Kodiak Island Ambulatory
Care Clinic Inc.

Patient Information

Patient Name_____ Male____ Female____ Today's date _____

Social Security # _____ Birth date_____

Home phone _____ Cell phone _____ Other _____

Mailing Address_____City_____ State_____ Zip_____

Driver's License # _____State_____

Please check one: Minor_____ Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

If patient is a minor, name(s) of parent(s): _____ // _____

Guarantor Name _____ **SSN**_____ **Birth Date**_____

Employer: _____ Work Phone_____

Work Address_____City_____ State_____ Zip_____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone_____

Insurance Information

A copy of your insurance card(s) will provide us with most of this information.

Name of insured or person responsible for this account: _____

Insurance Company_____Date in Effect _____

Policy Number #_____ Group#_____

Relation to Insured_____ Insured Birthday _____

Do you have additional insurance coverage? Yes___ No___ (If yes, complete the following):

Name of insured or person responsible for this account: _____

Insurance Company_____Date in Effect _____

Policy Number #_____ Group#_____

Relation to Insured_____ Insured Birthday _____

Name of insured or person responsible for this account: _____

Insurance Company_____Date in Effect _____

Policy Number #_____ Group#_____

Relation to Insured_____ Insured Birthday _____

Acknowledgement of receipt of notice of privacy practices

I have received a copy of the Notice of Privacy Practices for K.I.A.C.C.

Agreement, Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I also agree to be fully responsible for payment of the medical services provided on this account in the event the insurance company does not pay, as well as for any costs or fees charged to this account for purposes of collections.

X_____ Date_____

Signature of patient (or parent if minor)

FINANCIAL RESPONSIBILITY AGREEMENT WITH KIACC INC.

Kodiak Island Ambulatory Care Clinic Inc., 202 Center Ave., Kodiak, AK 99615

PATIENT NAME:_____ DOB: _____

PAYMENT:
We offer the following payment options for medical services:

- ☐ Cash, Check, or Credit Card** (2% surcharge) – to be paid in full today
- ☐ Bill to my insurance. Co-pay or Deductable to be paid in full today
- ☐ Workman's compensation / Fisherman's Fund / Auto-Insurance

**There is a 2% surcharge on Credit Card not greater than our cost of acceptance.

INSURANCE:
We will accept most all insurances, but KIACC Inc. is a participating "in network" provider with:

AK Medicaid/Denali KidCare	TriCare
Medicare	Blue Cross/Blue Shield

You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. We may bill your insurance as a courtesy, but you are responsible for full payment on your account. You are responsible to know what coverage your insurance policy provides, your deductable, your "in and out of network" benefits, co-payments, etc. If you are uncertain what your insurance policy covers, we can assist you in calling your insurance to clarify yours or your family's benefits.
KIACC makes no guarantee that your insurance benefits will cover today's services in-part or in-full. It is your responsibility to know what your insurance will cover and to see that your account is paid in full. It is your responsibility to inform us immediately of any changes to your or your family's insurance policy, phone number, or mailing address.

WORKMANS COMPENSATION and FISHERMANS FUND:
If you have a work related injury or wish to apply to the Fisherman's Fund for a commercial fishing related injury or illness, you are ultimately responsible to see that all forms and inquiries required are filled out, responded to, and turned in on time. You are responsible to inform your employer about your injury timely. Patients may be expected to pay in full (or personal insurance billed) at the time of initial service unless confirmation by employer or work insurance of coverage is confirmed. Any unpaid claims will be your responsibility to pay in full.

FINANCIAL RESPONSIBILITY AND AGREEMENT
I have read and understand the above policies and accept the terms of patient responsibility. I agree to be fully responsible for payment of medical services provided on this account in the event the insurance company does not pay as well as any costs or fees charged to this account for purposes of collections. If I receive a billing statement, I agree to make a payment in full within thirty (30) days of receipt, or contact patient Accounts to make special arrangements for payment. I understand and agree that: 1) any balance not paid within thirty (30) days will begin to accrue a late fee interest at the rate of 2% per month I also will be responsible to pay, 2) that any such interest assessed on the account as a late fee as a result of delinquency on the account is not deemed interest as a part of a credit transaction, 3) that any balance not paid within sixty (60) days will be in default and referred to a collection agency, 4) that I am responsible for all costs of collection including but not limited to late fees and interest due as a result of the default, all collection fees, court costs, lien fees and attorney fees which may be as much as 30% of the outstanding balance and up to $250/hour for attorney fees (but only up to the maximum allowed by law) if collection and legal action is taken to repay such debt. I understand that if the account is referred to a collection agency, attorney, or court, related portions of the account, including the fact that related services and treatment were rendered at these offices, may become a matter of public record.

