Independence Park Medical Services

PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME	DATE OF BIRTH	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W
STREET ADDRESS		APT. NO.

CITY	STATE	ZIP	HOME PHONE
SOCIAL SECURITY NUMBER	AGE	BIRTH GENDER ☐ Male ☐ Female	CELL PHONE
EMPLOYER	OCCUPATION		WORK PHONE
EMERGENCY CONTACT | RELATION TO PATIENT			EMERGENCY CONTACT PHONE

SPOUSE INFORMATION OR PARENT / RESPONSIBLE PARTY INFORMATION

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT ☐ Spouse ☐ Parent ☐ Legal guardian ☐ Other _____
STREET ADDRESS		APT. NO.	HOME PHONE
CITY	STATE	ZIP	CELL PHONE
SOCIAL SECURITY #			DATE OF BIRTH
RESPONSIBLE PARTY EMPLOYER	OCCUPATION		RESPONSIBLE PARTY WORK PHONE/EXT.

ADDITONAL INFORMATION

PREFERED PHARMACY	PRIMARY CARE PHYSICIAN
RACE ☐ White ☐ Black/African American ☐ Indian or Native ☐ Asian ☐ Pacific Islander ☐ Other _____ ☐ Unknown	ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Unreported

PREFERRED LANGAUAGE:

☐ English ☐ Spanish ☐ Other

PERSON(S) AUTHORIZED ACCESS TO YOUR MEDICAL INFORMATION. LIST NAME(S) BELOW:

NAME	DATE OF BIRTH	RELATIONSHIP

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		COPAY	EFFECTIVE DATE
ID (POLICY NO.)	GROUP NO.		
SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S DATE OF BIRTH
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S SOCIAL SECURITY NO.
SECONDARY INSURANCE COMPANY		COPAY	EFFECTIVE DATE
ID (POLICY NO.)	GROUP NO.		
SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S DATE OF BIRTH
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S SOCIAL SECURITY NO.

Insurance Payment Authorization and Release: I hereby authorize my insurance benefits to be paid directly to the Independence Park Medical Services, Inc. for all medical services rendered to myself or my dependents and acknowledge that I am financially responsible for any services not covered by insurance or unpaid balance. I also authorize the release of any information concerning my illness and treatments requested by my insurance company.

Authorized signature _____ *Date* _____

Independence Park Medical Services

IPMS Financial Policy

Thank you for choosing Independence Park Medical Services as your primary care provider. We are committed to providing you and your family with quality and affordable health care. IPMS believes that part of a good healthcare practice is to establish and communicate a financial policy to our patients. IPMS's policies are listed below. Please read and sign in the space provided. If you have any questions, please ask one of our front office staff to call a Billing Account Representative for assistance.

PAYMENT

IPMS accepts cash, check and all major credit cards. We expect payment at time of service. If you have insurance, all deductible, co-pay and/or co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. We will also collect on any past due balances on your account. If you request an appointment and have any unresolved balances on your account, you will be referred to a Billing Account Representative to discuss payment arrangements. IPMS payment plans are based on financial need and requires physician's approval.

ADDITIONAL CHARGES (charges that may be billed after you leave IPMS)

Your bill will include office visit, x-rays, lab work, procedures performed and other charges related to your care. Please be advised that some charges may not appear on your fee slip when checking out, and are subject to change upon review.

NON-COVERED SERVICES

Some treatments are not covered by insurance, and are expected to be paid at time of service. Because individual policies vary, it is not possible for our staff to know exactly what your policy will cover. We highly encourage patients to contact their insurance carrier to preauthorize treatment and inquire about service coverage prior to their visit. You may be asked to sign a waiver assuming financial responsibility for non-covered services on procedures your insurance deems not medically necessary or experimental.

PROOF OF INSURANCE

We must obtain a copy of your driver's license and current valid insurance card(s) to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

SELF PAY – NO INSURANCE

Should you find yourself to be uninsured, payment in full is expected at time of service. Patients who do not have insurance may qualify for a discount. Please be advised that the discount is only good when the charges are paid in full at the time of service. Discounts do not apply to FAA, DOT, DDS, laboratory fees, imaging/radiology and ancillary fees.

