SportsMed Alaska

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:
Street Address:		
City, State, Zip:		
Home Phone: May we leave a voicemail message? ❑ Yes ❑ No If Yes, select type of message: ❑ Brief ❑ Extended	Cell Phone: May we leave a voicemail message? ❑ Yes ❑ No If Yes, select type of message: ❑ Brief ❑ Extended	
Date of Birth:	Gender: ❑ Male ❑Female	
Marital status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated	SSN:	
Email Address:		
Preferred Language: ❑ English ❑Spanish ❑ Other		
Race: (Select one) ❑American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other Race	Ethnicity: (Select one) ❑ Hispanic or Latino ❑ Not Hispanic or Latino	

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Home Phone:
Address (if different):		
Primary Insurance Name:		
Subscriber's Name:	Policy #:	Copay: $
Subscriber DOB: Subscriber SSN:	Group #:	Group Name:
Patient's relationship to subscriber: : ❑ Self ❑Child ❑ Spouse ❑ Other		
Secondary Insurance Name:		
Subscriber's Name:	Policy #:	Copay: $
Subscriber DOB: Subscriber SSN:	Group #:	Group Name:
Patient's relationship to subscriber: ❑ Self ❑Child ❑ Spouse ❑ Other		

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Contact Number:

PREFERRED PHARMACY

Name: Location:	Phone:	Fax:

PRIMARY CARE PHYSICIAN

Name: Location:	Phone:	Fax:

Patient Name (Printed) _____ Signature of Patient / Patient Representative _____ Date _____

PATIENT FINANCIAL POLICY

Thank you for choosing SportsMed Alaska. We understand that many patients find financial matters surrounding their medical care to be very complex and often times confusing. If you have any questions regarding our billing policies, we will be happy to assist you.

Private Health Insurance	**Initial Here** _____	We are ***NOT*** a contracted, "preferred", or considered In-Network with most private health insurance plans. As the patient, you are responsible for requesting prior approval and/or Out-of-Network benefit level exceptions from your insurance company as required. Our office collects a standard 20% of amount due at the time of service. You will be billed for any amount not covered by your plan in addition to your deductible, and/or co-insurance amounts not collected at the time of service.
Medicare	**Initial Here** _____	We are a contracted provider with Medicare. You must be enrolled in Medicare Part B to be eligible for benefits. You will be billed for any remaining deductible, co-insurance amounts and/or patient-notified non-covered services after Medicare processes your claim. No payment is required at the time of service.
Medicaid	**Initial Here** _____	We are a contracted provider with Medicaid. You must present a current sticker/card for each month of eligibility. Please note, a referral is required if you are in the Lock-in Program; without a referral you will be considered a self- pay patient. Your co-pay is due at the time of service and failure to make payment may result in delayed future appointments.
Tricare / Triwest / VA	**Initial Here** _____	We are a non-network provider with Tricare and Triwest. We will bill Tricare and Triwest on your behalf as a courtesy. You will be responsible for any account balance not covered by your plan. VA visits must be preauthorized by your referring physician.
Workers Compensation	**Initial Here** _____	We only accept Workers' Compensation claims that were filed with the Alaska or Washington Departments of Labor. Your claim must be open and accepted. You must complete a Physician Report as well as provide your carrier's information including claim number and date of injury. No payment is required at the time of service.
Self-Pay / Uninsured	**Initial Here** _____	Payment is due in full at the time of service unless other billing arrangements have been approved by the SportsMed Billing Department
Auto Accident	**Initial Here** _____	A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance policy) regardless of fault. Once your medical benefits are exhausted your private insurance may be billed. YOU MUST CONTACT YOUR PRIVATE INSURANCE TO DISCLOSE YOUR LIABILITY CLAIM. If you have no other insurance coverage, your account will be transferred to a self-pay status and payment will be due upon receipt unless other billing arrangements have been approved by the Kenai Spine Billing Department
Payment Plan	**Initial Here** _____	Payment plans must be established through the SportsMed Billing Department. Please note our payment plans are determined on an individual bases. All payments will be applied to the oldest date of service first.
Other	**Initial Here** _____	

