems with ear/nose/throat/mouth
- ☐ Hearing Loss
- ☐ Ear pain
- ☐ Sinus pressure
- ☐ Bleeding gums
- ☐ Snoring

Lungs/Breathing
- ☐ No problems with lungs/breathing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing/asthma
- ☐ Coughing up blood

Heart/Circulation
- ☐ No problems with heart
- ☐ Chest pain or discomfort
- ☐ Shortness of breath
- ☐ Wheezing/asthma
- ☐ Swelling in ankles
- ☐ Light headed/fainting
- ☐ Racing heartbeat (palpitations)

Stomach/Digestion
- ☐ No problems with stomach/digestion
- ☐ Colorectal cancer screening date: _____
- ☐ Nausea or vomiting
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Loose stool or diarrhea
- ☐ Red blood in bowel movement

Bones/Muscles/Joints
- ☐ No problems with bones/muscles/joints
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Difficulty walking
- ☐ Osteoporosis bone scan date: _____

Brain/Emotions/Nerves
- ☐ No problems with brain/emotions/nerves
- ☐ Headaches
- ☐ Tremors
- ☐ Numbness or tingling
- ☐ Depression
- ☐ Anxiety/nervousness
- ☐ Abuse/neglect
- ☐ Having trouble sleeping
- ☐ Loss of balance
- ☐ Memory loss

Urine/Sexual
- ☐ No problems with urine/sex
- ☐ Pain during urination
- ☐ Blood in urine
- ☐ Change in urine
- ☐ Urinary loss of control
- ☐ Sexual difficulty

Male
- ☐ No problems with testicles
- ☐ Testicle pain

Female
- ☐ No problems with vaginal discharge/itching
- ☐ Vaginal discharge or itching

Last menstrual period date: _____

Periods are:
- ☐ Regular
- ☐ Irregular
- ☐ Menopausal

Length of Menses: _____# of days

Monthly Cycle: _____ # of days

Number of pregnancies: _____

Number of live births: _____

Date of last pap smear: _____

Date of last mammogram: _____

Skin/Breast/Immune System
- ☐ No problems with skin/breast/immune system
- ☐ Itching skin rash or sores
- ☐ Change in mole
- ☐ Breast Pain
- ☐ Breast discharge
- ☐ Breast lump

ANCHORAGE NEIGHBORHOOD HEALTH CENTER

DENTAL HEALTH HISTORY

Name: _____ DOB: ____/____/_____ Today's Date: ____/____/_____

Please check yes or no:	
☐Yes ☐No	Is your general health good?
☐Yes ☐No	Did your health change in the last year? If yes, what changed:
☐Yes ☐No	Have you taken blood thinners in the last 30 days? (Aspirin, Warfarin, Dabigatran/Pradaxa, Rivaroxaban/Xarelto, Apixaban/Eliquis, etc)
☐Yes ☐No	Have you taken bisphosphonates in the last 5 years? (Fosamax, Actonel, Boniva, Didronel, Reclast/Zometa, etc)
☐Yes ☐No	Are you allergic to: ☐ Penicillin, ☐ Latex, or ☐ Other medications:
☐Yes ☐No	Did you have a serious illness/hospitalization in the last 3 years? If yes, why:
☐Yes ☐No	Do you currently have dental pain? If yes, how long:
Female questions:	
☐Yes ☐No	Are you currently pregnant or nursing?
☐Yes ☐No	Are you currently taking birth control pills?

Current/recent symptoms:

☐ Weight loss/fever/night sweats	☐ Blurred vision	☐ Swollen ankles
☐ Bleeding problems, bruising easily	☐ Diarrhea, constipation, blood in stool	☐ Shortness of breath
☐ Ringing in ears	☐ Frequent vomiting, nausea	☐ Persistent cough, coughing up blood
☐ Headaches	☐ Frequent urination, difficult urination, blood in urine	☐ Difficulty swallowing
☐ Sinus problems	☐ Jaundice	☐ Dry mouth
☐ Fainting spells/Dizziness		☐ Excessive thirst

Health History (please check if you have ever had any of the following):