MEDICARE | MEDICAID

Patients receiving Medicare/Medicaid benefits are required to pay their copay at each visit. Any service not covered by Medicare/Medicaid is your responsibility. You will be required to pay for your portion at each visit. You may be asked to sign a waiver of liability to ensure you understand your Medicare payment responsibilities.

IPMS is not accepting NEW Medicare/Medicaid patients at this time.

PRIVATE INSURANCE

IPMS participates in most insurance plans. Because healthcare benefits and coverage options have become increasingly complex, it is your responsibility to know your insurance benefits (i.e. copays, coinsurance, deductibles, preferred providers/hospitals, referrals, preauthorization's, non-covered services, etc.). Your health plan determines your coverage and limits. We will do our best to assist you with understanding your proposed treatment and in answering any insurance questions you may have. ***Examples of insurances we do not bill are:*** *Student Insurances, HMO's, out of state insurances which cannot be verified and Third-Party Liability Auto Insurance.* ***IPMS is not accepting NEW Tricare/VA patients at this time.***

FAA/DOT/DDS

These visits and related charges are typically not covered by insurance. Furthermore, as IPMS has a reduced self-pay fee schedule for these services we may not bill insurance for them even though some insurance companies may pay for such services. Payment in full is expected on the day you are seen. Discounts do not apply to these types of visits.

PATIENT REFUNDS

At times, refunds or credits are created on the account. If you receive indication from your insurance company that a possible refund is due, please contact our Billing Office. Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

REFILL/PRESCRIPTION REQUESTS

Refills are designed to expire when you are due for your follow up appointment. You may be required to schedule an appointment to see a provider first. You may request a refill through your pharmacy or call the clinic with your refill request. Please allow 48 hours' notice for your prescription. At that time, we recommend that you contact your pharmacy to make sure that your medication is ready for pick up. We will call you if we have additional questions, concerns or if we are unable to refill your prescription.

APPOINTMENT POLICY

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to arrive for their visit on time. If it's necessary to reschedule an appointment, please call us immediately. We may be able to accommodate same day sick appointments, although these might not be scheduled with your regular PCP.

- **Late Arrival:** IPMS Clinic makes every effort to keep clinic visits on time. By accepting late arrival patients, other patients arriving on time could be delayed. Patients arriving 10-minutes past their scheduled appointment time, may be asked to reschedule their appointment and possibly subject to a late fee. Note: if staffing is available, we may be able to ask the patient to wait and be worked in without causing additional delays in the clinic schedule. A late arrival that needs to be rescheduled will be considered a No-Show appointment on the patient's record.
- **Reminder calls/texts:** These are courtesy calls made 24 hours prior to appointment. Patients are responsible for arriving to their appointments on time
- **Cancellations:** A Minimum of 24 hours' notice is required when cancelling appointments. Less than 24 hours' notice is considered a "Missed Appointment" or "No Show"

_____ **NO SHOW POLICY**

PT Initials

No-show appointments have a significant negative impact on our practice and the healthcare we provide to our patients. Any patient who fails to arrive for a scheduled appointment or fails to cancel the appointment with less than 24 hours' notice is considered a "NO-SHOW". A patient who no-shows (3) times within a 12-month period is subject to dismissal from IPMS.

COLLECTIONS

Payment for services received at IPMS is ultimately the responsibility of the patient, regardless of insurance status. Balances are due **within 30 days** of the first statement. If you are unable to make payment in full, payment plans are available. Accounts **past 90 days** are considered delinquent. If patient refuses to remit payment or make payment plan arrangements, the patient account will be reviewed for possible collection action and possible dismissal from IPMS. Should your account go to an outside collection agency it will be assigned to **Cornerstone Credit Services.** You are responsible for IPMS balance including all fees to any collection agency charges.

AS A FINAL NOTE:

Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims.

