WELCOME TO OUR PRACTICE

Dr. Peter Lawrason, PC
1919 Lathrop Street, Suite 101, Fairbanks, AK 99701
Phone (907)452-1622 Fax (907)452-1664

FIRST NAME: **MIDDLE INITIAL:** **LAST**: **DOB**:

MAIDEN NAME/PREVIOUS NAME(S):

MAILING ADDRESS: **CITY**: **ZIP**:

NOTICE: You may receive statements, appointment reminders, &/or correspondence that could include private health information.

E-MAIL ADDRESS:

NOTICE: E-mail is not required. Information sent via e-mail is NOT guaranteed to be secure & could include private health information. You will receive an email inviting you to our patient portal.

PREFERRED CONTACT PHONE#: **ALT. CONTACT PHONE #**:

1) May we leave a detailed message? ☐ YES ☐ NO **1) May we leave a detailed message? ☐ YES ☐ NO**

2) How would you like to be reminded of your appointments at this phone #?

☐ VOICE MESSAGE ☐ TEXT MESSAGE

DRIVERS LICENSE: State ID# SSN #:

EMPLOYER: **☐ Part-time ☐ Full-time**

MARITAL STATUS: **☐ Married ☐ Single ☐ Divorced ☐ Widowed** **ARE YOU: ☐ A Student? ☐ A Minor?**

If Married, Spouse's Name: DOB:

Spouse's Employer: Spouse SSN #:

Race: ☐ American Indian/AK Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White ☐ Other ☐ I don't wish to report

Recognized Ethnicity: ☐ Hispanic/Latin ☐ Non-Hispanic/Latin ☐ Other ☐ I don't wish to report

PREFERRED PHARMACY: HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT: DOB: RELATION:

PHONE # ADDRESS:

Insurance Information

PRIMARY INSURANCE: **SECONDARY INSURANCE:**

ID # GROUP #: **ID # GROUP #:**

Are you the primary insured? ☐YES ☐NO **Are you the primary insured? ☐YES ☐NO**

If no, please fill out below: **If no, please fill out below:**

Name of Insured: **Name of Insured:**

DOB: RELATION: **DOB: RELATION:**

Consent for Treatment

I hereby authorize the office of Dr. Peter Lawrason PC to provide me (or those for which I am legally responsible) with medical services. I understand that I am ultimately responsible for all professional fees even if insurance does not pay for the service(s) provided.

Patient/Responsible Party Signature Date

Dr Peter Lawrason, PC
1919 Lathrop Street, Ste 101, Fairbanks, AK 99701

Notice of Privacy Practices / Uses and Disclosures

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

Federal law dictates how and why your information may be shared without your permission.

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources of coverage such as credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day –to-day activities and management of Dr. Peter D. Lawrason. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your protected information may be disclosed if we believe it is necessary to prevent or lessen a serious and imminent threat to a person or the public, when we believe it can prevent or lessen the threat. We may also disclose to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION:

--Appointment reminders: Your health information will be used by our staff to call you or leave messages for appointment reminders.

--Information about Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

--The right to request restrictions on the use and disclosure of your protected health information.
--The right to receive confidential communications concerning your medical condition and treatment.
--The right to inspect and copy your protected health information.
--The right to amend or submit corrections to your protected health information.
--The right to receive an accounting of how and to whom your protected health information has been disclosed.
--The right to receive a printed copy of this notice.

Dr. Peter Lawrason PC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices." We also are required to abide by the privacy policies and practices that are outlined in this notice.

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information by submitted in writing. You may obtain a form to request access to your records by contacting the receptionist. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact of your complaint.

I have reviewed the Notice of Privacy Practices/Uses and Disclosures of Dr. Peter Lawrason, PC _____(patient initials)

Printed Name:_____ **Date of Birth:**___/____/____

PLEASE CHOOSE ONE OPTION BELOW:

☐ **I authorize** the office of Dr. Lawrason to disclose my health information to an individual other than myself, should I not be available or incapacitated**.**

I authorize (Name and DOB):_____

Signature:_____ **Todays Date:** ___/____/____

☐ **I do not authorize** the release of my health information except as noted in the Notice of Privacy Practices/Uses and Disclosures.

Signature: _____ **Todays Date:** ___/____/____

Dr Peter Lawrason, PC
1919 Lathrop Street, Ste 101, Fairbanks, AK 99701

STATEMENT OF INTENT TO PAY

I understand that the office of Dr. Peter Lawrason PC will make every effort to bill and collect payment from my insurance company for the services that I receive. I agree to be compliant and make every effort to keep my personal information updated with the office and my insurance company. I agree to answer any correspondence from this office or my insurance company and to provide necessary information to them as needed to process my claim in a timely manner. I understand that the insurance company may deny payment of service according to my policy coverage rules. It is my responsibility to keep myself informed of what my policy covers or does not cover. I agree to be responsible for my balance (or anyone I am legally responsible for, such as a minor) if the insurance company does not cover a product or service.

