New Patient Registration Form

ANCHORAGE NEIGHBORHOOD HEALTH CENTER

General Information

Name (first, middle, last)		Preferred first name
Social Security number	**Sex (legal)**	**Date of birth**
	☐ Female ☐ Male ☐ Other ☐ Unknown	

Mailing address: PO box or street	Mailing address: City, state, and zip code

Cell phone number	Alternate phone number	Email address

Do you need an interpreter?	Do you need an American Sign Language (ASL) interpreter?	What is your preferred language (if other than English)
☐ Yes ☐ No	☐ Yes ☐ No	

Do you have any of the following impairments?

☐ Hearing ☐ Vision ☐ Speech ☐ Other:

Marital status

☐ Divorced ☐ Married ☐ Significant other ☐ Unknown
☐ Domestic partner ☐ Refuse to say ☐ Single ☐ Widowed
☐ Legally separated

Ethnicity

☐ Cuban
☐ Mexican, Mexican American, or Chicano/a
☐ Puerto Rican
☐ Another Hispanic, Latino/a, or Spanish origin
☐ Not Hispanic, Latino/a, or Spanish origin
☐ Choose not to disclose
☐ Unknown

Race (check all that apply)

☐ American Indian ☐ Pacific Islander
☐ Alaska Native ☐ Samoan
☐ Asian ☐ White/Caucasian
☐ Black/African American ☐ Choose not to disclose
☐ Hmong ☐ Unknown
☐ Korean ☐ Other:
☐ Native Hawaiian

Sexual Orientation and Gender Identity

Sexual orientation

☐ Heterosexual (or straight) ☐ Bisexual ☐ Something else
☐ Don't know ☐ Choose not to disclose ☐ Gay
☐ Lesbian ☐ Unknown ☐ Asexual
☐ Pansexual ☐ Queer

Gender identity

☐ Female ☐ Male
☐ Transgender woman/transfeminine ☐ Transgender man/transmasculine
☐ Other ☐ Choose not to disclose
☐ Agender ☐ Demigirl
☐ Demiboy ☐ Genderfluid
☐ Genderqueer ☐ Nonbinary
☐ Two spirit ☐ Uncertain

Sex assigned at birth

☐ Female
☐ Unknown
☐ Choose not to disclose
☐ Male
☐ Not recorded on birth certificate
☐ Uncertain

Preferred pronouns

☐ She/her/hers
☐ Decline to answer
☐ He/him/his
☐ Unknown
☐ They/them/theirs
☐ Your name

Provider Preference

I would prefer to see a provider who is a:

☐ woman.
☐ man.
☐ I do not have a preference.

If you would like to see a specific provider, please write their name here:

Prescription Practices for Certain Controlled Medications

ANHC has specific policies in place regarding the prescription of certain controlled medications, including:

- Stimulants (including Ritalin and Adderall)
- Opioids (pain medications including Vicodin and OxyContin)
- Benzodiazepines (anti-anxiety medications including Xanax and Ativan)

Are you seeking a prescription for any of the medications listed above?

☐ Yes ☐ No

Employment Status (check all that apply)

☐ Disabled
☐ Full-time
☐ Not employed
☐ Active-duty military
☐ Part-time
☐ Retired
☐ Self-employed
☐ Student (full-time)
☐ Student (part-time)
☐ Other:

Emergency Contact

Note: *We are not authorized to release your protected health information (PHI) to your emergency contact. To authorize us to release your PHI to another party, please complete the PHI Disclosure Agreement.*

Emergency contact name (first and last)	Relationship to patient
Emergency contact phone number	**Emergency contact notes**

Veteran Status

☐ Not a veteran
☐ Active-duty military
☐ National Guard
☐ Reservist
☐ Veteran (prior service)
☐ Veteran (retired)

Guarantor

Note: *The guarantor is responsible for the charges associated with the account. For example, if the patient is a child, the child's parent or guardian is the guarantor.*

Who is the guarantor for this account?

☐ Self ☐ Patient's parent/guardian ☐ Patient's spouse
☐ Other:

Guarantor name (if not self)	Guarantor contact number
Guarantor Social Security number	Guarantor date of birth

Insurance (write "none" if not insured)

Primary insurance company	Subscriber/policyholder name
Patient's relationship to subscriber/policyholder (e.g. self, spouse, child, etc.)	Subscriber/policyholder identification number
Secondary insurance company	Subscriber/policyholder name
Patient's relationship to subscriber/policyholder (e.g. self, spouse, child, etc.)	Subscriber/policyholder identification number

Sliding Fee Discount Program Eligibility

Note: *These questions help us identify patients who may qualify for discounted services at ANHC.*

How many people are in your household?	What is your household's estimated annual income?
	$

What is your estimated household annual income? (If amount not entered above.)

