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

Name: _____ Preferred First Name: _____ Date of Birth: _____

SSN: _____ Marital Status: _____ Previous Name: _____

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: _____ Pharmacy: _____

Primary Phone Number: _____ Alternate Phone Number: _____

Email: _____ Preferred Communication: ☐ Phone ☐ Email ☐ Text

Employer: _____ Occupation: _____

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 know am also responsible for payment of non-covered services. I give permission for Arete Family Care, LLC to give me medical treatment.

Signature: _____ **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, AFC 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, in order 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 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** are subject to review and could be sent to our collection agency, Cornerstone Credit Services, and/or subject to patient dismissal from AFC. Payment plans are available upon request.

Portal Messages. Patient portal messages sometimes incurs charges. Charges typically apply to messages involving new issues, medication changes, doing referrals, or filling out forms that take several minutes of a provider's time, similar to an office visit. Most private insurance plans cover these charges, although out-of-pocket costs can range from $5 to $45.

Missed appointments. If you arrive more than **10 minutes** late you 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.

Updated September 2025

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: _____

ARETE FAMILY CARE, LLC

Patient name: _____ Patient DoB: _____
Patient signature: _____

Patient Health History Questionnaire (Adult)

Today's date: _____

Medications/supplements (include name and dosage): _____

_____

_____

Allergies to medications/food (include reaction): _____

Surgical/hospitalization history (include month/year): _____

Family History (specify relation for each)

- ☐ Autoimmune disease _____
- ☐ Cancer (type) _____
- ☐ Diabetes _____
- ☐ Heart disease before 55 _____
- ☐ Other: _____
- ☐ High cholesterol _____
- ☐ Hypertension _____
- ☐ Lung disease _____
- ☐ Thyroid problems _____

Social History

Occupation: _____

Relationship status: _____

Name of partner: _____

Number of children: _____

Alcohol use? ☐ Yes ☐ No How much? _____

Tobacco use? ☐ Current ☐ Former ☐ Never

Form? ☐ Cigarette ☐ Cigar ☐ Chew ☐ Vape

How much per day? _____

years of use / quit year: _____ / _____

Recreational drugs: _____

Medical History Diagnosed by a Healthcare Provider

Allergy, Immune
- ☐ Anaphylaxis
- ☐ Environmental allergies
- ☐ Urticaria (hives) (frequent)

Cancers and Blood
- ☐ Anemia
- ☐ Blood clots (location) _____
- ☐ Cancer

Endocrine
- ☐ Diabetes
- ☐ Osteoporosis or osteopenia
- ☐ Thyroid disorder
- ☐ Vitamin D deficiency

Eye, Ear, Nose, Throat
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss

Gastrointestinal
- ☐ Colon polyps
- ☐ Diverticulosis or diverticulitis
- ☐ Hemorrhoids
- ☐ Hepatitis (type): _____
- ☐ Irritable bowel syndrome
- ☐ Reflux disease (GERD)
- ☐ Ulcers, stomach or duodenal

Genitourinary, STD, Reproductive
- ☐ Endometriosis
- ☐ Genital herpes or warts
- ☐ HIV/AIDS
- ☐ Infertility
- ☐ Menopause (age) _____
- ☐ Prostate enlargement (BPH)
- ☐ Sexually transmitted infections
- ☐ Urinary incontinence
- ☐ Urinary tract infections (frequent)
- ☐ Vaginal yeast or infections (frequent)

Heart and Vascular
- ☐ Angina (cardiac chest pain)
- ☐ Atrial fibrillation
- ☐ Congestive heart failure
- ☐ Coronary disease or heart attack
- ☐ High blood pressure
- ☐ High cholesterol

Kidney
- ☐ Kidney failure
- ☐ Kidney stones

Lung and Respiratory
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Emphysema (COPD)
- ☐ Tuberculosis or positive PPD

Mental Health
- ☐ Addiction to drugs
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Musculoskeletal
- ☐ Back/neck pain
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis

Neurological
- ☐ Alzheimer's dementia
- ☐ Migraine/tension headaches
- ☐ Multiple sclerosis
- ☐ Seizures or epilepsy
- ☐ Stroke

Skin
- ☐ Acne
- ☐ Cold sores
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer or pre-cancer

Other
- ☐ (Specify): _____
- ☐ (Specify): _____