- I have read, understand, and agree to this financial policy.
- I understand that I am ultimately responsible for my balance, not my insurance carrier.
- I authorize SportsMed to release medical information to my insurance carrier to facilitate payment.
- I understand that my signature authorizes benefits to be paid directly to SportsMed Alaska.
- I understand that should my account balance become delinquent, the balance may be referred to a collection agency.
- I will be held responsible for all fees associated with the collection of my account balance.

_____ _____ _____

Patient Name (Printed) Signature of Patient / Patient Representative Date

MEDICATION POLICY

Narcotics / Controlled Substances

The providers of SportsMed Alaska do not routinely prescribe narcotics on a long-term basis. Individuals who are seeking "pain killers" for chronic use are hereby advised to seek treatment with an appropriate pain management provider. When indicated, long-acting opiates are prescribed in extremely limited quantities without automatic refills. Narcotic prescriptions will not be refilled after office hours or on weekends. By signing this policy, you agree to stay consistent with the use of the one pharmacy as listed below. If you have a current pain control contract in place please provide the name of the provider with whom you have the contract and bring this to our attention at the time of your first appointment. We will assist you in arranging for postoperative pain control through that provider.

NAME OF PAIN CONTRACT PROVIDER: _____ ☐ N/A

PHARMACY: _____

We ask that you report either lost or stolen medications to the police immediately and that you provide a copy of the police report for our records. We will not replace lost or stolen pain medications without a copy of a valid police report. Having a copy of a valid police report does not guarantee that we will replace your prescription and each situation will be assessed on a case-by-case basis. It is an inherently dangerous practice to receive prescriptions for narcotics and other controlled substances from several physicians at the same time. Therefore you agree that, unless otherwise authorized, the physicians at SportsMed Alaska will be the sole narcotic prescribing source for you at this time. Furthermore, by accepting controlled substances from SportsMed Alaska, you agree to grant us permission to contact pharmacies and other physicians in order to ensure compliance with this policy. If we determine multiple physicians are ordering prescriptions for pain medications, we will immediately cease all orders for such treatments from our office. In the postoperative period, we may continue to aid you in pain control with the goal that you will taper and eventually discontinue your pain medications. If this cannot happen in a timely manner, you will be referred to a provider who can aid in this process.

Regarding Prescription Refills

SportsMed Alaska has a 48 hour medication turn-around. Prescription requests submitted after 3 pm may not be called in until 2 business days later. Please allow ample time for this process. We do not refill prescriptions over the weekend. Be sure to submit your request before noon on Friday if you need your prescription filled on Monday. This is not guaranteed. For your own convenience, call your pharmacy before leaving home to make sure they have your prescription ready. SportsMed providers will not refill prescriptions for patients not seen in the past 90 days by a SportsMed provider.

Acknowledgement of Prescription Policy

I have read and understand SportsMed Alaska's policy regarding prescription medications. I agree to the terms involved in the Medication Policy.

_____	_____	_____
Patient Name (Printed)	Signature of Patient / Patient Representative	Date

Consent to Obtain External Prescription History

I, _____, authorize SportsMed Alaska to view my external prescription history via the RxHub service. I understand that prescription history from other medical providers, insurance companies, and pharmacy benefit managers may be viewed by my providers and staff here. My signature certifies that I have read and understand the scope of my consent and authorize the access.

_____	_____
Signature of Patient / Patient Representative Date	Date

A copy of this policy will be provided if requested.

