Solstice Medicine and Wellness, LLC

Email: solsticemedi@alaska.net
475 Riverstone Way Suite 2
Fairbanks, AK 99709
Phone: (907) 456-6334
Fax: (907) 456-6336

Date: ________________

Name: ____ Date of Birth: ______________________

Phone Number: Home __________________ Cell __________________ Work _________________

Mailing Address: ____

City: ____________________________________ State: _________ Zip Code: ________________

Email: ____

Referral Source: ____

____

Payment Method: Cash Insurance If Insurance, What Type: _______________________ Primary reason

you want to be seen: ____

____

Who is your current medical provider? ____

If applicable, when were you last seen? ____

What were you seen for? ____
(***Please sign a medical records release so we can obtain your records***).

Authorization to Bill Insurance

SECTION 1: PATIENT INFORMATION

Last Name: ______________________________________ First Name: ________________________________

Middle Initial: ________

DOB: ___________________ SS#: ____________________________________ Daytime Phone: (_________)___________________

SECTION 2: INSURANCE INFORMATION

Please notify the front desk staff if your visit is related to an injury or accident

I. Does your insurance have alternative medicine benefits? Yes No

Who is your Primary Care Provider?: Dr. ____ Clinic Phone #: (____)_________
Clinic Address: ____________________________________ City:__________________ State: ______ Zip Code: _________
Does your plan require you to have a referral from you Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic?:____

Insurance Company & Plan Name: ____

ID Number: ________________________ Group/Policy Number: _________________________

Name of Policy Holder: ____ Policy Holder's Date of Birth: ___________________

Relationship to the policy holder: ___________________________________ Policy Holder's Gender (circle): Male Female

Secondary Insurance

Insurance Company & Plan Name: ____

ID Number: ________________________ Group/Policy Number: _________________________

Name of Policy Holder: ____ Policy Holder's Date of Birth: ___________________

Relationship to the policy holder: ___________________________________ Policy Holder's Gender (circle): Male Female

SECTION 3: GUARANTOR INFORMATION

Last Name: ________________________First Name: ______________________Middle Initial: ________

Address: ___________________________________ City: _______________ State: _______ Zip: ___________ Phone: (_______)____________

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below. X ____
_______________________ Guarantor's Signature Date

___ I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize **Solstice Medicine & Wellness, LLC** to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

Financial and Payment Policies

A clear understanding of **your financial responsibility** for the medical care and services provided to you is essential. **Please read this form carefully and have any questions answered prior to signing**.

Insurance coverage is a contract between YOU and YOUR INSURANCE COMPANY. Payment is not guaranteed and is based on your insurance contract. Please review your insurance policy or contact your insurance company for questions regarding coverage.

Regardless of insurance coverage, you are financially responsible for payment on your account, SMW bills insurance as a courtesy only.

Payment

We accept cash, Visa, Mastercard, and Care Credit. Established patients may pay by personal check.
All deductible, Co-pay, or Co-insurance amounts are due at each visit.
If you do not know your deductible, copay or coinsurance amount, a 20% co-pay will be collected each visit. All patients must provide a current, valid insurance card and driver's license at each appointment.

Refunds: Refunds are subject to final insurance payment and verification ______

NO SHOW/CANCELLATION: Subject to a $25 fee if less than 24-hour notice ____

NON-SUFFICIENT CHECK: A $35 fee per check. No exceptions. _____

Solstice Medicine and Wellness is NOT a financial lending institution

Delinquent Accounts: A $5 service charge will be added to patient balances and co-pays greater than 30 days overdue. A $10 service charge will be added to patient balances and co-pays greater than 60 days overdue. A $20 service charge will be added to patient balance and co-pays greater than 90 days overdue. Past due accounts greater than 120 days are subject to a collection agency. **SMW is not liable for any consequences arising from a collections agency's effort to secure payment.**

Payment arrangements can be made with the office staff or billing department of SMW if a patient is unable to pay their account balance. The patient will be required to provide a credit card to place on file to process on an arranged date for a set payment amount. **SMW is not liable for any consequences arising from overdraft fees or financial institution's fees or charges.**

HIPAA Compliance

SMW complies with current federal guidelines for HIPAA. A copy of our HIPAA policy is available for your review. "I understand that my signature on this form indicates that I have had an opportunity to review the SMW HIPAA policy and may be given a copy of the same, upon request."

I have read the above and have had all questions answered to my satisfaction.

This authorization shall expire **one year** from the date below

_______________________________ _______________________________ ______________

Print Name Signature Date

Solstice Medicine and Wellness, LLC

<u>HIPAA Consent for Patient Medical Information Release</u>

Patient Name: ____ Date of Birth: ________________

I authorize Solstice Medicine and Wellness, LLC to release my personal health information to family members or others involved in my care or assisting me with financial payment arrangements.

Name: ___________________Relationship: __________Phone Number: _______________

Name: ___________________ Relationship: __________Phone Number: _______________

Use the back of this form for additional people

Privacy Information: Please circle Yes or No for the following statements. By circling Yes for the following statements this office will leave voicemail or answering machine messages at your home, work, cell, or emergency contact on file briefly requesting you to call us back to discuss your medical information.

Location	**Call back message**	**Phone Number**
HOME	YES NO	
WORK / CELL	YES NO	
Emergency Contact	YES NO	

Patient Signature: ______________________________________ Date: ____________

Witness: ____ Date: ____________

This form will remain in effect for **One Year** from the date of signature. Any changes to this form must be submitted, by the patient, on a new form, signed, dated, and witnessed by a SMW staff member.

