2741 Debarr Road, Suite C-307
Anchorage, AK 99508
907-777-1850
855-468-1357

Name: _____ Preferred Name: _____ Date of Birth: _____ SSN: _____

Birth Gender: _____ (Optional) Gender Identity: _____ Personal Pronouns: _____

Race/Ethnicity is needed for some diagnostic testing

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other: _____ ☐ Prefer not to answer

Address: _____

Primary Phone Number: _____ Pharmacy: _____

Guarantor / Guardian Information

Last Name:	Gender: ☐ F / ☐ M DOB:
First Name:	Mobile Phone:
Middle Name: Suffix:	Employer:
Relationship to Patient:	Email:

Additional Parent / Guardian Information

Last Name:	Gender: ☐ F / ☐ M DOB:
First Name:	Mobile Phone:
Middle Name: Suffix:	Employer:
Relationship to Patient:	Email:
Access to: ☐ EMERGENCY ☐ BILLING ☐ MEDICAL ☐ SCHEDULING	

Insurance Information

Primary Insurance Name:	Secondary Insurance Name:
Member ID:	Member ID:
Group ID:	Group ID:
Policyholder Name:	Policyholder Name:
Policyholder DOB:	Policyholder DOB:
Policyholder relation to patient:	Policyholder relation to patient:

Please list any Contacts for emergencies and/or disclosures of Protected Health Information (PHI)

Name:	Relationship:	Phone:
DOB: Access to: ☐ EMERGENCY ☐ BILLING ☐ MEDICAL ☐ SCHEDULING		
Name:	Relationship:	Phone:
DOB: Access to: ☐ EMERGENCY ☐ BILLING ☐ MEDICAL ☐ SCHEDULING		

Please read and sign below

I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits to be paid directly to Arete Family Care. I am also responsible for payment of non-covered services. I give permission for Arete Family Care, LLC to give medical treatment.

Signature of parent/guardian: _____ Date: _____

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Parental Consent Form

I, _____ the parent/legal guardian of _____, authorize medical treatment by any provider of Arete Family Care, LLC. (AFC)

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, AFC may release protected health information relative to that decision to that designated person. **Initials _____**

Name:		Name:	
Phone:	DOB:	Phone:	DOB:
Relationship to patient:		Relationship to patient:	

I request that my child who is 17 years or older be seen by a provider at AFC for treatment without a parent/legal guardian present. **Initials _____ **

I agree to be fully and completely financially responsible for all incurred charges. I understand that the provider has the option to refuse service if he/she feels it is in the minor's best interest that I be present. I further agree to be available by phone if needed during the appointment time.

Contact phone number: _____

This authorization is in effect until the minor named above becomes an adult or I notify AFC in writing of a change.

Signature of parent/legal guardian: _____ Date: _____

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Patient Financial Policy

Arete Family Care, LLC (AFC) is committed to providing high-quality care that aligns mind, body, and spirit to all patients. We also feel it is important for our patients to understand that any care they receive is a result of a mutually agreeable, voluntary service. It can be terminated at any time by either party. To effectively bill and collect charges incurred, we require all patients to read and sign the following financial policy.

**We accept cash, checks, and all major credit cards. Your bill can include office visits, procedures performed, lab work, or other charges related to your care. **

Insurance. As a courtesy to our patients, Arete Family Care will bill most U.S. health plans. Deductibles, co-pays, and/or coinsurance will be collected in full at the time of service. The amount due at the time of the visit depends on your insurance plan. Please be aware that your insurance may need you to supply information directly from you for claims to be paid. It is your responsibility to comply with their request, failure to do so can cause a denial and full patient responsibility.

Proof of insurance. On arrival, we will verify your current insurance at every visit. If you are unable to provide correct insurance information in a timely manner, you may be responsible for the claim's balance. You are responsible to pay any charges denied by your insurance because of missing/inaccurate information.

Uninsured patients. If you do not have insurance, payment in full is expected at the time of service. We require partial payment before the appointment with a provider (this will be applied to the visit), and the remaining balance will be collected at the end of the visit. There is a time-of-service discount of 10% that will be applied. Due to the high cost of drugs, vaccinations, lab reagents, and other injectables/implants, the 10% paid-in-full discount will not be applied to these services.

Non-covered services. Any care not paid for by your existing insurance coverage will be your responsibility upon notice of insurance claim denial. We do not routinely research whether a service is covered, so it is up to you, the patient, to contact your insurance carrier or employer to determine coverage information.

Nonpayment. Payment for services received is the responsibility of the patient or guarantor, regardless of insurance status. Balances are due within **30 days** of the first statement. Accounts past **60 days** are considered delinquent. Accounts past **90 days (about 3 months)** are subject to review as well the account being sent to our collection agency, Cornerstone Credit Services, and/or subject to patient dismissal from AFC.

Payment Plans. If you are unable to make payment in full, payment plans are available. Payment plans consist of a term rate of no greater than 1 year. If new services are incurred, recurring payments must be adjusted to reflect the new balance.

Missed appointments. Any appointments not canceled within 24-hours prior of scheduled time; OR arrives more than **10 minutes** late will be considered a “no-show”. Patients who no-show 3 times within a 12-month period could be dismissed from the practice. Please help us serve you better by keeping your regularly scheduled appointments.

Returned checks. There is a $25 charge for all returned checks. After the first returned check, we will only accept credit/debit, cash, and money orders.

Printed Name: _____ Signature: _____

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Receipt of Privacy Practices and Financial Policy Written Acknowledgement

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name (if applicable: _____

I acknowledge I have reviewed and been offered a copy of Arete Family Care's HIPAA policy.

Signature: _____Date: _____

I have received a copy of the financial policy; I have read it and agree to abide by its guidelines:

I hereby assign Arete Family Care, LLC (AFC) any insurance or other third-party benefits available for healthcare services provided to me. I understand that AFC has the right to refuse or accept such benefits. If these benefits are not assigned to AFC, I agree to forward AFC all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

Signature: _____ Date: _____

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New Patient Medicare Policy

Patients with less than 4 years of established care with Arete Family Care, LLC prior to their Medicare Part B eligibility or activation of their Medicare Part B benefits will be considered a new Medicare patient when their Medicare Part B benefits becomes their primary insurance.

Arete Family Care, LLC is **not** accepting new Medicare patients at this time.

By my signature, I acknowledge that I have read, and agree to this Arete Family Care, LLC Medicare Policy and I understand that if I am not established with Arete for 4 years prior to Medicare Part B becoming my primary insurance that I will need to find a new primary care provider at that time.

Printed Name: _____

Signature: _____ Date: _____