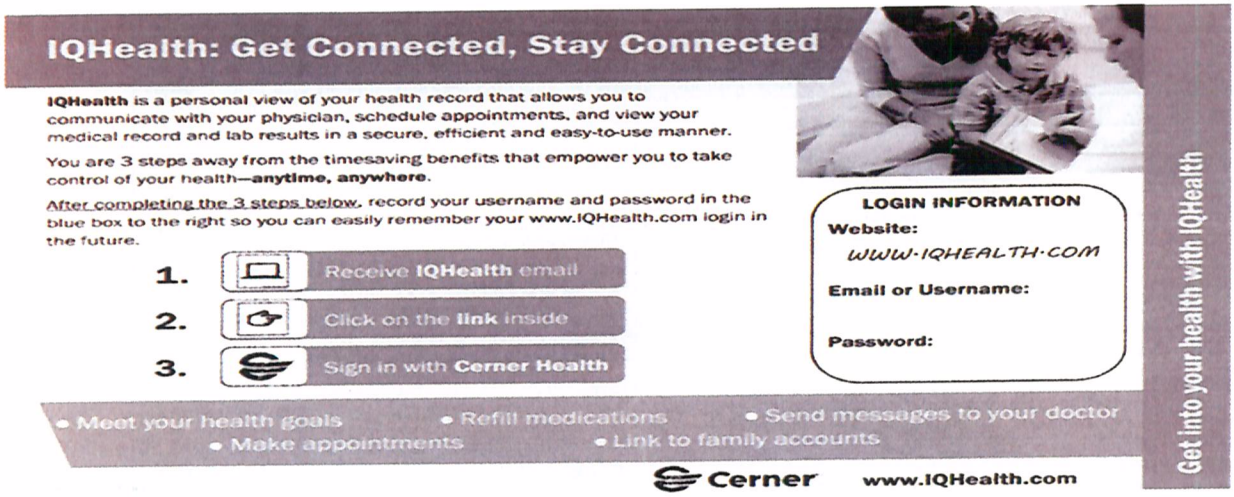
If you have any questions regarding this financial policy, please ask or call to speak with one of our Billing Account Representatives prior to being seen by the doctor. If you have any questions or concerns regarding your financial responsibility to IPMS, please do not hesitate to ask. We hope that by providing this detailed information, our patients will be more aware and empowered when receiving treatment at Independence Park Medical Services.

By signing below, I have read and acknowledge the above financial policies. I understand that I am ultimately responsible for any charges, regardless of insurance coverage. I agree to update this office on any changes in my contact or insurance information during the course of billing and treatment.

Signature_____ Date_____

Print Patient Name_____ DOB_____

Independence Park
Medical Services



To sign up for IQHealth, please provide the following information

Name: _____

Date of Birth: _____

Email Address: _____

Choose ONE of the following as your temporary password:

Last 4 of Social: _____

Year your mother was born: _____

Year your father was born: _____

Patient's postal code: _____

Signature: _____ **Date:** _____

Independence Park Medical Services

HIPAA Omnibus Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. PURPOSES OF THE NOTICE.

Independence Park Medical Services, Inc. is committed to preserving the privacy and confidentiality of your health information that is created and/or maintained at our clinic. State and federal laws and regulations require us to implement policies and procedures to safeguard the privacy of your health information. This Notice will provide you with information regarding our privacy practices and applies to all of your health information created and/or maintained at our clinic, including any information that we receive from other health care providers or facilities. The Notice describes the ways in which we may use or disclose your health information and also describes your rights and our obligations concerning such uses or disclosures. We will abide by the terms of this Notice, including any future revisions that we may make to the Notice as required or authorized by law. We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, which will identify its effective date, in our clinic.

The privacy practices described in this Notice will be followed by:

1. Any health care professional authorized to enter information into your medical record created and/or maintained at our clinic;

2. All employees, students, residents, and other service providers who have access to your health information at our clinic

3. Business associates and Subcontractors

4. Any member of a volunteer group that is allowed to help you while receiving services at our clinic.

The individuals identified above will share your health information with each other for purposes of treatment, payment, and health care operations, as further described in the Notice.

B. USE AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

1. Treatment, Payment and Health Care Operations. The following section describes different ways that we may use and disclose your health information for purposes of treatment, payment, and health care operations. We explain each of these purposes below and include examples of the types of uses or disclosures that may be made for each purpose. We have not listed every type of use or disclosure, but the ways in which we use or disclose your information will fall under one of these purposes.

a. Treatment - We may use your health information to provide you with health care treatment and services. We may disclose your health information to doctors, nurses, nursing assistants, medication aides, technicians, medical and nursing students, rehabilitation therapy specialists, or other personnel who are involved in your health care.