HIPAA NOTICE AND 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

SPORTSMED ALASKA and its employees are dedicated to maintaining the privacy of your personal health information ("PHI"), as required by law. These laws require us to provide you with this Notice of Privacy Practices, and to inform you of your rights and our obligations concerning Protected Health Information, or PHI, which is information that identifies you and that relates to your physical or mental health condition. We are required to follow the privacy practices described below.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

A. **PERMITTED DISCLOSURES OF PHI**. We may use and disclose your PHI for the following reasons:

1. **Treatment**. We may use health information about you to provide you with medical treatment or services. We nay disclose your PHI to a physician or other health care provider providing treatment to you, such as nurses, technicians or personnel who are involved in your care.

2. **Payment**. We may use and disclose your PHI to bill and collect payment for the services we provide to you. For example, we may send a bill to you or to a third party payer for the rendering of services by us. The bill may contain information that identifies you, your diagnosis and procedures and supplies used. We may need to disclose this information to insurance companies to establish insurance eligibility benefits for you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

3. **Health Care Operations**. We may use or disclose your PHI in connection with our health care operations. Health care operations include quality assessment activities, reviewing the competence or qualifications of health care professionals, evaluating provider performance, and other business operations. For example, we may use your PHI to evaluate the performance of the health care services you received. We may also provide your PHI to accountants, attorneys, consultants and others to make sure we comply with the laws that govern us.

4. **Emergency Treatment**. We may use and disclose your PHI if you require emergency treatment or are unable to communicate with us.

5. **Family and Friends**. We may disclose your PHI to a family member, friend or any other person whom you identify as being involved with your care or payment for care, unless you object.

5. **Required by Law**. We may disclose your PHI for law enforcement purposes and as required by state or federal law. For example, the law may require us to report instances of abuse, neglect or domestic violence; to report certain injuries such as gunshot wounds; or to disclose PHI to assist law enforcement in locating a suspect, fugitive, material witness or missing person. We will inform you or your representative if we disclose your PHI because we believe you are a victim of abuse, neglect or domestic violence, unless we determine that informing you or your representative would place you at risk. In addition, we must provide PHI to comply with an order in a legal or administrative proceeding. Finally, we may be required to provide PHI in response to a subpoena discovery request or other lawful process, but only if efforts have been made, by us or the requesting party, to contact you about the request or to obtain an order to protect the requested PHI.

B. SPECIAL SITUATIONS. We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

1. **Serious Threat to Health or Safety**. We may use and disclose your PHI if we believe it is necessary to avoid a serious threat to the health and safety of you or the public.

2. **Public Health**. We may disclose your PHI to public health or other authorities charged with preventing or controlling disease, injury or disability, or charged with collecting public health data.

3. **Health Oversight Activities**. We may disclose your PHI to a health oversight agency for activities authorized by law. These activities include audits; civil, administrative or criminal investigations or proceedings; inspections; licensure or disciplinary actions; or other activities necessary for oversight of the health care system, government programs and compliance with civil rights laws.

4. **Research**. We may disclose your PHI for certain research purposes, but only if we have protections and protocols in place to ensure the privacy of your PHI.

5. **Workers' Compensation**. We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs.

6. **Specialized Government Activities**. If you are active military or a veteran, we may use and disclose your PHI as required by military command authorities. We may also be required to disclose PHI to authorized federal officials for the conduct of intelligence or other national security activities.

7. **Organ Donation**. If you are an organ donor, or have not indicated that you do not wish to be a donor, we may disclose your PHI to organ procurement organizations to facilitate organ, eye or tissue donation and transplantation.

8. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your PHI to coroners or medical examiners for the purposes of identifying a deceased person or determining the cause of death, and to funeral directors as necessary to carry out their duties.

9. **Disaster Relief**. Unless you object, we may disclose your PHI to a governmental agency or private entity (such as FEMA or Red Cross) assisting with disaster relief efforts.

10. **Business Associates**. Certain aspects and components of our healthcare operations are performed through contracts with outside persons or organizations as contractors, such as auditing, accreditation, legal services, etc. At times, it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our healthcare operations. In all cases, those business associates are required to appropriately safeguard the privacy of your information in the same ways as SPORTSMED ALASKA.