Any account balance owed to Dr. Peter Lawrason PC that goes unpaid may be forwarded to a collection agency and a collection fee may be added to the patient's outstanding balance, increasing the amount due. If no corrective action is taken to pay the balance in a timely manner, the practice may discharge the patient from care and no further appointments will be made. If you have a concern regarding your bill or are having financial difficulties, please call the business office at 907-452-1622 to discuss repayment options.

_____

Patient/Responsible Party Signature Date

OFFICE FINANCIAL POLICY

PATIENTS WITH INSURANCE – Our office policy is that all insurance information must be up-to-date prior to being seen by a provider. Please be prepared to show proof of insurance and a picture ID prior to each visit.

We are a contracted provider with Blue Cross, Medicare, Medicaid of Alaska, Tricare, Aetna, Multiplan/Beechstreet, Cigna, United Health, Meritain, and Moda. We accept and bill for all forms of insurance. If your insurance considers us "out of network" or "non-preferred" you may pay more out of pocket for any services you receive from us. It is your responsibility to know and understand your policy. Call your insurance carrier if you have questions about your coverage or want to verify our status in your health plan's network.

SELF PAY & OUT OF STATE PATIENTS -- payment is due in full at time of service.

ALL DEDUCTIBLES AND CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. If you are receiving a service and we have confirmation that it will NOT be covered by your insurance plan, **payment will be due at the time of service.** Most cost-share amounts due will be billed to you after your insurance has processed our claim for your visit.

MATERNITY PATIENTS -- Most insurance plans require you to pay a cost-share (co-insurance) percentage of the delivery fee. Please be courteous to your provider and pay your portion within 30 days of delivery. Many patients find it helpful to budget for this fee by calling their insurance company in advance to check what their portion will be. You should expect multiple bills for your delivery: one from the delivery provider, one from the hospital for room & board, and one from the anesthesia doctor (if applicable). You may also have a bill from the assistant delivery provider, should one be necessary.

We accept the following methods of payments: Visa, MasterCard, Discover, Check, Debit Card, or Cash. If you present a check as payment, you authorize us to make a one-time electronic funds transfer from your account. Funds may be withdrawn from your account as soon as the same day we receive your payment. You will not receive your check back from your financial institution. **Our fee for returned checks/Non-sufficient funds is $30.00.** Statements are due upon receipt; questions can be referred to our business office at 907-452-1622.

I hereby authorize Dr Peter Lawrason, to release information to my insurance company, and for my insurance company to release information to Dr Peter Lawrason. I hereby assign benefits to be paid directly to Dr Peter Lawrason PC, for this date of service and any other future visits I may have. I have read, understood and agreed to the above financial policy for payment of professional fees.

_____

Patient/Responsible Party Signature Date

Preventative Care Visit vs. Problem Focused Care Visit

If you are here today for a Preventative Care Visit (ie Annual Exam), any services not considered screening or preventative will require an additional visit/charge to your insurance for the problem focused care provided. How your insurance plan pays your claims for problem focused care and preventative care may differ. ***It is possible that some insurance plans do not cover both services on the same day.*** If you have a problem that needs to be addressed today, your Provider may address that condition and reschedule your Preventative Exam.

What may happen at a Preventative Visit?

- Screening for Cancer
- Screening for Heart Disease
- Screening for Mental Health & Substance Abuse
- Screening for Metabolic, Nutritional, & Endocrine Conditions (i.e. checking for Diabetes or Anemia)
- Screening for Sexual Health & Protection
- Vaccination History & Recommendations
- **Medication renewals & management may not be considered preventative.**

(This list is not all-inclusive & each category may contain several different screening scenarios based on your personal age, health, & history. Related labs, radiology, & procedures may or may not be covered. Please check with your insurance carrier.)

What may happen at a Problem Focused Visit?

- Treatment of Chronic Conditions (ie Diabetes, Hypertension, or Thyroid Disorders)
- Medication renewals & management
- Ordering Tests for Chronic Conditions
- Treatment of a New Condition
- Treatment of an Illness or Injury

I have read this form & understand that if I have questions, I can contact my insurance carrier. Dr. Lawrason & his staff are not responsible for knowing nor determining my insurance benefits. I understand that I am responsible for all co-pays, co-insurance, deductibles &/or office visit fees should I choose to have ***both*** *Problem Focused & Preventative Care services from my provider during my scheduled appointment today.*

Printed Name:_____Date of Birth:_____

Patient Signature: _____Date: _____

Peter D. Lawrason, M.D. ~ 1919 Lathrop Street Suite 101 ~ Fairbanks, Alaska 99701
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