For example, we may order physical therapy services to improve your strength and walking abilities. We will need to talk with the physical therapist so that we can coordinate services and develop a plan of care. We also may need to refer you to another health care provider to receive certain services. We will share information with that health care provider in order to coordinate your care and services.

b. Payment. We may use or disclose your health information so that we may bill and receive payment from you, an insurance company, or another third party for the health care services you receive from us. We also may disclose health information about you to your health plan in order to obtain prior approval for the services we provide to you, or to determine that your health plan will pay for the treatment.

For example, we may need to give health information to your health plan in order to obtain prior approval to refer you to a health care specialist, such as a neurologist or orthopedic surgeon, or to perform a diagnostic test such as a magnetic resonance imaging scan ("MRI") or a CT scan.

c. **Health Care Operation**. We may use or disclose your health information in order to perform the necessary administrative, educational, quality assurance, and business functions of our clinic.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We also may use your health information to evaluate whether certain treatment or services offered by our clinic are effective. We also may disclose your health information to other physicians, nurses, technicians, or health profession student for teaching and learning purposes.

C. USES AND DISCLOSURES OF HEALTH INFORMATION IN SPECIAL SITUATIONS.

We may use or disclose your health information in certain special situations as described below. For these situations, you have the right to limit these uses and disclosures as provided for in Section F4 of this Notice.

1. **Appointment Reminders.** We may use or disclose your health information for purposes of contacting you to remind you of a health care appointment.

2. **Treatment Alternatives & Health-Related Products and Services.** We may use or disclose your health information for purposes of contacting you to inform you of treatment alternatives or health-related products or services that may be of interest to you. For example, if you are diagnosed with a diabetic condition, we may contact you to inform you of a diabetic instruction class that we offer at our clinic.

3. **Family Members and Friends.** We may disclose your health information to individuals, such as family members and friends, who are involved in your care or help pay for your health care. We may make such disclosures when:

(a) We have your verbal agreement to do so;

(b) We make such disclosures and you do not object;

(c) We can infer from the circumstances that you would not object to such disclosures.

For example, if your spouse comes into the exam room with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room.

We also may disclose your health information to the family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interests to make such disclosures and the disclosures relate to that family member or friend's involvement in your care. For example, if you present to our clinic with an emergency medical condition, we may share information with the family member or friend that comes with you to our clinic. We also may share your health information with a family member or friend who calls us to request a prescription refill for you.

4. **Judicial or administrative proceedings.** We may disclose your health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. We may disclose your health information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, but only if efforts have been made to (i) notify you of the request for disclosure or (ii) obtain an order protecting your health information.

5. **Worker's Compensation.** We may disclose your health information to workers compensation programs when your health condition arises out of a work-related illness or injury.

6. **Law Enforcement Official.** We may disclose your health information in response to a request received from a law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons, or similar process.

7. **Coroners, Medical Examiners, or Funeral Directors**. We may disclose your health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We also may disclose your health information to a funeral director for the purpose of carrying out his/her necessary activities.

8. Organ Procurement Organizations or Tissue Banks. If you are an organ donor, we may disclose your health information to organizations that handle organ procurement, transplantation, or tissue banking for the purpose of facilitating organ or tissue donation or transplantation.

9. Research. We may use or disclose your health information for research purposes under certain limited circumstances. Because all research projects are subject to a special approval process, we will not use or disclose your health information for research purposes until the particular research project for which your health information may be used or disclosed has been approved through this special approval process. However, we may use or disclose your health information to individuals preparing to conduct the research project in order to assist them in identifying patients with specific health care needs who may qualify to participate in the research project. Any use or disclosure of your health information that is done for the purpose of identifying qualified participants will be conducted onsite at our facility. In most instances, we will ask for your specific permission to use other identifying information if the researcher will have access to your name, address, or other identifying information.

10 To Avert a Serious Threat to Health or Safety. We may use or disclose your health information when necessary to prevent a serious threat to the health or safety of you or other individuals.