☐ Less than $27,000 per year
☐ Approximately $27,000 per year
☐ Approximately $36,000 per year
☐ Approximately $46,000 per year
☐ Approximately $56,000 per year
☐ More than $75,000 per year

Would you like to apply for ANHC's Sliding Fee Discount Program? ☐ Yes ☐ No ☐ I don't know

Important Documents for New Patients

View the following documents by visiting our website (www.anhc.org/patient-information or scan the QR code) or by asking any staff member for a copy. Please initial below to acknowledge that you understand that these documents are available to you at any time.

Initials: _____ Sliding Fee Discount Application

Initials: _____ Patient Rights and Responsibilities

Initials: _____ Notice of Privacy Practices

Initials: _____ PHI Disclosure Agreement

Initials: _____ Consent for Treatment and Billing Practices

Initials: _____ Prescription Practices and Controlled Medications

Important Information

24-hour access: Need to contact ANHC outside of normal business hours? Call 907-743-7200. Your call will be answered by ANHC's answering service and, if appropriate, routed to our on-call provider. **If you experience an emergency, please call 911.**

Integrated care at ANHC: Anchorage Neighborhood Health Center (ANHC) is a Patient-Centered Medical Home (PCMH), certified by The National Committee for Quality Assurance (NCQA).

ANHC services: As a PCMH, ANHC cares for the whole person. We provide care for patients of all ages and offer a variety of health care services, all in one location.

- Medical care
- Dental care
- Pharmacy
- Behavioral health care
- Lab and x-ray
- Mammography
- Nutrition counseling
- Health insurance enrollment assistance
- Sliding fee discount program
- Free language interpretation
- Care coordination
- Evening hours
- Telehealth

ANHC is a Health Center Program grantee under 42 U.S.C. 254b and a deemed Public Health Service employee under 42 U.S.C. 233 (g)-(n).

For more information: Visit our website (scan the QR code to the left or type www.anhc.org) for more information about our organization and the services we provide.

Consent for Treatment and Billing Practices

Appointment Policies

If you need to cancel or reschedule your appointment, please let us know as soon as possible. If do not arrive in time for your appointment, it may be considered a "no show." If you "no show" three (3) appointments in one year, you may be unable to schedule future appointments for up to 12 months. You will only be able to schedule appointments for the same day.

Informed Consent for Treatment

I, for myself or for my minor child or adult with a legal guardian, consent (agree) to health care including routine diagnostic procedures including x-ray and laboratory testing/screening, medical treatment, behavioral health treatment, dental treatment, substance use treatment, and all other health services provided by the Anchorage Neighborhood Health Center (ANHC) and its authorized personnel and agents in person and/or via telehealth. Physical and emotional issues often occur together; we believe the best care is given when health providers work together. ANHC providers may refer you to providers from other health care specialties within our team. Members of those teams will share clinical information with each other and document in the same medical record. I understand that:

- The practice of medicine, behavioral health care, dentistry, and surgery are not exact sciences, and that diagnosis and treatment involve risks of injury and sometimes death. I acknowledge that there are no guarantees about the results of the examinations, treatments, or other health services provided by ANHC. Ask your provider questions about the benefits, risks, or available options.
- ANHC staff use my statements, medical history, and other information to evaluate my condition and determine the best treatment. The evaluation and treatment of minors often will require the involvement of parent(s), legal guardians, and other family members.
- Except in emergency or extraordinary circumstances, no substantial procedures are performed on me unless, and until, I have had an opportunity to discuss them with a physician, dentist, or other health professional.
- I have the right to consent or refuse to any proposed procedure and/or treatment plan.
- I will not be involved in any research or experimental procedure without my full knowledge and consent.
- ANHC is a teaching facility and that resident physicians (physicians in training), medical students, nursing students, and other health professional students may be involved in my care. I recognize that these students are supervised by experienced staff and my primary provider has full authority for my care. I understand that I may refuse care by any resident or student at any time, and that such refusal will not result in any reduction of the quality of care provided.

Patient Confidentiality

We are required by law to maintain the privacy of your protected health information (PHI). We are also required to notify you of our legal duties and privacy practices regarding your health information and abide by the practices of our Notice unless more stringent laws or regulations apply.

Notice of Privacy Practices

A copy of the Notice of Privacy Practices will be given to you. Please read this notice. This notice includes information about when we may release patient information to others without the patient's permission, including when:

- The patient poses a threat to him/her/their self or others.
- The patient is unable to protect him/her/their self from risk of harm.

- The patient is in the legal custody of a government agency or facility.
- There is evidence of abuse, neglect, or domestic violence.
- Clinical records are requested by court order.

Statement for Release of Information

ANHC receives federal, state, and private grant funding to help support our operations and allow us to serve you and our community. As a stipulation of receiving this funding, ANHC is required to participate in audits and to occasionally release patient/client information for purposes of quality assurance and status reporting. Information released will only be used to verify that ANHC is following the grant requirements, processing applications correctly, and processing payments/billing correctly.