_____	_____	_____
Printed Name	Signature	Date

Today's date: _____

WELCOME
TO

Kodiak Island Ambulatory CARE CLINIC

It is our mission and interest to provide you and your family with quality and compassionate medical health care that is affordable and convenient. In order for you to best access our many services smoothly and efficiently, it is important that we share an understanding of how we provide those services here in the Care Clinic:

Urgent Care. We are an Urgent Care and Walk-In Family Medical Clinic. We primarily see acute medical concerns on a walk-in basis. We do take some scheduled appointments; however, urgencies that present may require immediate medical attention. We ask your patience and understanding in these situations.

Scheduled Appointments. Please show early for your appointment, there is always paperwork that needs to be updates. When you arrive, we will inquire about your medical insurance and method of payment. Payment in full is expected at the time of your appointment, including all co-pays or deductibles. On each subsequent visit to our clinic, we will again ask and update out files about your insurance and personal information.

Focused Medical Visits. Your appointment was prepared to address one specific medical concern. If you have an additional medical issue you would like to discuss, we ask that you schedule a separate appointment to address that concern for another time. If there is something more urgent that cannot wait, please inform the nurse when you are being roomed so that we can best prioritize your appointment today and reschedule for another day any additional medical concerns.

Laboratory Testing. KIACC Inc. contracts with Quest Diagnostics for laboratory services. If you have any laboratory blood work done here, you will receive a separate bill from Quest Diagnostics for these services or tests.

Pain Medications. This clinic does not manage chronic pain issues nor prescribe or refill narcotic pain medications, anti-anxiety, or benzodiazepine medications. There are no exceptions. If you have a condition that requires pain management, we can assist your referral to one of the specialized pain centers in Anchorage.

This clinic provides a wide range of quality family medical services as advertised in our brochure. Please see our brochure for the many services we provide here. We also provide services after hours and on weekends for your convenience. We are designated an Urgent Care and Walk-In Family Medical Clinic and manage most acute illnesses and injuries at a lower cost to you than an emergency room. In order to provide these services, Dr. John M. Koller and providers of this clinic have chosen not to carry nor re-new inpatient hospital privileges or emergency room call. However, they are available at all times after hours and weekends if you have a concern that cannot wait for the clinic to open during regular business hours or if the emergency room needs to contact the doctor. We are listed in the local phone directory and the hospital directory as well.

Thank You! Welcome to the Kodiak Island Ambulatory Care Clinic!

I _____ have read and understand the above statement.

HIPAA

Health Insurance Portability and Accountability Act

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax this number

☐Work Telephone _____
- ☐ O.K. to leave message with detailed information

☐ Other _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limits the use or disclosure of and request for *PHI* to the minimum necessary to accomplish the intended purposed. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Kodiak Island Ambulatory

Care Clinic Inc.

Welcome to Our Practice

Patient Name: _____ Date of Birth:_____ Today's Date:_____
Last First MI

Patient Medical History

List All Medications and Dosages (Include nonprescription):

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8:_____
9._____
10._____

List Any Medical Allergies (medication, latex, iodine, etc)

1._____
2._____
3._____
4._____
5._____
6._____

Preferred Pharmacy:
Walmart / Safeway / Other: _____

Active Medical Issues / Concerns:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Past Surgeries:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8:_____
9._____
10._____

Social & Family History

Occupation:_____ Employer:_____ ☐ Unemployed ☐ Retired
Marital Status: ☐ Single ☐ Married ☐ Sep./Div. ☐ Widowed # Children: _____
Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily Use of tobacco: ☐ Never ☐ Yes but quit. ☐ Smoker, packs/day _____
Use of drugs: ☐ Never ☐ Yes, Type/frequency: _____
Travel out of U.S. (countries):_____

****AUTHORIZATION & RELEASE****

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services and referals I may need.

X_____ **Date**_____
Signature of patient (or parent if minor)

JMK10/18