☐ Heart disease	☐ Artificial/replaced joint, date:	☐ Hepatitis ☐A ☐B ☐C
☐ Heart defect/murmurs	☐ Tumors, cancer, date:	☐ Other liver disease
☐ Rheumatic fever/heart disease	☐ Radiation treatment, date:	☐ HIV/AIDS
☐ Stroke/hardening of arteries, date:	☐ Chemotherapy, date:	☐ STD (syphilis, gonorrhea, herpes)
☐ Prosthetic heart valve, date:	☐ Seizures, date:	☐ Kidney or bladder disease
☐ Pacemaker	☐ Skin disease	☐ Thyroid or adrenal disease
☐ Blood Transfusion	☐ Diabetes	☐ Stomach problems, ulcers
☐ High blood pressure	☐ Anemia	☐ Asthma, TB, emphysema, lung disease
☐ Chest pain or angina	☐ Arthritis, rheumatism	

☐Yes ☐No	Do you have any disease or medical problem that is not listed on this form? If yes, what:
☐Yes ☐No	Are you currently being treated by a behavioral health provider? (depression, anxiety, PTSD, drug abuse)
☐Yes ☐No	Are you currently being treated by a medical provider?
☐Yes ☐No	Have you ever had problems with dental treatment? Date of your last dental exam: _____

Are you currently using: ☐Recreational/street drugs ☐Tobacco ☐Alcohol ☐None

Current Medications (Including inhalers, herbs, supplements, and over-the-counter):

_____

_____

Date of your last medical exam: _____ Name of provider: _____

I have answered each question completely and accurately. I will tell my dentist if my health or medications change.

Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

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ANCHORAGE NEIGHBORHOOD HEALTH CENTER

BILLING PRACTICES & PAYMENT EXPECTATIONS

HEALTH INSURANCE

We accept all health insurance plans, including private insurance, Tri-Care, Medicare, and Medicaid. If you have insurance, we expect you to pay your patient responsibility (co- payment, co-insurance and/or deductible) at the time of service. **It is your responsibility to check if a provider is preferred or in-network for your health insurance plan.**

If you do not have health insurance, we expect you to pay the total estimated amount due, after discounts, at the time of service. We can help you apply for health insurance programs on the 3rd floor.

WHEN DO I PAY?

We expect you to pay at check-out based on the charges for your visit.
Supplies that are not normally included in an office visit will be charged in addition to the office visit fee. Examples of supplies with an additional cost include splints, birth control devices, or injected medications.
Our staff will try to provide an estimate of charges by the time you check-out. We may send you a bill for additional services, such as labs or x-ray.

If we mail you a bill, we expect you to pay the total amount due when you receive it. If you cannot pay your bill in full, contact us as soon as possible to discuss your payment options.
If your bill is returned because of an incorrect address, we will make one attempt to contact you by phone. If you do not respond, we may send your bill to a collections agency.

If we over-collected on the date of service, and there are no other outstanding charges on your account, we will send you a refund. You can expect to receive this refund within 90 days.

ANHC is a non-profit 501(c)(3) organization that receives limited funding under section 330 of the Public Health Service Act (42 U.S.C. §254b). This allows us to discount our normal and customary charges for those that qualify. Please refer to our Sliding Scale Discount instructions for more details on how to qualify.

ANCHORAGE NEIGHBORHOOD HEALTH CENTER

BILLING PRACTICES & PAYMENT EXPECTATIONS

WHAT IF I HAVE NOT PAID MY BILL, BUT I NEED AN APPOINTMENT?

If you have an existing account balance, and you have not made a payment plan with the Financial Office, the Front Desk Staff will need to collect the entire account balance before you see your provider. If you are unable to pay the total account balance, but you can pay the estimated charge for your current visit, you will be seen by a provider. You will be asked to pay for the current visit at check-out. The front desk staff will ask you to meet with the financial representative on the 3rd floor to make a payment plan.

If you cannot make any payment on your account balance or the current visit, you may be triaged by a nurse and may be rescheduled. We do not refuse service solely based on your ability to pay.

WHY DO I HAVE A BALANCE ON MY ACCOUNT IF I PAID AT THE TIME OF VISIT?

Additional charges may be billed from labs or x-rays that were related to your visit. Sometimes a provider cannot finish all of the paperwork at the time of your visit, and may complete it later in the day. This may include updating the billing codes that describe the type of office visit. Billing codes for office visits vary depending on the complexity of your visit. If your insurance plan does not pay for your visit, you will receive a bill for the amount you are responsible for paying.

WHO DO I CALL FOR BILLING HELP?

