



### Patient Information

Please review the following information and initial below confirming that **ALL** information is correct.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Employment Status: \_\_\_\_\_ Employer: \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Preferred Contact:  Home  Cell  Work

Work Phone \_\_\_\_\_ Preferred Reminder Calls:  Call  Text  Email

Initial: \_\_\_\_\_

### Insurance

Please complete the below section OR provide the front office with your insurance card.

Company: \_\_\_\_\_ ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Company: \_\_\_\_\_ ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Initial: \_\_\_\_\_

### Emergency Contact or Parent/Legal Guardian

Name: \_\_\_\_\_

Patient Relationship to Contact: \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

If this patient is over 18, do they have a legal guardian, conservator, or power of attorney? If yes, a copy of the related paperwork MUST be provided.  No  Yes

I hereby authorize Internal Medicine Associates to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. I hereby authorize Internal Medicine Associates to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

**X** \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Legal Patient or Legal Representative Signature

Employee Initials: \_\_\_\_\_



## Acknowledgement of Patient Financial Responsibility

All patients are required to complete provided forms as determined by Internal Medicine Associates, LLC. No provider-patient relationship is established until forms are completed and the provider has personally evaluated the patient. Refusal to complete certain forms is a basis for the provider to decline evaluation of a prospective patient.

- Internal Medicine Associates, LLC bills your insurance. In order to verify your plan, you must provide current insurance information and valid government issued photo identification.
- It is not possible for Internal Medicine Associates to know the specific benefits of your plan. **It is your responsibility to be aware of your coverage and to ensure that your bill is paid.**
- **It is your responsibility to verify coverage and benefits with your insurance company prior to an evaluation, testing, or procedure. This may include getting authorization by your insurance company before the service, if that is required under your plan.** In many instances, your provider may order testing independent from Internal Medicine Associates. Such organizations can include laboratories, imaging facilities, outpatient procedure centers and hospitals. These facilities and related professionals will bill you and your insurance for their services. Our office will provide them with your billing information, but is not responsible for the administration or billing of those services.
- **Payment of deductible:** if not already met, the portion of charges that the patient is responsible for, is required **at the time of service.** Payment can be made by cash, check, or credit card. Payments are accepted in office, by telephone or online via our secure payment portal [www.internalmedak.com](http://www.internalmedak.com). If you need to make other financial arrangements, please ask for an account representative.
- **Your insurance company** may pay on charges according to their **usual and customary fee scale.** In the event your insurance company determines a service is “not covered” or above the “usual or customary charges”, you will be responsible for the balance due.
- **Cancellation Policy/ Fee Scale:** In order to manage provider availability, if you need to cancel or reschedule, it is your responsibility to notify Internal Medicine Associates **prior to your appointment/procedure. Failure to do so, failure to show for appointment/procedure or failure to show up on time may result in the following charges as noted in the below fee table, for which you are personally responsible:**

Office Visits	Procedures*
<p style="text-align: center;">Locations: Internal Medicine Associates: Anchorage Wasilla, and Fairbanks</p> <p style="text-align: center;"><i>Must be cancelled with at least 24 hours' notice to avoid incurring a <b>\$50.00 no show/late cancel fee.</b></i></p>	<p style="text-align: center;">Locations: Anchorage Endoscopy Center, Alaska Regional Hospital, or Providence Hospital, Susitna Surgery Center, Fairbanks Memorial Hospital</p> <p style="text-align: center;"><i>Must be cancelled with at least 48 hours' notice to avoid incurring a <b>\$250.00 no show/late cancel fee.</b></i></p>

*\*Other facilities may have separate no show/late cancel fees.*

- **I acknowledge and agree that I have been offered a copy of Internal Medicine Associates Notice of Privacy Practices.**
- **I acknowledge and agree to all financial responsibilities as outlined in this agreement.**
- **I authorize Internal Medicine Associates, LLC to bill my insurance and release medical or other information necessary to process my medical claims. I request payment of government or other insurance benefits to Internal Medicine Associates, LLC.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
DOB



## Authorization to Use and/or Disclose Health Information

(REQUEST FOR RELEASE OF MEDICAL RECORDS)

I, \_\_\_\_\_, date of birth \_\_\_\_\_, authorize Internal Medicine Associates, LLC, to use and/or disclose my health information to: **Myself** and/or \_\_\_\_\_ (please print full name)

I authorize disclosure of the following types of health information

**Types of Health Information**

*If not checked, default is ALL TYPES*

- Office/Provider Notes
- Laboratory Reports
- Pathology and Biopsy Reports
- Imaging Studies
- Billing Statements
- Other: \_\_\_\_\_

**Date(s) of Service for requested records:**

*If left blank, default is ALL DATES*

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**For the following purpose(s):**

*If not checked, default is CONTINUATION OF CARE*

- Continuation of Care
- Personal Request
- Insurance Claims
- Legal Request
- Other: \_\_\_\_\_

**The following items must be initialed to be included in the use or disclosure of other health information:**

- \_\_\_\_\_ HIV/HCV/AIDS / SEXUALLY TRANSMITTED related health information and/or records
- \_\_\_\_\_ Mental health information and/or records
- \_\_\_\_\_ Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information): \_\_\_\_\_

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Practice Manager or the Privacy Officer. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand I have a right to obtain a copy of this Authorization, upon requesting. I understand that this form does not supersede any previously signed Release of Information.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

This release is effective for one year after the date of signature or until \_\_\_\_\_ (date or event).