Notice of Privacy Practices
Acknowledgement of Receipt

Patient Name: _________________________ Date of Birth: _______________

Solstice Medicine & Wellness, LLC, is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call (907)456-6334.

***The Privacy Practices document is available online at solsticemedicine.com and posted in the front lobby of the clinic ***

I hereby acknowledge that I have reviewed and received a copy of Solstice Medicine and Wellness LLC, Health Notice of Privacy Practices.

X ____ _________________________
Patient's Signature Date

X ____ ___________________ ______________
Guardian/Representative Signature Relationship to Patient Date

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For Office Use only:

I hereby affirm that Solstice Medicine and Wellness, LLC has made a good faith effort to obtain written acknowledgement from the above named patient.

Staff members initials:_______

0 Patient was offered form but refused to sign

0 Patient was physically unable to sign acknowledgement

0 Other:____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date of request: ____________________

Patient Name: ____ Date of Birth: ______________ Address:

____________________________________ City: ____________ State: ___ Zip code: _______

I authorize (Clinic or Provider name) ____ to release the following medical records to Solstice Medicine & Wellness:

______ **Complete Medical Record** ______ All Chart notes between ____________ ______ All labs and Imaging

______ Flow Sheets(Vital signs/ Height/Weight) ______ Medication List ______ Mental Health Record ______

STD/HIV Status ______ Other: _________________________

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the staff member of Solstice Medicine & Wellness. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Patient Signature: ____ Date: ___________________

MEDICAL HISTORY

Name: ____ DOB:_____________________

ALLERGIES/ ADVERSE REACTIONS

(List all allergies- medications/food/environmental/ other substances- and type of reaction:

____

____

____

CURRENT MEDICATIONS AND SUPPLEMENTS

(including prescription, over-the-counter medication, supplements/ herbal remedies- taken daily and on as needed basis. Please list name, dosage and frequency)

____

____

____

____

____

____

____

Please list the date you have received any of the following preventative health items:

Colonoscopy: ________________ Tetanus/Tdap: _______________

Shingles Vaccine: _____________ TB Skin Test (PPD): __________ positive or negative?

Pneumovax: _________________ Eye Exam: _________________ Location: _________ Flu Shot: ____________________ Chest Xray: _________________

Female History:

Age of first menstrual period: ____ Date of last menstrual flow: _______ Current birth control: __________

Describe your cycle: Light ___ Moderate ___ Heavy ___ Regular ___ Irregular ___ Painful ___ #of days: ___

Number of pregnancies: ___ Live Births: ___ Last pap smear date: _______ (Normal ___/ Abnormal ___) Date of last Bone Density Scan: ____________ Date of last Mammogram: _____________ Location: _________

SOCIAL HISTORY

OCCUPATION: ____ How many hours do you work per week: ________ Highest level of education: ___________________

Marital Status: ___________________ Are you sexually active? ______________ # of Children: ___________ Do you eat a balanced diet? _______ Do you partake in special diet trends? Which ones? ____________________________________ Do you exercise routinely? _______ What type of exercise and frequency? ____ Do you consume alcohol? ________ How many per week? ________ What kind? ____ Do you smoke? _____ How many a day? ______ Have you ever smoked? _____ When did you quit (month/year)? ______________ Do you consume caffeine? ________ How many a day? _____________ What type? __________________________________ Do you use recreational drugs? ________ How often? __________ What type? ____ Are there guns in your home? ________ Are they secured/locked? ___________

Do you use a seatbelt while driving? ___________

Have you ever had or currently have:

___ Anxiety ___ Depression ___ Insomnia ___ Anemia ___ Asthma ___ Congestive Heart Failure ___ COPD/ Emphysema ___ Pneumonia ___ Tuberculosis ___ Sleep Apnea (___use CPAP) ___ Seasonal Allergies ___ Diabetes (or prediabetes) ___ GERD/ Reflux/ Esophagitis ___ Gallbladder disease ___ Cancer (site: ______________)	___ High blood pressure ___ High Cholesterol ___ Heart Attack ___ Clotting disorder ___ Varicose Veins ___ Blood clots in legs/ lungs ___ Kidney disease ___ Kidney stones ___ UTI ___ Seizure Disorder ___ TIA ___ Stroke ___ Thyroid disease (type: ____________) ___ HIV/ AIDS ___ Hepatitis	___ Headaches ___ Chronic migraines ___ Arthritis ___ Rheumatoid arthritis ___ Back Problems ___ Fractures (site:_________________) ___ Gout ___ Ulcers (GI) ___ PCOS ___ Prostate enlargement/ BPH ___ Low testosterone/ erectile dysfunction ___ Osteoporosis ___ Bowel disorder (Type: ___________) ___ Liver disorder (Type: ____________) ___ Skin disorder (Type:______________)

Other:____
____
_ ____

Medical Providers/ Specialists participating in your past or current medical care (name/specialty/location):

____

____

Surgical or Hospitalization history:

(Please list all surgeries, dates, any complications. List any hospitalizations, length of stay and reason)

____

____

____

____

____

Family History:

Have any of your blood relatives had any of the following:

___ Heart disease ___ Stroke ___ Diabetes ___ High Blood Pressure ___ High Cholesterol ___ Mental Health Illness

___ Substance Abuse ___Cancer (site: ______________________________)

What medical conditions do/did these relatives have:

Father: ____

Mother: ____

Paternal Grandfather: ______________________________ Grandmother: ______________________________

Maternal Grandfather: ______________________________ Grandmother: _____________________________

Brothers: ____ Sisters: ___________________________________