Questions about your bill: 907-743-7301
Payment plans: 907-743-7338
Help with health insurance: 907-743-7220
Update address or phone number: 907-743-7201

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ANCHORAGE NEIGHBORHOOD HEALTH CENTER

PRÁCTICAS DE FACTURACIÓN Y EXPECTATIVAS DE PAGO

SEGURO MÉDICO

Aceptamos todos los planes de seguros médicos, inclusive seguros privados, Tri-Care, Medicare y Medicaid. Si usted cuenta con un seguro médico, esperamos que pague lo que le corresponde como paciente (copagos, coseguros o deducibles) al momento de la prestación del servicio. **Es su responsabilidad comprobar si un proveedor es preferido o si se encuentra dentro de la red de su plan de seguro médico.**

Si no cuenta con un seguro médico, esperamos que pague el importe estimado total adeudado, menos descuentos, al momento de la prestación del servicio. Podemos ayudarlo a inscribirse en programas de seguros médicos en el piso 3.

¿CUÁNDO DEBO PAGAR?

Esperamos que pague los costos de su visita al retirarse.

Los suministros que normalmente no están incluidos en una visita medica se cobrarán además del costo de la visita al consultorio. Los ejemplos de suministros con un costo adicional pueden ser férulas, dispositivos de control de la natalidad ó medicamentos inyectados.

Nuestro personal tratará de proporcionar los costos estimados para el momento en que usted se retira. Es posible que le enviemos una factura por servicios adicionales, como análisis de laboratorio o radiografías. Si esto sucede, esperamos que pague el importe total adeudado cuando la reciba. Si no puede pagar la totalidad del importe, comuníquese con nosotros lo antes posible para evaluar sus opciones de pago.

Si su factura es devuelta porque la dirección es incorrecta, intentaremos comunicarnos con usted por teléfono una vez. Si no responde, es posible que le enviemos su factura a una agencia de cobros.

Si le cobramos de más el día de la prestación del servicio y no quedan saldos pendientes de pago en su cuenta, le enviaremos un reembolso. Lo recibirá dentro de los 90 días.

ANHC es una organización sin fines de lucro, conforme a la sección 501(c)(3), que recibe financiamiento limitado de conformidad con la sección 330 de la Public Health Service Act (Ley de Servicios de Salud Pública) (42 U.S.C. §254b). Esto nos permite reducir nuestras tarifas usuales para las personas elegibles. Consulte las instrucciones Sliding Scale Discount (Descuentos de escala móvil) para obtener más información acerca de cómo calificar.

ANCHORAGE NEIGHBORHOOD HEALTH CENTER

PRÁCTICAS DE FACTURACIÓN Y EXPECTATIVAS DE PAGO

¿QUÉ SUCEDE SI NO ABONÉ MI FACTURA, PERO NECESITO UNA CONSULTA?

Si su cuenta tiene un saldo adeudado y usted no ha hecho un plan de pago con el Departamento de Finanzas, el personal de la recepción deberá cobrar el saldo pendiente total antes de que usted tenga una consulta con su proveedor. Si no puede pagar el saldo total adeudado, pero sí puede pagar el costo estimado de la visita actual, tendrá la consulta con el proveedor. Se le solicitará que abone la visita actual al momento de retirarse. El personal de la recepción le solicitará una reunión con el representante financiero en el piso 3 para hacer un plan de pago mensual.

Si no puede pagar el saldo adeudado de su cuenta ni la visita actual, es posible que sea atendido por un enfermero y que se reprograme su consulta. No nos negamos a brindarle el servicio basándonos únicamente en su capacidad de pago.

¿POR QUÉ MI CUENTA TIENE UN SALDO ADEUDADO SI PAGUÉ AL MOMENTO DE MI VISITA?

Es posible que se facturen costos adicionales por análisis de laboratorio o radiografías en relación con su visita. A veces, el proveedor no puede terminar toda la documentación al momento de su visita y quizás la completa más tarde, ese día. Esto puede incluir la actualización de los códigos de facturación que describen los tipos de visitas al consultorio. Los códigos de facturación de las visitas al consultorio varían según la complejidad de su visita. Si su plan de seguro no cubre su visita, recibirá una factura por el importe que usted deba pagar.

¿CON QUIÉN ME COMUNICO PARA SOLICITAR ASISTENCIA EN RELACIÓN CON LA FACTURACIÓN?