- I consent (agree) to the release of any of my records that may be considered necessary for
- review for any assistance program that I am eligible for or participating in.
- Programs may include but are not limited to sliding fee scale, Ryan White grant-funded
- programs, other grant-funded programs, and pharmacy assistance programs.
- Any records that may be deemed necessary for review include but are not limited to: sliding fee
- scale application and supporting documents, patient information, insurance information, and
- any other types of information contained within my electronic health and/or dental records.

Patient Notice of Billing Practice and Office Policy

I understand that payment for services provided by ANHC is due at the time of service. We accept cash, Visa, MasterCard, Discover Credit Cards, debit cards, and personal checks. Payment plan options are available and reviewed individually. If there is any patient liability that wasn't anticipated/collected at time of service but identified after Insurance processes the claim, ANHC will notify the patient of the balance owed via a statement. Payment is expected by the due date on the statement. ANHC may send the balance owed to collections if not paid by the due date.

Upon request or if uninsured/self-pay, ANHC will make a good faith effort to give the patient or guarantor a reasonable estimate of charges using the most current pricing for a same or similar service. These estimates provide no guarantee to a person's actual bill charges due to the inability to predict all services that may be required with the individual care plan.

If you have health insurance, we will send the bill to your insurance company for you.

- If you are not sure if your provider is in-network or preferred with your insurance plan, please ask us before your appointment.
- We expect you to pay at the time of service for any estimated patient responsibility portion, including co-pays, deductibles, coinsurance, and/or charges for non-covered services.
- We allow a 90-day grace period for your insurance to respond to our claims. If the insurance company does not respond to our claims within 90 days, you will be responsible for paying the full balance.

Due to specialized equipment required for some laboratory testing, ANHC does not have the ability to perform all laboratory services. ANHC contracts with an outside vendor to perform testing we are unable to perform. Our vendor will bill separately for any tests performed at their location. Because of this, you may receive two statements (one from ANHC and one from laboratory vendor) if the tests ordered could not be completely performed at ANHC. We are not responsible for billing practices of the vendor.

Sliding Fee Discount Program

We have a sliding fee discount program for patients whose household income is below 200% of Alaska's Federal Poverty Level. This discount is available to all qualified patients regardless of insurance status.

- The Sliding Fee Discount can be used for any non-covered charges, including but not limited to co-pays, deductibles, and coinsurance.
- If your income or household size changes, you must update your sliding fee application.
- You must update your application at least every 12 months to qualify for the sliding fee scale discount.

Release, Assignment, and Statement of Responsibility

I consent (agree) to the release of any information necessary to process my insurance claims and assign and request payment directly to the Anchorage Neighborhood Health Center, Inc. (ANHC). I understand that:

- I am responsible for payment for all services and products provided to me, or any patient for which I am the guarantor of payment.
- I agree, whether I sign as legal guardian, guarantor, or patient, to pay that account in accordance with the regular rates and terms of ANHC.
- If the account is referred to an attorney or collection agency for collection, I will pay actual attorney's fees and the collection expense. If your account is 30 days past due, you may be charged interest at the legal rate.

Signature for Consent for Treatment and Billing Practices*

By signing my signature, I acknowledge and agree that:

- I have reviewed a copy of ANHC's Notice of Privacy Practices made available to me and I understand that I may request a copy of the notice at any time.
- I have read and understand the Consent for Treatment and Billing Practices (this document) regarding treatment for myself or if signing as a parent or guardian, for my minor child or the person for whom I am responsible.

I have read the statements above. I understand my rights as a patient and my financial responsibility to the Anchorage Neighborhood Health Center. If I have questions about this form, I have asked a staff member and understood the answers to my questions before signing. I understand that at any time, I can ask ANHC staff questions about treatment, privacy practices, and billing.

Printed name	
Signature	Date

**This agreement expires one year from date signed, unless revoked (cancelled) in writing prior, or a new agreement is signed.*

PHI Disclosure Agreement

Your name	Your date of birth

ANHC Protected Health Information Policy

Protected health information (PHI) includes demographic information, health history, test results, insurance information, and more. **We will only disclose your PHI to other parties with your written permission.**

Who should you list on this form?

- Anyone you would like to have access to your PHI.
- **Language interpretation assistance:** People who will provide you with language interpretation assistance when you receive health care at ANHC.
- **Parents and/or guardians:** If you are age 12 to 17, your parents and/or guardians will only have access to your MyChart account as a proxy if you list them on this form.

How long does the PHI Disclosure Agreement last?

This PHI disclosure agreement will remain in effect unless we receive written notice from you. You may make changes to your PHI disclosure agreement at any time. To make changes, request another copy of this form.

I allow ANHC to disclose my personal health information to the following people:

Name	Relationship to you	Date of birth	Do you authorize this person to have proxy access to your MyChart account?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Signature

Signature	Today's date