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Legal Representative

\_\_\_\_\_  
Relationship of Legal Representative to Individual



## Code of Conduct

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Internal Medicine Associates expects *patients, and accompanying family members and visitors* to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff. The code of conduct is not representative of past or present events or behaviors.

### The following behaviors are prohibited:

- Possession of firearms or any type of weapon
- Physical assault, arson or inflicting bodily harm
- Throwing objects
- Intentionally damaging equipment or property
- Climbing on furniture
- Making verbal threats to harm another individual or destroy property
- Unwelcomed sexual comments or advances
- Making menacing comments or gestures
- Attempting to intimidate or harass other individuals
- Making harassing, offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication
- Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality

**Violators are subject to removal from the facility and/or discharge from the practice. Management reserves the right to include behaviors and actions not listed above that are deemed disruptive or threaten the rights or safety of other patients and staff.**

If you are subjected to any of these behaviors or witness inappropriate behavior, please immediately report to any staff member.

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Patient Signature

Date

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Printed Name of Patient or Legal Representative

Relationship of Legal Representative to Individual



## Internal Medicine Associates, LLC

### Acknowledgement of Prohibition on Photography, Videography & Other Recordings

I understand that while I am receiving services at Internal Medicine Associates, LLC (IMA), I am required to comply with the following rules and restrictions with regard to photography, videography and other recordings:

- Patients, family members and visitors are not permitted to take photographs of, or audio or video recordings of patient visits, medical equipment or patient records. If patient records are requested, a copy will be provided in accordance with IMA policy.
- Individuals are also not permitted to photograph or record others in the IMA facilities.
- Written consent of all individuals involved is required for any variance from these rules.
- If staff becomes aware of any attempt to photograph or record in violation of these rules, staff may take reasonable steps to stop the activity, including a call to security.
- I understand that the penalties for violating one of the above requirements are at the reasonable discretion of my provider and may include termination of services.

I agree to follow the rules outlined above, and will not photograph or record anything while I am receiving services at Internal Medicine Associates, LLC.

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**Print Full Name (first, middle initial, last):**

**Signature:**

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**Date Signed:**



## Health and History

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referring Provider: Referral Self Primary Care Provider: \_\_\_\_\_

Chief Complaint/Reason for Visit: \_\_\_\_\_

### Medications & Vitamins (Prescription and/or Over the Counter)

Name:	Dose:	Times/day:	Prescribed By:

### Allergies

Name:	Reaction:

### Surgery

Surgery	Year

### Hospitalization

Hospitalization	Year

### Social History

Do you currently use tobacco?  Yes  No      Have you ever used tobacco?  Yes  No  
 # per day: \_\_\_ Cigarettes \_\_\_ Cigars \_\_\_ Chewing      How many years have/did you use tobacco? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No      # per week of: \_\_\_ Beer \_\_\_ Wine \_\_\_ Liquor  
 Do you drink caffeine?  Yes  No      # per day of: \_\_\_ Coffee \_\_\_ Tea \_\_\_ Cola  
 Do you use recreational or IV drug use?  Yes  No      How many/what kind of pets? \_\_\_\_\_

### Family History

<input type="checkbox"/> Heart disease – Relative: _____ <input type="checkbox"/> Hypertension – Relative: _____ <input type="checkbox"/> Emphysema – Relative: _____ <input type="checkbox"/> Colon polyps – Relative: _____ <input type="checkbox"/> Gallbladder disease – Relative: _____ <input type="checkbox"/> Diabetes – Relative: _____ <input type="checkbox"/> Sleep apnea – Relative: _____	<input type="checkbox"/> Cancer – Relative: _____ <input type="checkbox"/> Asthma – Relative: _____ <input type="checkbox"/> Colitis – Relative: _____ <input type="checkbox"/> Colon cancer – Relative: _____ <input type="checkbox"/> Hepatitis – Relative: _____ <input type="checkbox"/> Depression – Relative: _____ <input type="checkbox"/> Other – Relative: _____
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### Relative

### Age

### Illness

### Deceased

Father	_____	_____	□Yes □No
Mother	_____	_____	□Yes □No
Sibling	_____	_____	□Yes □No
Child	_____	_____	□Yes □No
Grandfather	_____	_____	□Yes □No
Grandmother	_____	_____	□Yes □No

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Systemic**

**Review of Systems:**

- Fatigue
- Fever
- Chills
- Change in weight
- Night sweats

**ENT**

**Past Medical History:**

- Glaucoma
- Hearing loss

**Review of Systems:**

- Headache
- Sinus pressure
- Neck pain/stiffness
- Neck swelling/lump
- Vision problems
- Eye itching/pain
- Ear ache
- Nasal discharge/blockage
- Hoarseness
- Sore throat
- Bleeding gums
- Mouth sores

