## CONSENT FOR TREATMENT AND BILLING PRACTICES

Printed Patient Name: ____________________________________ Patient Date of Birth: ___________

**Informed Consent for Treatment**
I consent (agree) to health care including routine diagnostic procedures, medical treatment and other health services provided by the Girdwood Health Clinic and its authorized personnel and agents.
I understand that:

- The practice of medicine is not an exact science and that diagnosis and treatment involve risks of injury and sometimes death. I acknowledge there is no guarantee about the results of the examinations, treatment or health services provided by GHCI.
- Except in emergency or extra ordinary circumstances, no substantial procedures are performed upon a patient unless, and until, he/she has had an opportunity to discuss them with a physician or other health professional to the patient's satisfaction.
- Each patient has the right to consent or refuse to any proposed procedure or treatment plan.
- No patient will be involved in any research or experimental procedure without his/her full knowledge and consent.

_________ Patient/Guardian Initials

**Notice of Privacy Practices**
I acknowledge and agree that I have reviewed a copy of GHCI's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of the notice at any time.

_________ Patient/Guardian Initials

**Statement for Release of Information for Audit Purposes**
The process of checking business records and policies is called an audit. Auditors are officials that check patient financial applications to make sure GHCI is following grant rules. Auditors will only use your information to that GHCI is processing applications and payments correctly.

- I consent to the release of any of my financial records that may be considered necessary for review by any auditor for any assistance program that I am eligible for, or participating in.
- Audited programs may include but are not limited to sliding fee scale and grant-assisted programs.
- Financial records that may be deemed necessary for review include but are not limited to: sliding fee scale application and supporting documents, patient information, insurance information, and any other types of information contained within my electronic medical records.

________ Patient/Guardian Initials

**Please complete both sides of this form**

**Release, Assignment, and Statement of Responsibility**
I authorize (give permission for) the release of any information necessary to process my insurance claims and assign and request payment directly to the Girdwood Health Clinic. I understand that I may revoke (withdraw) this consent at any time in writing to this office.

I understand that:
- I am responsible for payment for all services and products provided to me, or any patient for which I am the guarantor of payment.
- I agree, whether I sign as legal guardian, guarantor, or patient to pay that account in accordance with the regular rates and terms of GHCI.
- If the account is referred to an attorney or collection agency for collection, I will pay actual attorney's fees and the collection expense. If your account is 30 days past due, you may be charged interest at the legal rate.

________ Patient/Guardian Initials

**Patient Notice of Billing Practice and Office Policy**
Payment for services provided by GHCI is due at the time of service. We accept: cash, Visa, MasterCard, debit cards and personal checks. Payment plan options are reviewed individually.

**Health Insurance:** If you have health insurance, we will send the bill to your insurance company for you.
- If you are not sure if your provider is in-network or preferred with your insurance plan, please as us before your appointment.
- We expect you to pay at the time of service for any estimated patient responsibility portion, including co-pays, deductibles, coinsurance, and/or charges for non-covered services.
- We allow a 90-day grace period for your insurance to respond to our claims. If the insurance company does not respond to our claims within 90 days, you will be responsible for paying the full balance.

**Sliding Fee Discount Program:** GHCI is non-profit community health center. We have a sliding fee discount for patients whose household income is below 200% of Alaska's Federal Poverty Level. This discount is available to qualified uninsured and under-insured patients.
- The Sliding Fee Discount can be used for co-pays, deductibles and co-insurance.
- If your income or household size changes, you must update your sliding fee application.
- You must update your application at least every 6 months to qualify for the sliding fee discount.

_________ Patient/Guardian Initials

**I have read the statements above. I understand my rights as a patient and financial responsibility to the Girdwood Health Clinic. If I have additional questions, I will speak to a staff member before my appointment.**

Patient Signature: ____________________________________________ Date:______________________

Printed Parent/Guardian Name: ____________________________________________________________

Parent/Guardian Signature: _______________________________________________________________
**(if patient is under the age of 18 a parent/guardian signature is required)**

**Please complete both sides of this form**

## HIPAA Privacy Authorization Form

I understand that the Girdwood Health Clinic may still use and disclose protected health information as indicated in the Notice of Privacy Practices.  Would you like to give someone else access to your medical records?

______ Yes                    _______ No

If you answered Yes, please provide the following information on who you would like to grant access:

| Full Name (please print) | Relationship to Patient | Phone | Authorized to Disclose: | |
|---|---|---|---|---|
| | | | Medical | Financial |
| | | | | |
| | | | | |
| | | | | |

This Authorization is being granted at the request of the patient.  Unless otherwise revoked, this Authorization expires 12 months after the date of signing this form.

