Providence Medical Group Behavioral Health
3760 Piper Street Suite 1108
Anchorage, AK, 99508
Tel: (907) 212-6900 Fax: (907) 212-6936

Providence

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: _____First Name: _____ M.I.:_____
SSN: _____ Marital Status: M / S / D Sex: M / F DOB: _____
Address: _____City _____ State ____ Zip _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____
EMPLOYMENT: Please indicate if unemployed, a student, disabled, or retired _____
Employer's Name: _____ Status: FULL TIME / PART TIME Occupation: _____
EMERGENCY CONTACT:
Name: _____ Relationship To Patient: _____ Phone: _____
PRIMARY CARE PROVIDER:_____

PARENT/GUARDIAN/RESPONSIBLE PARTY: Who is responsible for the bill?

Last Name: _____ First Name: _____ M.I.:_____
Relationship to Patient: _____
Marital Status: M / S / D SSN: _____ DOB: _____ Sex: M / F
Address: _____ City _____ State ____ Zip _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer's Name & Address: _____

PRIMARY INSURANCE

Policy Holder: _____ Relationship to Patient: _____
SSN: _____ Date of Birth: _____ M_____F_____
Insurance Name & Address: _____
Policy #: _____ Group #: _____ Effective Date: _____
Employer Name & Address: _____

SECONDARY INSURANCE

Policy Holder: _____ Relationship to Patient: _____
SSN: _____ Date of Birth: _____ M_____F_____
Insurance Name & Address: _____
Policy #: _____ Group #: _____ Effective Date: _____
Employer Name & Address: _____

Has any member of your immediate family been treated by Providence Medical Group Mat-Su Behavioral Health Clinic before? ___ If yes, under what name? _____

Patient/Parent/Legal Guardian Signature_____ **Date**_____

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HIPAA ACKNOWLEDGEMENT

NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge I was offered a copy of the Providence Health Systems in Alaska Notice of Privacy Practices.

Signature of Acknowledgement_____ Date_____

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CLINIC POLICIES

CONFIDENTIALITY: We respect your right to confidentiality and what you share with us will be kept in strict confidence. By law, we are required to report instances of abuse or intent to harm yourself or others. We cannot speak with anyone about your health condition or care without your specific written permission. Please ask the front desk staff for a release of information if you want us to be able to speak with your family member or outside provider about your care.

Patient/Parent/Legal Guardian Initials _____

CANCELLATIONS/NO SHOW: We are glad to make a reminder call or text prior to each appointment, but you are responsible for keeping your appointments. If you are unable to attend an appointment, we need at least 24 hours' notice so that we can offer that time to someone on our wait list. If you regularly miss or cancel appointments with less than 24 hours' notice, we may no longer be able to provide you with services in our clinic.

Patient/Parent/Legal Guardian Initials _____

TELEHEALTH: If you are seen through telehealth for an appointment, you must be present in the state of Alaska. If you are outside of Alaska, please call our office in advance to cancel the appointment.

Patient/Parent/Legal Guardian Initials _____

FINANCIAL: As a courtesy, we will bill your insurance for you if you provide an insurance card(s) and/or proof of coverage at the time of service. If you have a change of insurance, please notify us as soon as possible. Deductibles and co-pays are expected at the time of service. It remains your responsibility to pay in full any balance not covered by your insurance. You are ultimately responsible for payment of services. If you do not make a payment, or make financial arrangements to settle your account within thirty (30) days after receiving your statement, you may be sent to collections. We accept cash, check, Visa, MasterCard, AMX and Debit.
Self-paying patients: I understand that I am responsible for my bill and that payment is expected at the time of service unless prior arrangements have been made.
Financial Assistance: If you are interested in applying for Providence Financial Aide, please notify the front desk so they can provide you with an application. You can also contact finance department at 866-747-2455.

Patient/Parent/Legal Guardian Initials _____

MEDICATION REFILLS: Patients are encouraged to contact their preferred pharmacy for prescription refills. You may also call our Medical Assistants to request prescription refills. However, if calling the clinic please allow three (3) to five (5) days for a prescription refill authorization. Refills requested after Noon on Friday will not be authorized until the following Monday. Refills will not be authorized on the weekend or holidays. If you do not have a scheduled appointment, we may require you schedule one prior to authorizing your refill. If the appointment is not kept, further refills may not be authorized.

Patient/Parent/Legal Guardian Initials _____

GUARANTEE OF PAYMENT/ASSIGNMENT OF BENEFITS: In order to bill my insurance I understand they will have access to records generated from services provided by PMG Behavioral Health. I authorize the exchange of information necessary for payment of services. I authorize payment directly to PMG Behavioral Health for services rendered to me regarding my illness and/or treatment. I also understand that I am responsible for any amount not covered or deemed over usual and customary by my insurance carrier or agency.