C. **DISCLOSURES REQUIRING WRITTEN AUTHORIZATION**.

1. **Not Otherwise Permitted**. In any other situation not described in Sections A and B above, we may not disclose your PHI without your written authorization.

2. **Psychotherapy Notes**. We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment or health care operations activities.

3. **Marketing and Sale of PHI**. We must receive your written authorization for any disclosure of PHI for marketing purposes or for any disclosure which is a sale of PHI.

YOUR RIGHTS

You have the following rights regarding your health information that we maintain about you:

1. **Right to Receive a Paper Copy of This Notice**. You have the right to receive a paper copy of this Notice upon request.

2. **Right to Access PHI**. You have the right to inspect and copy your PHI for as long as we maintain your medical record. You must make a written request for access to the Privacy/Compliance Officer of SPORTSMED ALASKA at the address listed at the end of this Notice. We may charge you a reasonable fee for the processing of your request and the copying of your medical record. In certain circumstances we may deny your request to access your PHI, and you may request that we reconsider our denial. Depending on the reason for the denial, another licensed health care professional chosen by us may review your request and the denial.

3. **Right to Request Restrictions**. You have the right to request a restriction on the use or disclosure of your PHI for the purpose of treatment, payment or health care operations, except for in the case of an emergency. You also have the right to request a restriction on the information we disclose to a family member or friend who is involved with your care or the payment of your care. However, we are not legally required to agree to such a restriction.

4. **Right to Restrict Disclosure for Services Paid by You in Full**. You have the right to restrict the disclosure of your PHI to a health plan if the PHI pertains to health care services for which you paid in full directly to us.

5. **Right to Request Amendment**. You have the right to request that we amend your PHI if you believe it is incorrect or incomplete, for as long as we maintain your medical record. We may deny your request to amend if (a) we did not create the PHI, (b) is not information that we maintain, (c) is not information that you are permitted to inspect or copy (such as psychotherapy notes), or (d) we determine that the PHI is accurate and complete.

6. **Right to an Accounting of Disclosures**. You have the right to request an accounting of disclosures of PHI made by us (other than those made for treatment, payment or health care operations purposes) during the 6 years prior to the date of your request. You must make a written request for an accounting, specifying the time period for the accounting, to the Privacy/Compliance Officer of SPORTSMED ALASKA at the address listed at the end of this Notice.

7. **Right to Confidential Communications**. You have the right to request that we communicate with you about your PHI by certain means or at certain locations. For example, you may specify that we call you only at your home phone number, and not at your work number. You must make a written request, specifying how and where we may contact you, to the [Privacy/Compliance Officer] at the address listed at the end of this Notice.

8. **Right to Notice of Breach**. You have the right to be notified if we or one of our business associates become aware of a breach of your unsecured PHI.

HIPAA NOTICE AND PRIVACY PRACTICES CONTINUED

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time in accordance with applicable law. Prior to a substantial change to this Notice related to the uses or disclosures of your PHI, your rights or our duties, we will revise and distribute this Notice.

RECEIPT OF NOTICE

Publication of this Notice on our website - http://www.sportsmedalaska.com/forms.html -- is notice to you. We also may ask you to sign an acknowledgment that you received this Notice.

QUESTIONS AND COMPLAINTS

If you would like more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding the use, disclosure, or access to you PHI, you may complain to us by contacting the Privacy/Compliance Officer of SPORTSMED ALASKA at the address and phone number at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your PHI. You will not be penalized for your questions or for making or filing a complaint. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Privacy/Compliance Officer
SPORTSMED ALASKA
P.O. Box 1534
Soldotna, AK 99669
(907) 420-3540

This notice is effective on the signed date below.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge receipt of a copy of SPORTSMED ALASKA's Notice of Privacy Practices regarding patient's personal health information ("PHI").

Patient Name (Printed)
Or Representative's Name: _____

Patient Name (Signature)
Or Representative's Name: _____Date: _____