Preguntas acerca de su facturación: 907-743-7301

Asistencia en relación con seguros médicos: 907-743-7220

Planes de pago: 907-743-7338

Actualización de dirección o número de teléfono: 907-743-7201

ANHC es una organización sin fines de lucro, conforme a la sección 501(c)(3), que recibe financiamiento limitado de conformidad con la sección 330 de la Public Health Service Act (Ley de Servicios de Salud Pública) (42 U.S.C. §254b). Esto nos permite reducir nuestras tarifas usuales para las personas elegibles. Consulte las instrucciones Sliding Scale Discount (Descuentos de escala móvil) para obtener más información acerca de cómo calificar.

ANCHORAGE NEIGHBORHOOD HEALTH CENTER

4951 Business Park Blvd
Anchorage AK 99503
907-743-7200 | anhc.org

SLIDING FEE DISCOUNT PROGRAM

You may qualify for a discount on our normal charges.

The discount is based on:

1. Income in your household, and
2. The number of people who live in your household

You must provide proof of income to be eligible for a discount.
Please read ANHC's definitions for income and household size on the next page.

If the income or number of people in your household change, you must update your information for the sliding fee discount. You must update your Information every 12 months to remain eligible for a discount, even if your information has not changed.

If you provide false information, you will not be eligible for the sliding fee discount program.

The Sliding Scale Application is subject to independent verification by the ANHC Finance Office, which may result in a determination that is different than the one provided on the current date.

If you do not have proof of income for everyone in your household at the time of your visit, we will ask you to complete a Temporary Self-Declaration of Income. This temporary discount status is valid for 30 days. You must bring proof of household income within 30 days for a discount to be valid for a full year. You can only use the Temporary Self-Declaration once in a year.

What counts as income?

Income is the gross income of all household members.
Income includes, but is not limited to: salary, wages, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trust fund income, alimony, Alaska Permanent Fund Dividend, assistance from friends or family members, and other miscellaneous sources.

Proof of income

- Pay check stubs for one month.
- Agency Letter -- A letter from the Social Security Administration, Medicaid, Social Service Agency (i.e. Food Stamps, Alaska Housing), or Veterans Administration stating income level.
- Unemployment Verification -- Paperwork proving unemployment status and the amount of unemployment compensation.
- Court Documents -- Official documents stating alimony amount as awarded by a judge.
- Official Paperwork – Paperwork documenting retirement, disability, SSI benefits.
- Employer Letter -- For those who do not have a recent pay check stub, a letter from the employer detailing current gross income and frequency of pay periods may be accepted. Contact information must be provided so information can be verified.
- Income Tax Return -- A signed copy of the most recent tax return showing Adjusted Gross Income and supporting schedules for business income and/or investments.
- If you are Unemployed, and/or do not have any source of verifiable income, please complete the "Self-Declaration of Income" and explain your current situation.

Who counts as part of my household?

Household members include but are not limited to the following definitions:

- All members of a household who are related and/or sharing resources are counted as one household.
  - Adult children living in parents' household are counted as one household if they are less than 19 years old, or 19 and older but still claimed as a dependent on their parents' tax return.
  - Adult children 19 and older who are not claimed as a dependent on the parents' tax return are considered a separated household.
- Unrelated members of a household who support each other financially, or share resources are considered one household (i.e. living as married/cohabitation).
- Family members living in the same household on a ***temporary*** basis due to a hardship and are receiving room and board are considered a separate household.
- Unrelated members of a household who do not share income are considered separate households.

If the income or number of people in your household change, you must update your information for the sliding fee discount. You must update your Information every 12 months to remain eligible for a discount, even if your information has not changed.

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PROGRAMA DE DESCUENTOS DE ESCALA MÓVIL DE HONORARIOS (SLIDING FEE DISCOUNT PROGRAM)

Es posible que usted sea elegible para recibir un descuento en nuestras tarifas normales.

El descuento se basa en lo siguiente:

1. los ingresos de su grupo familiar; y
2. la cantidad de personas que integran su grupo familiar.

Debe proporcionar pruebas de sus ingresos a fin de ser elegible para recibir un descuento.
Lea las definiciones del ANHC de "ingresos" y "tamaño del grupo familiar" en la siguiente página.

