



Alaska Center for Pediatrics
BIRTH THROUGH ADOLESCENT CARE

1200 Airport Heights Drive Suite 140
Anchorage, Alaska 99508
907.777.1800
www.akpeds.com

Patient Information

* some of this information is requested by the US government*

First Name:	Middle:	Last:	Suffix:
Address:	City:	State:	Zip:
Date of Birth: ____ / ____ / ____	Sex: M / F	Ethnicity:	<input type="checkbox"/> Hispanic or Latin <input type="checkbox"/> Not Hispanic or Unknown
Primary Language:	Birth Order(1 st , 2 nd child):	Race:	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic
Primary Pharmacy:		<input type="checkbox"/> Native Alaskan/Indian <input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> White <input type="checkbox"/> Other
How did you find out about ACP? <input type="checkbox"/> friend or referral - please list: _____ <input type="checkbox"/> internet search <input type="checkbox"/> advertisement <input type="checkbox"/> insurance company <input type="checkbox"/> yellow pages			

Primary Guarantor Information

First Name:	Middle:	Last:	Suffix:
Address:	City:	State:	Zip:
Date of Birth: ____ / ____ / ____	Sex: M / F	Relationship to Patient:	
Primary Phone:	Work Phone:		
Permission to leave message: <input type="checkbox"/> brief <input type="checkbox"/> extended	Permission to leave message: <input type="checkbox"/> brief <input type="checkbox"/> extended		
Email:	<input type="checkbox"/> Patient Portal Enabled (online)	Employer:	

Additional Parent / Guardian Information

First Name:	Middle:	Last:	Suffix:
Address:	City:	State:	
Date of Birth: ____ / ____ / ____	Sex: M / F	Relationship to Patient:	
Primary Phone:	Work Phone:		
Permission to leave message: <input type="checkbox"/> brief <input type="checkbox"/> extended	Permission to leave message: <input type="checkbox"/> brief <input type="checkbox"/> extended		
Email:	Employer:		

Primary Insurance (Please provide your ID card)

Insurance Company:	Subscriber ID:	Group ID:
Insured/Relation to Patient:	Date of Birth: ____ / ____ / ____	

Secondary Insurance (Please provide your ID card)

Insurance Company:	Subscriber ID:	Group ID:
Insured/Relation to Patient:	Date of Birth: ____ / ____ / ____	



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Emergency Contact Info

If I am unable to attend my child’s appointment, the following adults may attend in my stead, sign for medical care and make medical decisions for my child. I understand that when I designate another person to authorize treatment decisions for my child, ACP may offer protected health information relative to that decision to the designated person.

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

ACP Policy Acknowledgement

***Families that are separated, divorced or unmarried-we do not allow more than one responsible party. Parents/Guardians are expected to make arrangements between themselves if they plan to split the charges for the patients’ medical care. (e.g. we cannot collect half of the current charges and bill the remainder to the other parent/guardian)**

I understand that the primary guarantor listed is financially responsible for all charges regardless of who holds the insurance policy (deductibles, co-payment and/or co-insurance amounts at the time of service), whether or not paid by insurance, and for all services rendered on my behalf or my dependents. After the current balance has been paid by insurance claim(s), it is the policy holder’s responsibility to submit to any secondary or tertiary insurance companies on a zero balance.

***HIPAA Privacy Rule (Consent, Information Disclosures and Authorization)**

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used only with patient consent. I hereby authorize Alaska Center for Pediatrics, P.C. to furnish information to other providers, healthcare or treatment facilities. I understand that the information to be released MAY include material that is protected by Federal Law. My initials below authorize release of the following type of information. However, if you elect not to provide consent, please mark N/A (not applicable).

Drug/Alcohol abuse _____ Mental Health _____ HIV/AIDS _____

***Prescription History Consent**

For safe, effective medication prescribing, our Electronic Health Record enables us to identify all of your current medications electronically. Please indicate your consent for our practice to obtain external prescription information from pharmacies.

YES _____ NO _____

***Receipt of Privacy Practices and Financial Policy Written Acknowledgement**

I, _____ have reviewed and been offered copies of Alaska Center for Pediatrics Notice of Privacy Practices and Financial Policy on behalf of my child listed above.

***Check-in Policies** - in our effort to provide excellent care and service to our patients, we request that you observe the following policies:

- Patient contact information and identification (when appropriate) will be verified at each visit
- Insurance information will be verified and if a copy of the card is not on file, one will be obtained
- No cell phone use in exam rooms
- All patients are expected to check out with the front desk after each visit
- Co-payments and co-insurances or applicable deductible amounts are due at the time of service
- If you have a school or daycare physical form completed, please give it to the front desk to stamp and scan into your child’s records

As the primary guarantor for this patient, I have read and understand all of the office policies listed above and agree to their terms.

***Signature of Responsible Party** _____ **Date:** _____

ACP staff initials: _____	Date: _____	ACP staff initials: _____	Date: _____
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