



Patient Registration/Information Update

3340 Providence Dr., Ste. 452
Anchorage, AK 99508
Phone: 907-562-2120 Fax: 907-562-6527

PLEASE FILL OUT FORM COMPLETELY AND RETURN TO THE FRONT DESK

Patient's Last Name _____ First Name _____ Date of Birth _____

Mailing Address _____ City, State, Zip _____ Sex _____

Primary Phone _____ Secondary Phone _____ Email _____

Full Names and Birthdates of your other children in our practice who should be linked with this patient:

Is the insurance information different for any of these children? Yes No Is the address the same? Yes No

Parent or Guardian(s) (if not the biological parent, proof of guardianship or consent from biological parent will be required)

First Name _____ Last Name _____

Relationship to Patient _____ Date of Birth _____ SS# _____

Employer _____ Occupation _____ Work Phone _____

First Name _____ Last Name _____

Relationship to Patient _____ Date of Birth _____ SS# _____

Employer _____ Occupation _____ Work Phone _____

Biological Mother/Father's Name(s), if different from above: _____

Address _____ Phone # _____

In the event of an emergency, whom should we call (besides parents)?

Name _____ Relationship _____ Phone # _____

Insurance Coverage Information (Including Medicaid or Denali Kid Care)

PLEASE SUPPLY YOUR INSURANCE CARD(S) OR STICKERS IN ADDITION TO THIS FORM, TO BE SCANNED INTO YOUR CHILD'S RECORD

Primary Insurance:

Insurance Company _____ Group/Plan# _____ ID# _____

Subscriber's Name _____ Date of Birth _____

Effective Date _____ Deductible \$ _____ Employer _____

Secondary Insurance:

Insurance Company _____ Group/Plan# _____ ID# _____

Subscriber's Name _____ Date of Birth _____

Effective Date _____ Deductible \$ _____ Employer _____

Signature of Parent or Guardian

Today's Date



Account Number _____

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT OUR PATIENTS MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A copy of this notice will be made available for you to read, sign, and have entered into your child's electronic chart.

Your Child's Health Record/Information

Your child's healthcare record contains symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information serves as a:

- basis for planning your child's care and treatment
- means for communicating with other health professionals who may contribute to your child's care.
- legal document describing the care your child received
- means by which you or a third-party payer can verify that services billed were actually provided
- source of information for public health officials charged with improving the health of the nation
- source of data only for our planning and marketing
- tool by which we may assess our processes and continually work to improve the care we render

Your Rights Regarding Your Child's Health Record/Information

Although your child's health record is the physical property of the healthcare facility that compiled it, the information belongs to you and your child. You have the right to:

- request a restriction on certain uses and disclosures of the information as provided by
- 45 CFR 164.522
- obtain a paper copy of the notice of the office privacy policy upon request
- inspect and copy the health record as provided for in 45 CFR 164.524
- amend the health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your child's health information as provided in
- 45 CFR 164.528
- request communications of your child's health information by alternative means or at alternative locations. (i.e. on paper, in person, on CD, and at any of our office locations)
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

LaTouche Pediatrics, LLC is required to:

- Maintain the privacy of your child's health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about your child
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will make available a revised notice on our website and printed copies at our office locations.

We will not use or disclose your child's health information without your authorization, except as described in this notice.

LaTouche Pediatrics LLC is permitted to make uses and disclosures of protected health information for treatment, payment, and health care operations, as described in the following examples:

- For treatment - referral to specialists
- For payment - release of chart note copies to an insurance company in order to facilitate reimbursement for procedures performed
- For health care operations – processing of patient information by staff into the Electronic Medical Records, appointment scheduling by our staff.
- LaTouche Pediatrics, LLC may be permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization such as in the case of a Public Health emergency.

If a use or disclosure for any purpose prescribed in the Privacy Regulation is prohibited or materially limited by other applicable State law, we are required to comply with the most stringent law.

Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization

Latouche Pediatrics, LLC may contact the parent or guardian to provide appointment reminders or information about treatment alternatives and other health-related benefits and services that may be of interest to the individual or patient. Authorization forms are available if you wish for this information to be released to anyone other than the parent, guardian or patient.

LaTouche Pediatrics, LLC requires a signed authorization for someone other than the parent or guardian to accompany a patient under 18 years of age for treatment in our facilities.

For More Information or to Report a Problem

Individuals may complain to LaTouche Pediatrics, LLC, and/or to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated.

LaTouche Pediatrics, LLC's contact person for matters relating to complaints is:

Susan Whitaker, Office Manager/Privacy Officer
3340 Providence Dr., Ste 452, Anchorage, AK 99508
Phone: (907) 562-2120

Patient Name

Date

Parent or Guardian

Account #

This Revised Privacy Notice is in effect as of October 09, 2008



LATOUCHE PEDIATRICS, LLC
FINANCIAL POLICY

Thank you for choosing us as your health care provider! We are committed to your treatment being successful. The following is a statement of our Financial Policy. Please read and sign this prior to any treatment in our clinic.