Si cambian sus ingresos o la cantidad de personas de su grupo familiar, debe actualizar la información del descuento de escala móvil de honorarios. Debe actualizar su información cada 12 meses para seguir siendo elegible para recibir un descuento, incluso si su información no se ha modificado.

Si proporciona información falsa, no será elegible para el programa de descuentos de escala móvil de honorarios.

La Solicitud de escala móvil está sujeta a la verificación independiente del Departamento de Finanzas del ANHC, cuya determinación puede diferir de lo indicado hasta la fecha.

Si usted no cuenta con pruebas de ingresos para todos los miembros de su grupo familiar al momento de su visita, le solicitaremos que complete una Autodeclaración temporal de ingresos. Este descuento temporal es válido por 30 días. Debe proporcionar pruebas de los ingresos del grupo familiar dentro de los 30 días para que el descuento sea válido por un año completo. Solo puede utilizar la Autodeclaración temporal una vez al año.

¿Qué se consideran ingresos?

"Ingresos" son los ingresos brutos de todos los miembros del grupo familiar.
Los ingresos incluyen, entre otros, los siguientes: sueldos, salarios, compensación por desempleo, compensación para los trabajadores, Social Security (Seguridad Social), Supplemental Security Income (Seguridad de Ingreso Suplementario o SSI, por sus siglas en inglés), asistencia pública, beneficios para veteranos y familiares sobrevivientes, pensiones y jubilaciones, intereses, dividendos, alquileres, regalías, ingresos de patrimonios, ingresos de fondos fiduciarios, pensiones alimenticias, dividendos del Alaska Permanent Fund Dividend (Fondo Permanente de Alaska), asistencia de amigos o familiares, y otras fuentes varias.

Pruebas de ingresos

- Recibos de sueldo por un mes.
- Carta de la agencia: una carta de la Social Security Administration (Administración del Seguro Social), de Medicaid, de la Social Service Agency (Agencia del Seguro Social) (por ejemplo: Food Stamps [Cupones de Alimentos], Alaska Housing [Vivienda de Alaska]), o de la Veterans Administration (Administración de Veteranos) que indique el nivel de ingresos.
- Verificación de desempleo: documentación que indique el estado de desempleado y el monto de la compensación por desempleo que recibe.
- Documentos judiciales: documentos oficiales que indiquen el monto de la pensión alimenticia asignada por un juez.
- Documentación oficial: documentos que certifiquen los beneficios por jubilación, discapacidad o SSI.
- Carta del empleador: para aquellos que no cuenten con un recibo de sueldo reciente, es posible que se acepte una carta del empleador que indique los ingresos brutos actuales y la frecuencia de los períodos de pago. Se deben proporcionar datos de contacto para poder verificar la información.
- Declaración de impuestos sobre la renta: una copia firmada de la última declaración de impuestos sobre la renta que indique los ingresos brutos ajustados y los documentos de respaldo de los ingresos empresariales o de las inversiones.
- Si está desempleado o no tiene una fuente de ingresos verificable, complete la "Autodeclaración de ingresos" y explique su situación actual.

¿Quiénes están incluidos en mi grupo familiar?

Los miembros del grupo familiar incluyen, entre otros, los siguientes:

- Todos los miembros emparentados de una vivienda que comparten recursos se consideran un grupo familiar.
    - Los hijos adultos que viven con sus padres se consideran miembros del grupo familiar si tienen menos de 19 años, o si son mayores de 19 años pero aún figuran como dependientes en la declaración de impuestos de los padres.
    - Los hijos adultos de 19 años o más que no figuren como dependientes en la declaración de impuestos de los padres se consideran miembros de un grupo familiar independiente.
- Los miembros no emparentados de una vivienda que se brindan apoyo financiero entre sí o comparten recursos se consideran parte del mismo grupo familiar (por ejemplo: unión de hecho, convivencia conyugal).
- Los familiares que viven en la misma vivienda de forma **temporal** debido a una situación adversa y reciben alojamiento y comida son considerados miembros de un grupo familiar independiente.
- Los miembros no emparentados de una vivienda que no comparten ingresos son considerados miembros de grupos familiares independientes.

Si cambian sus ingresos o la cantidad de personas de su grupo familiar, debe actualizar la información del descuento de escala móvil de honorarios. Debe actualizar su información cada 12 meses para seguir siendo elegible para recibir un descuento, incluso si su información no se ha modificado.