11. Military and Veterans. If you are a member of the armed forces, we may use or disclose your health information as required by military command authorities.

12. National Security and Intelligence Activities. We may use or disclose your health information to authorized federal officials for purposes of intelligence, counterintelligence, and other national security activities, as authorized by law.

13. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose your health information to the correctional institution or to the law enforcement official as may be necessary (i) for the institution to provide you with health care; (ii) to protect the health or safety of you or another person; (iii) for the safety and security of the correctional institution.

D. OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES OF HEALTH INFORMATION

There are certain instances in which we may be required or permitted by law to use or disclose your health information without your permission.

These instances are as follows:

1. As required by law. We may disclose your health information when required by federal, state, or local law to do so. For example, we are required by the Department of Health and Human Services (DHHS) to disclose your health information in order to allow DHHS to evaluate whether we are in compliance with the federal privacy regulations.

2. Public Health Activities. We may disclose your health information to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling disease, injury, or disability; to report births, deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recalls.

3. Health Oversight Activities. We may disclose your health information to a health oversight agency that is authorized by law to conduct health oversight activities, including audits, investigations, inspections, or licensure and certification surveys. These activities are necessary for the government to monitor the persons or organizations that provide health care to individuals and to ensure compliance with applicable state and federal laws and regulations.

E. USES AND DISCLOSURES PURSUANT TO YOUR WRITTEN AUTHORIZATION.

Except for the purposes identified in Sections B through D, we will not use or disclose your health information for any other purposes unless we have your specific written authorization. You have the right to revoke a written authorization at any time as long as you do so in writing If you revoke your authorization, we will no longer use or disclose your health information for the purposes identified in the authorization, except to the extent that we have already taken some action in reliance upon your authorization.

F. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have the following rights regarding your health information. You may exercise each of these rights, in writing, by providing us with a completed form that you can obtain from our Privacy Officer, Suzi C. by phone at (907) 522-1341 or by writing to us at Independence Park Medical Services, Inc., 9500 Independence Drive, St. 900, Anchorage, AK 99507. In

some instances, we may charge you for the cost(s) associated with providing you with the requested information. Additional information regarding how to exercise your rights, and the associated costs, can be obtained from Suzi C., Privacy Officer.

1. **Right to Inspect and Copy.** You have the right to inspect and copy health information that may be used to make decisions about your care. We may deny your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.

2. **Right to Amend**. You have the right to request an amendment of your health information that is maintained by or for our clinic and is used to make health care decisions about you. We may deny your request if it is not properly submitted or does not include a reason to support your request. We may also deny your request if the information sought to be amended; (a) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (b) is not part of the information that is kept by or for our clinic; (c) is not part of the information which you are permitted to inspect and copy; or (d) is accurate and complete.

3. **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures of your health information made by us. This accounting will not include disclosures of health information that we made for purposes of treatment, payment, or health care operations or pursuant to a written authorization that you have signed.

4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone, such as a family member or friend, who is involved in your care or in the payment of your care. For example, you could ask that we not use or disclose information regarding a particular treatment that you received. We are not required to agree to your request unless you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket at time of appointment. If we do agree, that agreement must be in writing and signed by you and us.

5. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about your health care in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

6 **Right to a Paper Copy of this Notice.** You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

G. QUESTIONS OR COMPLAINTS.

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our Privacy Office at Independence Park Medical Services, Inc., 9500 Independence Drive, St 900, Anchorage, Alaska 99507. (907) 522-1341. If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of the Department of Health Human Services. To file a complaint with our clinic, contact our Privacy Officer at Independence Park Medical Services, Inc., 9500 Independence Drive, St 900, Anchorage, Alaska 99507. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Independence Park
Medical Services

Independence Park Medical Services, Inc
HIPAA
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (*name of patient*) _____, acknowledge and agree that I have received a copy of **Independence Park Medical Services, Inc.'s** notice of **Privacy Practices**.

_____ _____
Signature **Date**

_____ _____
Print Name of Responsible Party (if applicable) **Relationship to Patient**

FOR CLINIC USE ONLY:

Independence Park Medical Services, Inc. made the following good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]

_____
_____
_____
_____