Date: _____

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Social Security Number: _____
(Responsible Party - required for health insurance)

Gender: [ ] Male [ ] Female

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email**:** _____

Preferred Pharmacy: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

Marital Status: Single ____ Married ____ Domestic Partner ____

Spouse Full Name: _____ Date of Birth: _____

Social Security Number: _____ Contact Phone: _____

If Patient is a Child:

Mother's Name: _____ DOB: _____ Phone: _____ SSN _____

Father's Name: _____ DOB: _____ Phone: _____ SSN _____

Address, if different from above: _____

Insurance: _____ Policy #_____ Group #_____

Name of insured: _____ Date of Birth of Insured: _____

Employer or Union: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ City: _____ State: _____

Printed Name: _____
(Patient or Legal Guardian)

Signature: _____ Date: _____

Updated: 4/8/21

Communication Permissions

I authorize the release of my medical and billing information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OR

[ ] My information is not to be released to anyone.

Regarding messages from Frontier Family Medicine:

[ ] You may leave a detailed message
[ ] Please leave a message asking me to return your call

We prefer to send text message appointment reminders:

[ ] Okay to text for appointment reminder
[ ] I prefer a phone call and voicemail reminder

Phone for Text: _____ Phone for Call: _____

Patient Printed Name: _____

Signature: _____ Date: _____
(Legal Guardian)

Financial Agreement

Billing Practices

As a service to you, we will file insurance claims for each of your insurance policies. Co-Payments are expected at the time service. You will need to furnish the clinic with all necessary information. *Please bring your insurance card(s) to every visit*. It should be understood your insurance policy is an arrangement between you and your insurance company to pay certain amounts for medical care. Your physician's bill is an arrangement between you and Frontier Family Medicine. You are responsible for full payment of your account, regardless of the status of your insurance claim. For patients without health insurance, we require payment at the time of service. This might not be the full charges for the visit, and you will be billed accordingly.

Special note- many insurance companies do not pay for certain physicals. Because of this, *at the time of the visit*, Frontier Family Medicine will collect $60.00 for sports physicals. If your insurance policy covers them, you may be entitled to a refund if you have met the requirements of your insurance company.

Fees for Services

Fees for medical services are based on the cost of procedures performed, the amount of professional skills involved, the amount of administration and record review required, and the amount of time spent. Frontier Family Medicine's fees for professional services are determined in the same manner as those of other various physicians' offices throughout Alaska and the United States. Appropriate charges for the completion of various forms will apply. We will be happy to estimate your charges however, due to the nature of diagnosing medical problems; it is sometimes difficult to be precise concerning total charges. If at any time you have questions about your charges, please let us know.

No Show Fee

Not showing up for an appointment or failing to call to cancel, prior to your scheduled appointment time, significantly affects our ability to provide flexible appointment times and same day appointments. Because this is unacceptable to us, Frontier Family Medicine has a "no-show" policy. There is a token administrative fee of $25.

Options for Payment

We accept cash, personal checks, Visa, MasterCard and Discover. Payments can be made over the phone, through the mail, or in person.

What if the Account is Not Paid?

We want to be understanding and cooperative with everyone. Our staff will work with you in setting up payment arrangements on approval. However, for those patients who do not fulfill their obligations after 60 days, it will be considered in everyone's best interest for those accounts to be referred to a collections agency and you will be assessed a $25 late fee. Thereafter, non-payment will affect the credit status of a person. If a patient has been referred to a collection agency, all future visits will be placed on hold for 60 days. If debt is not paid, you will be discharged from the practice.

Acceptance of Responsibility

I understand that I am financially responsible for all charges whether paid by an insurance company. I know that it is my responsibility to notify Frontier Family Medicine of any changes to my account. This includes changes in insurance, address, telephone numbers, emergency contacts, etc.

Printed Name: _____ Date: _____
(Patient or Legal Guardian)

Signature: _____ Staff Witness Initials: _____

Updated: 4/8/21