ANCHORAGE NEIGHBORHOOD HEALTH CENTER

SLIDING FEE SCALE DISCOUNTS

Household Size	Federal Poverty Level				
	A ≤100%	B 101% - 133%	C 134% - 166%	D 167% - 200%	> 200%
1	$16,090	$16,091 - $21,400	$21,401 - $26,710	$26,711 - $32,180	$32,181
2	$21,770	$21,771 - $28,955	$28,956 - $36,139	$36,140 - $43,540	$43,541
3	$27,450	$27,451 - $36,509	$36,510 - $45,567	$45,568 - $54,900	$54,901
4	$33,130	$33,131 - $44,063	$44,064 - $54,996	$54,997 - $66,260	$66,261
Example of Charges					
Category	A (Nominal) ≤100%	B 101% - 133%	C 134% - 166%	D 167% - 200%	> 200%
Medical	$20	$30	$40	$50	No discount, charges depend on type of visit
Behavioral	$5	$10	$15	$20	
Nutrition	$5	$10	$15	$20	
Dental visit A	$40	$50	$70	$80	
Dental visit B	$85	$110	$140	$175	
Lab Visit	$15	$30	$45	$60	
X-ray Visit	$20	$40	$60	$80	

Updated 01/19/2021

Dental supplies and lab costs are charged in addition to the visit charge.

Examples of dental visits types:

Dental A: Exams, cleanings, extractions, and fillings

Dental B: Crowns, root canals, partials

Pharmacy discounts and charges will vary by medication, please see pharmacy staff for more information.

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ANCHORAGE NEIGHBORHOOD HEALTH CENTER

SLIDING FEE DISCOUNT APPLICATION

Applicant Information		Office Use Only	
Name:	Date of Birth:	Acct #:	PSR
Mailing Address:		Date Provided	
		Date Due Back	
Preferred Phone Number:	Alternate Phone Number:	Date Returned	

Household Member Name (First, Last)	Relationship (Spouse, Child)	Birth Date (MM/DD/YYYY)	Types of Income Received (Check all that apply. Include the PFD if it was garnished.)
	SELF		☐ Job ☐ PFD ☐ Self-Employment ☐ Social Security ☐ Pension/Retirement ☐ Adult Public Assistance ☐ Unemployment Benefits ☐ Other:
			☐ Job ☐ PFD ☐ Self-Employment ☐ Social Security ☐ Pension/Retirement ☐ Adult Public Assistance ☐ Unemployment Benefits ☐ Other:
			☐ Job ☐ PFD ☐ Self-Employment ☐ Social Security ☐ Pension/Retirement ☐ Adult Public Assistance ☐ Unemployment Benefits ☐ Other:
			☐ Job ☐ PFD ☐ Self-Employment ☐ Social Security ☐ Pension/Retirement ☐ Adult Public Assistance ☐ Unemployment Benefits ☐ Other:
			☐ Job ☐ PFD ☐ Self-Employment ☐ Social Security ☐ Pension/Retirement ☐ Adult Public Assistance ☐ Unemployment Benefits ☐ Other:
			☐ Job ☐ PFD ☐ Self-Employment ☐ Social Security ☐ Pension/Retirement ☐ Adult Public Assistance ☐ Unemployment Benefits ☐ Other:

Please Bring Proof Of Income With This Application Before Your Appointment

- ☐ Pay Stubs for 1 month
- ☐ Letter from Employer w/ average weekly hours and rate of pay
- ☐ Food Stamps Benefit Letter
- ☐ Alaska Housing Benefit Letter
- ☐ Unemployment Benefit Letter
- ☐ Retirement/Pension Statements
- ☐ Social Security/Disability/SSI Benefit Letter
- ☐ Adult Public Assistance Benefit Letter
- ☐ Rental Income
- ☐ Alimony
- ☐ Child Support
- ☐ Worker's Compensation
- ☐ Student Tuition Grant

I declare the above information and supporting documentation is true and correct to the best of my belief and knowledge. I understand it is my responsibility to inform ANHC of any changes to my income that may affect my eligibility for sliding fee discounts or for participation in discount drug programs. I understand that if I falsify any information to fraudulently receive services, including but not limited to medical, dental, lab, x-ray or prescription drug benefit programs, my participation will be revoked and I will be responsible for 100% of the usual and customary charges of ANHC.

Signature of Applicant ______________________ Date ______________

[Office Use Only] Date Scanned: ______________

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