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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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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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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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: _____