**Cardiovascular**

**Past Medical History:**

- High blood pressure
- High cholesterol
- Heart attack
- Heart murmur
- Prolapsing Mitral Valve
- CAD
- On blood thinners
- Blood clots
- Angina

**Review of Systems:**

- Chest pain
- Palpitations

**Pulmonary**

**Past Medical History:**

- Asthma
  - Bronchitis
  - History of TB
  - Use of BCG vaccine
  - Emphysema
  - COPD
  - Apnea
  - Abnormal chest X-ray/chest CT
- Date/Location: \_\_\_\_\_

**Pulmonary - continued**

**Review of Systems:**

- Cough
- Wheezing
- Shortness of breath
- Snoring
- Excessive daytime sleepiness
- Chest pain w/ deep breathing
- Chest pain w/ rotating torso

**Gastrointestinal**

**Past Medical History:**

- Crohn's Disease
- Ulcerative Colitis
- Esophageal Reflux
- Hepatitis
- Gallbladder Disease/Gallstones
- Colon cancer
- Intestinal Polyps removed

Date: \_\_\_\_\_

**Review of Systems:**

- Appetite changes
- Difficulty swallowing
- Heartburn
- Nausea
- Vomiting
- Abdominal pain
- Diarrhea
- Constipation
- Change in bowel habits
- Bloody or black stools
- Uncontrollable gas/bloating

**Genitourinary**

**Past Medical History:**

- Urinary tract infection (UTI)
- Kidney stones
- Are you pregnant?

Date of last period: \_\_\_\_\_

**Review of Systems:**

- Blood in urine
- Burning during urination
- Increased urinary frequency

**Musculoskeletal/Rheumatology**

**Review of Systems:**

- Joint pain/stiffness
- Joint swelling
- Back pain
- Muscle aches or weakness
- Scleroderma
- Other: \_\_\_\_\_

**Neurological**

**Review of Systems:**

- Dizziness
- Fainting
- Numbness
- Sensory disturbances
- Stroke
- Seizure disorder

**Endocrine**

**Past Medical History:**

- Thyroid disease
- Thyroid cancer
- Adrenal tumor
- Pituitary tumor
- Parathyroid disease
- Osteoporosis
- Diabetes
- Gestational diabetes

**Review of Systems:**

- Heat or cold intolerance
- Excessive thirst or urination
- Excessive sweating
- Change in libido (sex drive)
- Change in shoe or ring size
- Stretch marks
- Facial hair growth (women)

**Psychological**

**Past Medical History:**

- Anxiety
  - Depression
- Review of Systems:**
- Sleep disturbances
  - Confusion
  - Memory lapse or loss
  - Other: \_\_\_\_\_

**Skin**

**Past Medical History:**

- Eczema
- Psoriasis

**Review of Systems:**

- Itching
- Skin lesions
- Rashes

**Hematologic**

**Past Medical History:**

- Anemia
- Easy bleeding

**Other**

- HIV-1 infection

\_\_\_\_\_  
Patient or Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

## Alaska's Tobacco Quit Line Enrollment/Referral Form



The Alaska Tobacco Quit Line Referral Form is best for patients who are ready to quit in the next 30 days AND ready to accept a Call from the quit line in the next 7 days.

### PATIENT INFORMATION

Full Name:

Date of Birth:  /  /  Race:

Email:  Address:

Gender:  Male  Female  Other City, State:

Phone:  Zip Code:

Preferred Language:

Tobacco Use Type (check all that apply):

Cigarettes  Pipe  Cigar

Smokeless Tobacco/Chewing  Other

The Alaska Tobacco Quit Line will call you using the number provided above. Please check the BEST 3-hour time frame for them to reach you.

6AM - 9AM  9AM - 12PM  12PM - 3 PM  3PM - 6PM  6PM - 9PM

I am ready to quit tobacco and request that Alaska's Tobacco Quit Line contact me to help me with my quit plan. By participating in this program, I understand that outcome information may be shared with my provider for purposes of my treatment.

Patient Signature: \_\_\_\_\_

### For Office Use Only

#### PROVIDER INFORMATION

TODAY'S DATE  /  /

Provider:

Clinic Name:

Fax:  Phone:

Clinic Admin:  Admin Email:



When complete please fax to QL Rep at (907)-771-6767







**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA OR OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE**

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and Internal Medicine Associates, LLC Billing Liaisons, and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan
- ✓ Institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor)
- ✓ Obtain copies of Plan Documents and Summary Plan Documents
- ✓ File Appeals with Employers after appeals are exhausted.

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031 (b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. **This constitutes an express and knowing assignment of ERISA breach and/or fiduciary duty claims and other legal and/or administrative claims.** I authorize communication with the Provider and its authorized representatives by email and my email address is \_\_\_\_\_@\_\_\_\_\_. I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date