Patient/Parent/Legal Guardian Initials _____

QUESTIONS: If you have any questions concerning Providence Medical Group Behavioral Health please contact our office at (907) 212-6900 and we will be happy to assist you.
Providence Medical Group Behavioral Health Clinic Policies have been reviewed, understood, and agreed to by me.
Patient Name:[Print] _____ Date:_____
Patient/Parent/Legal Guardian Signature:_____

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AUTHORIZATION FOR
TREATMENT / FINANCIAL RESPONSIBILTY STATEMENT

Patient Name:
Patient Date of Birth:

AUTHORIZATION FOR TREATMENT: I authorize the Provider(s) or their designee(s), in charge of my or the patient's care to administer any treatment including medication(s) or vaccine(s) as deemed necessary or advisable in the diagnosis and treatment of any conditions related to me or the patient. I authorize the Physician(s) or their designee(s), in charge of my or the patient's care to use communications technology-based services ("CTBS") for treatment and billing of care or consultation with other professionals about the care of the patient. This authorization is valid and in effect until such time I withdraw it in writing or in person.

ASSIGNMENT OF BENEFITS AND PAYMENT TERMS

MEDICARE / MEDICAID AND OTHER GOVERNMENT PROGRAMS: If I qualify for benefits under Medicare, Medicaid, or any other government program, I authorize these program(s) to make payment directly to Providence for my care. I also authorize Providence to release all relevant information about me and my health care necessary to receive payment to the applicable government program(s). I am responsible for paying deductible and/or co-insurance under such program(s).

INSURANCE: If I qualify for benefits from any insurance company(s), I assign those benefits to Providence to pay for care provided. I also authorize Providence to release all relevant information about me and my health care to the company(s) necessary to receive payment. I am responsible for paying any co-payments and/or deductible required under your insurance plan(s). I understand, to check with my insurance to confirm my coverage and anticipated out-of-pocket costs.

PAYMENT TERMS: Providence has agreed to accept assignment of benefits from governmental health care programs and certain insurance companies. I remain personally responsible for payment in full of billed charges, unless otherwise required by law.

EXPRESS CARE CLINIC LOCATIONS: Providence Express Care services are set at a basic low rate. Providence's usual discount policy does not apply to Express Care services.

FINANCIAL ASSISTANCE: If I am unable to meet the financial requirements for the services rendered, I am aware that I may apply for financial assistance or establish a payment plan by contacting a Providence financial representative.

If you have questions or would like to receive a financial assistance application form, please contact below:
By telephone: 1-866-747-2455 **On our website at:** www.providence.org

RIGHT TO REVOKE AUTHORIZATION: I have the right to cancel my assignment or my authorization for Providence to release information about me and my health to government programs and insurance company(s). My revocation must be in writing and will be effective when it is received by Providence.

USE AND DISCLOSURE OF INFORMATION: The way Providence Physician Services may use information about me is explained in the "Notice of Privacy Practices."

PHOTOGRAPHS: I agree to allow Providence to take, reproduce and use photos, video tape, video monitoring / recording, or audio recording for the purpose of diagnosis, testing, medical evaluation, care, or treatment (including invasive procedures), patient safety or medical education, and to preserve clinical information. I understand that this material may be treated as a part of my medical record and that Providence privacy policies apply.

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FINANCIAL RESPONSIBILITY STATEMENT: I accept financial responsibility for all treatment provided. The balance is due 30 days from the date of billing. If I need financial assistance or wish to establish a payment plan, I can contact a Providence financial representative. Should this account be assigned to an attorney or collection agency, I will be obligated to pay associated costs. I request direct payment of benefits to Providence for any clinical services rendered.

- I understand Providence will make inquiries regarding insurance coverage and my financial responsibility from third party payors or financial references. In addition, I approve these payors and/or references to release information to Providence.
- I understand Providence (collectively "Providence") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, or gender identity.
- I have read, or have had explained to me, the above Authorization for Treatment and Financial Responsibility Statement. I understand the contents and by signing; I agree to be legally bound by this document.
- By signing this document via electronic signature pad, I certify that I am of lawful age and legally competent to consent.

TELEPHONE CONSUMER PROTECTION ACT

By providing us with a telephone number for a cellular or other wireless device, you agree that in order for us or our service providers to service your account(s) (including contacting you about obtaining potential financial assistance for your account(s)) or to collect any amounts you may owe, we, our agents, representatives, or other service providers may contact you at the above listed telephone number(s) which could result in charges to you. You expressly consent that methods of contact may include using pre-recorded and artificial voice messages and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with this account and is not a condition of purchasing property, goods, or services. You are not required to sign this consent as a condition of treatment.

Patient/Personal Representative Signature:

By signing this document via electronic signature pad, I certify that I am of lawful age and legally competent to consent to this authorization for treatment.

_____ _____
Signature of Patient Date of Signature

_____ _____
Signature of Patient Representative / Agent Relationship to Patient

_____ _____
Name of interpreter (if used to explain document to patient) Relationship to Patient