I understand that I have the right to revoke this Authorization at any time by sending a written notification to the address listed at the bottom of this form.  I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.

I understand that information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Name (print): ___________________________________ Date of Birth: _______________

Signature: _____________________________________________ Date: ______________________

Parent/Guardian Signature: ____________________________________________________________
(required if patient is under 18)

Send any correspondence to:
Girdwood Health Clinic, PO Box 1130, Girdwood, AK 99587

# CONSENT FOR PATIENT RECORD SHARING AND MEDICATION HISTORY AUTHORIZATION

*Patient Name:* ____________________________________________________

*Patient Date of Birth:* ______________

**Consent to Share Medical Records**
I consent to allow GHCI to share and receive my medical records with providers at connected care locations.

_________ Patient/Guardian Initials

**Consent to Access Medication History**
I consent to allow GHCI to download my medication history automatically from pharmacy benefit managers.

_________ Patient/Guardian Initials

**I have read the statements above. I understand my rights as a patient and financial responsibility to the Girdwood Health Clinic. If I have additional questions, I will speak to a staff member before my appointment.**

*Patient Signature:* ____________________________________________

*Date:* ______________________

*Printed Parent/Guardian Name:*

___________________________________________________________

*Parent/Guardian Signature:*

______________________________________________________________
**(if patient is under the age of 18 a parent/guardian signature is required)**

131 Lindblad Ave (physical address)
PO Box 1130 (mailing address)
Girdwood, AK 99587
907-783-1355 | girdwoodhealthclinic.org

# PATIENT REGISTRATION

Today's date: ______________

| Required Patient Information | | |
|---|---|---|
| First Name: | Middle Name: | Last Name: |
| Assigned Sex at birth: M F | Date of Birth: | Social Security Number: |
| Mailing Address (PO Box **required** if you do not have home delivery of mail): | | |
| Phone Numbers:<br>☐ Cell: ______________<br>☐ Home: ______________<br>☐ Work: ______________ | Email Address:<br>**Consent to text? ☐ Yes ☐ No** | |

***We are required by our federal funding to ask the questions below. If you do not want to answer, please check "CHOSE NOT TO DISCLOSE"***

Is English your primary language? ☐ Yes ☐ No If no, what is?______________
If no, do you require a translator? ☐ Yes ☐ No

| Ethnicity: | Race: |
|---|---|
| ☐ Latino/Hispanic<br>☐ Not Latino/Hispanic<br>☐ CHOSE NOT TO DISCLOSE | ☐ Caucasian/White ☐ Asian ☐ Pacific Islander<br>☐ Black/African American ☐ Native Hawaiian ☐ Other<br>☐ American Indian/Alaska Native ☐ CHOSE NOT TO DISCLOSE |

| Marital Status: | Sexual Orientation: |
|---|---|
| ☐ Single ☐ Married ☐ Divorced<br>☐ Separated ☐ Other | ☐ Straight (not lesbian or gay) ☐ Something else<br>☐ Lesbian or Gay ☐ Bisexual ☐ Don't know<br>☐ CHOSE NOT TO DISCLOSE |

| Gender Identity: | # of people in household (adults + children) | Yearly household Income |
|---|---|---|
| ☐ Male ☐ Female ☐ Other<br>☐ Transgender Male<br>☐ Transgender Female<br>☐ CHOSE NOT TO DISCLOSE | | $ ______________<br>☐ CHOSE NOT TO DISCLOSE |

Please mark all that apply: ☐ Veteran ☐ Homeless ☐ Public Housing ☐ Agricultural Worker
☐ CHOSE NOT TO DISCLOSE

**~PLEASE COMPLETE OTHER SIDE~**

## Emergency Contact Information

Name of next of Kin: ______________________________ Phone: ______________

Relationship to patient: ______________________________

Emergency Contact Name: ______________________________ Phone: ______________

Relationship to patient: ☐ Wife ☐ Husband ☐ Parent ☐ Grandparent ☐ Other

## Guarantor Information

**(Person paying for account charges; fill out if person paying for care is not the patient)**

| Legal First Name: | Middle Initial: | Last Name: |
|---|---|---|
| City: | State: | Zip: |
| Guarantor Date of Birth: | Social Security Number: | Phone Number: |

Patient relationship to guarantor:

☐ Wife ☐ Husband ☐ Parent ☐ Grandparent ☐ Life Partner ☐ Other

## Primary Insurance Information

| Subscriber Name (name on insurance card): | Subscriber Social Security Number: |
|---|---|
| Subscriber Date of Birth: | Subscriber ID Number: |
| Plan Carrier (Insurance Company): | |
| Group ID: | Claims Address: |

