Solstice Medicine & Wellness, LLC

475 Riverstone Way Suite 2
Fairbanks, AK 99709
Phone: 456-6334
Fax: 456-6336

Date: _____

Name: _____ Date of Birth: _____

Phone Number: Home _____ Cell _____ Work _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Referral Source: _____

_____

Payment Method (please circle one): 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 _____ 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

HIPAA Consent for Patient Medical Information Release

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: _____

( ) Patient was offered form but refused to sign

( ) Patient was physically unable to sign acknowledgement

( ) 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 _____ and _____

_____ 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** (please circle one)

Pneumovax: _____ Eye Exam: _____ Location: _____

Flu Shot: _____ Chest Xray: _____

Female History:

Age of first menstrual period: _____ Date of last menstrual flow: _____

# of days in cycle: _____ Current birth control: _____

Describe your cycle: Light ____ Moderate ____ Heavy ____ Regular ____ Irregular ____ Painful _____

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? _____

Do you use a seatbelt while driving? _____

Have you ever had or currently have:

[ ] Anemia	[ ] Fractures (Site:_____)	[ ] Osteoporosis
[ ] Anxiety	[ ] Gallbladder Disease	[ ] PCOS
[ ] Arthritis (Rheumatoid? ____)	[ ] GERD/Reflux/Esophagitis	[ ] Pneumonia
[ ] Asthma	[ ] Gout	[ ] Prostate Enlargement/BPH
[ ] Back Problems	[ ] Hepatitis	[ ] Seasonal Allergies
[ ] Blood clots in legs/lungs	[ ] Headaches	[ ] Seizure Disorder
[ ] Bowel Disorder (Type:_____)	[ ] Heart Attack	[ ] Skin Disorder (Type:_____)
[ ] Cancer (site: _____)	[ ] High Blood Pressure	[ ] Sleep Apnea (____use CPAP)
[ ] Chronic Migraines	[ ] High Cholesterol	[ ] Stroke
[ ] Clotting Disorder	[ ] HIV/AIDS	[ ] Thyroid Disease (Type:_____)
[ ] Congestive Heart Failure	[ ] Insomnia	[ ] TIA
[ ] COPD/Emphysema	[ ] Kidney Disease	[ ] Tuberculosis
[ ] Depression	[ ] Kidney Stones	[ ] Ulcers (GI)
[ ] Diabetes (or prediabetes)	[ ] Liver Disorder (Type:_____)	[ ] UTI
[ ] Erectile Dysfunction	[ ] Low Testosterone	

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: _____