

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

Name:	Preferred Name:	Date of Birtl	n:SSN:
Birth G	ender: (Optional) Gender	Identity: Pe	ersonal Pronouns:
	Race/Ethnicity is neede	ed for some diagnost	ic testing
☐ American Indian or A	laska Native Asian Black	or African American	☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Hisp	anic or Latino 🔲 Not Hispanic or	Latino 🗆 Other:	Prefer not to answer
Address:			·
Primary Phone Number: _	Pha	rmacy:	
Guarantor / Guardian I	nformation		
Last Name:		Gender: □ F	/ DM DOB:
First Name:		Mobile Phone	::
Middle Name:	Suffix:	Employer:	
Relationship to Patient:		Email:	
Additional Parent / Gua	ardian Information	•	
Last Name:		Gender: □ F	/ \square M DOB:
First Name:		Mobile Phone	::
Middle Name:	Suffix:	Employer:	
Relationship to Patient:		Email:	
Accessto: ☐ EMERGENCY	/ □ BILLING □ MEDICAL □	SCHEDULING	
Insurance Information	1		
Primary Insurance Name	2:	Secondary Ins	urance Name:
MemberID:		MemberID:	
Group ID:		Group ID:	
Policyholder Name:		Policyholder N	lame:
Policyholder DOB:		Policyholder D	OOB:
Policyholder relation to p	patient:	Policyholder r	elation to patient:
			Protected Health Information (PHI)
Name:	Relationship:		Phone:
DOB:	Access to: ☐ EMERGEN	NCY BILLING	☐ MEDICAL ☐ SCHEDULING
Name:	Relationship:		Phone:
DOB:	Access to: ☐ EMERGE	NCY BILLING	☐ MEDICAL ☐ SCHEDULING
Please read and sign I	helow		
I authorize the release of a government benefits to be	any medical or other information	are. I am also respo	ress claims. I also request payment of onsible for payment of non -covered nt.

Signature of parent/guardian: ______ Date: _____



FAMILY CARE, LLC

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

Receipt of Privacy Practices and Financial Policy Written Acknowledgement

Patient Name:	
Date of Birth:	
Parent/Guardian Name (if applicable	e:
I acknowledge I have reviewed a	nd been offered a copy of Arete Family Care's HIPAA policy.
Signature:	Date:
I have received a copy of the fina	ncial policy; I have read it and agree to abide by its guidelines:
healthcare services provided to me. I	C (AFC) any insurance or other third-party benefits available for understand that AFC has the right to refuse or accept such benefits. If C, I agree to forward AFC all health insurance and other third-party ered to me immediately upon receipt.
Signature:	Date:



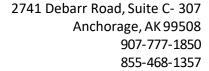
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907-777-1850

855-468-1357

Parental Consent Form

l,	the	parent/legal guardian of	,		
		of Arete Family Care, LLC. (AFC)			
make medical ded	cisions for my child. I underst hild, AFC may release protec	nt, the following adults may attend and that when I designate another ated health information relative to	•		
Name:		Name:	Name:		
Phone:	DOB:	Phone:	DOB:		
Relationship to p	patient:	Relationship to patien	nt:		
option to refuse s		he minor's best interest that I be p	. I understand that the provider has the present. I further agree to be available		
Contact phone nu	mber:	_			
This authorization	is in effect until the minor n	amed above becomes an adult or	I notify AFC in writing of a change.		
Signature of pare	nt/legal guardian:	D	ate:		





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:	