## Secondary Insurance Information (if applicable)

| Subscriber Name (Name on insurance card): | |
|---|---|
| Subscriber Date of Birth: | Subscriber ID Number: |
| Plan Carrier (Insurance Company): | |
| Group ID: | Claims Address: |

**GIRDWOOD HEALTH CLINIC**
**Adult Health History Ages 12+**

Name:______________________________ DOB:___/___/___ Visit Date: ___/___/___

Reason for visit:

## Patient Preferences

Date of last physical: ___/___/___
Preferred pharmacy: ____________________________________________________________
Preferred Lab: ________________________________________________________________
Other Providers you see: ______________________________________________________

## Allergies

List and describe reaction: medicine, food, environmental

| | |
|---|---|
| | |
| | |
| | |
| | |

## Current Medications

Including inhalers, herbs, supplements, and over-the-counter

| Medication Name | Dose (mg, ml) | Frequency (how often)? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Women's Health

Duration of Flow (days):
Past Abnormal Pap? □ Yes □ No
LMP: □ Unknown □ Approximate □ Definite
Age of menstruation:
Menopause at age:
Date of last Mammogram: Performing Provider:
Date of last Pap smear: Performing Provider:

## Family History

| Family Medical History | Relationship to you | | | | |
|---|---|---|---|---|---|
| Breast Cancer | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Colon Cancer | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Other Cancer | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Heart attack/ Disease | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| High cholesterol | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| High Blood Pressure | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Diabetes | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Osteroporosis | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Bleeding disorder | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Stroke | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Depression | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Alcoholism | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Suicide | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Death before age 50 | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |
| Other: ______________ | ☐Father | ☐Mother | ☐ Sibling | ☐ Child | ☐ Other: |

**GIRDWOOD HEALTH CLINIC**
**Adult Health History Ages 12+**

<table>
<tr><td colspan="3">Social History<br>Check any that apply</td></tr>
<tr><td colspan="3">Tobacco Use: Cigarettes-<br>□ Never □ Former Smoker □ Current Every Day Smoker □ Current Some Day Smoker □ Unknown if ever smoked<br>How Much: □ 1PPW □ 2PPW □ 1/4 PPD □ ½ PPD □ 1PPD □ 1.5PPD □ 2PPD □ 3+PPD Years of Use____________<br>Chewing Tobacco: □ None □ 1/Day □ 2-4/Day □ 5+/Day</td></tr>
<tr><td colspan="2">Advanced Directive: □ Yes □ No</td><td>Alcohol: □ None □ Occasional □ Moderate □ Heavy</td></tr>
<tr><td colspan="2">Caffeine Intake:<br>□ None □ Occasional □ Moderate □ Heavy</td><td>Illicit Drugs:</td></tr>
<tr><td colspan="2">Occupation:</td><td>Exercise: □ None □ Occasional □ Moderate □ Heavy</td></tr>
<tr><td colspan="3">Marital Status: □ Unknown □ Married □ Single □ Divorced □ Separated □ Domestic Partner</td></tr>
<tr><td colspan="3">Diet: □ Regular □ Vegetarian □ Vegan □ Gluten Free □ Specific □ Carbohydrate □ Cardiac □ Diabetic</td></tr>
<tr><td colspan="3">Tetanus Immunization: Tetanus immunization in the past 10 years? □ Yes □ No □ Unknown</td></tr>
<tr><td colspan="3">School Aged: check any that apply</td></tr>
<tr><td colspan="3">Sporting Activities:</td></tr>
<tr><td colspan="3">Parents marital status: □ Unknown □ Married □ Single □ Divorced □ Separated □ Widowed □ Domestic Partner</td></tr>
<tr><td colspan="3">Home situation: □ Both parents □ Mother □ Father □Relatives □ Adoptive parents □ Foster parents<br>Other:</td></tr>
<tr><td colspan="3">Siblings (include ages):</td></tr>
<tr><td colspan="3">Childcare: □ None □ Relative □ Private Sitter □ Daycare/preschool</td></tr>
<tr><td>Animal exposure:<br>□ Yes □ No</td><td>Passive smoke exposure:<br>□ Yes □ No</td><td>Smoke/CO detector, home:<br>□ Yes □ No</td></tr>
<tr><td>Seat belt/car seat used:<br>□ Yes □ No</td><td>Guns present in home:<br>□ Yes □ No</td><td>Year in school:</td></tr>
<tr><td>Bike helmets: □ Yes □ No</td><td>Bullying: □ Yes □ No</td><td>School Name:</td></tr>
<tr><td colspan="3">Have you seen a dentist in the past 12 months? □ Yes □ No</td></tr>
<tr><td colspan="3">Surgical History<br>(include date and preforming provider)</td></tr>
<tr><td colspan="2">Date of last colonoscopy:</td><td>Performing Provider:</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3"></td></tr>
</table>

<table>
<tr><td colspan="4">Past Medical History<br>Please CIRCLE if you have ever had any of the following:</td></tr>
<tr><td>Breast Cancer</td><td>Other Cancer</td><td>Colon Cancer</td><td>Heart Attack</td></tr>
<tr><td>Heart Failure</td><td>Liver Disease</td><td>Asthma</td><td>COPD</td></tr>
<tr><td>High cholesterol</td><td>High blood pressure</td><td>Thyroid Disease</td><td>Bleeding/clotting disorder</td></tr>
<tr><td>Stroke</td><td>Depression/Anxiety</td><td>Alcoholism/Drug use</td><td>Migraines</td></tr>
<tr><td>Chronic Kidney Disease</td><td colspan="3">Please Explain other:</td></tr>
</table>

**GIRDWOOD HEALTH CLINIC**
**Adult Health History Ages 12+**

# Patient Health Questionnaire

* This questionnaire should be completed by the patient.

**Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully and circle your response.**

1. Feeling down, depressed, or hopeless:

Not at all | Several days | More than half the days | Nearly every day

2. Little interest or pleasure in doing things:

Not at all | Several days | More than half the days | Nearly every day

3. Trouble falling asleep, staying asleep, or sleeping too much:

Not at all | Several days | More than half the days | Nearly every day

4. Feeling tired or having little energy:

Not at all | Several days | More than half the days | Nearly every day

5. Poor appetite or overeating:

Not at all | Several days | More than half the days | Nearly every day

6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down:

Not at all | Several days | More than half the days | Nearly every day

7. Trouble concentrating on things such as reading the newspaper or watching television:

Not at all | Several days | More than half the days | Nearly every day

8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual:

Not at all | Several days | More than half the days | Nearly every day

9. Thinking that you would be better off dead or that you want to hurt yourself in some way:

Not at all | Several days | More than half the days | Nearly every day

10. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult

11. If these Problems have caused you difficulty, have they caused you difficulty for two years or more?

- Yes, I have had difficulty with these problems for two years or more.
- No, I have not had difficulty with these problems for two years or more.

**GIRDWOOD HEALTH CLINIC**
**Adult Health History Ages 12+**

| Review of Systems<br>Please check if you experince any of the following: | | | | | | | |
|---|---|---|---|---|---|---|---|
| **General Symptoms** | | | Arm pain on exertion | | Increased urinary freq | **Psychiatric** | |
| | Fever | | Shortness of breath walking | | Blood in urine | | Depression |
| | Night sweats | | Shortness of breath laying | | Incomplete emptying | | Sleep distrubances |
| | Unexplained weight loss/gain | | Palpitations | **Musculoskeletal** | | | Restless sleep |
| | Exercise intolerance | | Known heart murmur | | Muscle aches | | Unsafe relationship |
| **Eyes** | | | Light-head on standing | | Muscle weakness | | Alcohol abuse |
| | Dry eyes | **Respiratory** | | | Back pain | **Endocrine** | |
| | Irritation | | Cough | | Swelling in extremeties | | Fatigue |
| | Vision change | | Wheezing | **Integumentary** | | | Increased thrist |
| **ENMT** | | | Shortness of breath | | Abnormal mole | | Hair loss |
| | Difficulty hearing | | Coughing up blood | | Jaundice | | Increased hair growth |
| | Ear pain | | Sleep apnea | | Rash | | Cold intolerance |
| | Frequent nosebleeds | **Gastrointestinal** | | | Itching | **Hematologic/lymph** | |
| | Nose/sinus problems | | Abdominal pain | | Dry skin | | Swollen glands |
| | Sore throat | | Vomiting | | Growth/lesion | | Easy bruising |
| | Bleeding gums | | Change in appetite | | Laceration | | Excessive bleeding |
| | snoring | | Black/tarry stool | **Neurologic** | | **Allergic/immunologic** | |
| | Dry mouth | | Frequent diarrhea | | Loss of consciousness | | Runny nose |
| | Oral abnormality | | Vomiting blood | | Weakness | | Sinus pressure |
| | Mouth ulcer | | Indigesting (dyspepsia) | | Seizures | | Itching |
| | Teeth abnormality | | GERD | | Dizziness | | Hives |
| | Mouth breathing | **Genitourinary** | | | Frequent headaches | | Frequent sneezing |
| **Cardiovascular** | | | Urinary loss of control | | Migraines | | |
| | Chest pain on exertion | | Difficulty urinating | | Restless legs | | |

Patient Name______________________________ DOB ____________________