All patients (parents or guardians) must complete our Patient Information and Financial Policy before seeing the Provider.

- **PAYMENT IS DUE AT THE TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, DISCOVER.**
- **WE OFFER A PAYMENT PLAN WITH PRIOR BUSINESS OFFICE APPROVAL**
- **10.5% APR ASSESSES ON ALL ACCOUNTS OVER 60 DAYS.**
- **THERE WILL BE A \$25.00 SERVICE CHARGE ON ALL NSF CHECKS.**

Regarding Insurance:

As a courtesy, we bill most insurance plans on your behalf. You authorize the clinic to release any information to process your claims, and insurance benefits to be paid directly to our providers. It is our goal to provide fast and efficient billing. In order to achieve this goal, **it is imperative that we are provided with complete, accurate, and timely insurance information.** It is your responsibility to inform us of any changes in your insurance coverage. *Many plans have a limited amount of time in which they will allow for billing of claims.* Knowledge of your deductible, co-pays, and plan benefits is your responsibility. **All deductibles and co-pays are due and payable at the time of treatment.** *Please have your insurance card at every visit in the event it may be required.* Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Please be aware that you are responsible for any charges not covered by your insurance for any reason.

We are **Participating Physicians with Blue Cross of Alaska, and Preferred Providers for Federal Blue Cross, Aetna, Great West, and Cigna.** Our providers are credentialed to provide services to **Medicaid/Denali Kid Care recipients.** As Medicaid/Denali Kid Care recipients, you are expected to provide proof of eligibility at every visit and to be aware of your (child's) eligibility dates to avoid any lapse in coverage. In the event coverage has lapsed, you may be asked to reschedule any non-acute visits until eligibility is obtained. You are responsible for payment of any services provided to your child if they are not eligible at the time of service.

Usual and Customary Rates

Our Practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

Minor Patients

The adult accompanying a minor, (parent, guardian or authorized representative) is responsible for payment. Anyone other than parent or legal guardian should have written authorization on file to accompany minor child for treatment.

Thank you for understanding our Financial Policy. Please let us know if you have any question or concern.

I have read, understand and agree to this Financial Policy:

X _____ **Date:** _____
Signature of Parent or Responsible Party Relationship to Patient

Patient Name: _____ Account Number: _____



Patient's name _____ **Date** _____

We would like to take this opportunity to welcome you to LaTouche Pediatrics, LLC. Please take a moment to tell us how you learned about our practice. If more than one, please check all but let us know which is the most important one.

_____ **Friend/Family Member**
Name _____
Child's name _____

_____ **Internet Search**

_____ **Website (*www.latouchepediatrics.com*)**

_____ **GCI Yellow Pages** _____ **ACS Yellow Pages**

Newspaper Advertisement:

_____ Anchorage Daily News _____ Alaska Star
_____ Eagle River/Valley Cache _____ Other Advertisement

Event Sponsor/Community Program:

_____ Ski for Women (supports AWAIC)
_____ Relay for Life (supports American Cancer Society)
_____ Heart Run (supports American Heart Association)
_____ Alaska Junior Theatre
_____ Imaginarium
_____ Other _____

_____ **Sign**

() Huffman location () Providence Hospital location () Eagle River location

_____ **Patient of Dr Brand**

_____ **Physician or other health care professional referral**
Name _____

_____ **Other**
Please explain _____

Thank you

Other hospitalizations		
Year	Reason	Hospital

List all the medications your child takes including vitamins, creams, inhalers, etc...

Name of the Medication	Strength	How Often?

Allergies to medications or foods:

Medication/Food	Reaction (examples: rash, hives, wheezing, etc.)

FAMILY HEALTH HISTORY										
Please let us know who in this child's family has any of the conditions listed below.										
Paternal:		Father (Dad) Grandfather (PGF) Grandmother (PGM)	Uncle (PU) Aunt (PA) Cousin (PC)	Maternal:		Mother (Mom) Grandfather (MGF) Grandmother (MGM)	Uncle (MU) Aunt (MA) Cousin (MC)	Siblings:		Brother (BRO) Sister (SIS)
Yes	No	Condition						What Disease(s) and Who: Please use the abbreviations above and be specific (Paternal or Maternal)		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma								
<input type="checkbox"/>	<input type="checkbox"/>	Bone Problems								
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, type: _____								
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes								
<input type="checkbox"/>	<input type="checkbox"/>	Digestive or Intestinal Problems (ulcers, reflux, Crohn's disease, etc...)								
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Addiction								
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Disease/Problems								
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack								
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure								
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol								
<input type="checkbox"/>	<input type="checkbox"/>	Joint Problems (arthritis)								
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder Problems								
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems (depression, anxiety, bipolar, etc...)								
<input type="checkbox"/>	<input type="checkbox"/>	Seizures or Epilepsy								
<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease (eczema, psoriasis, etc...)								
<input type="checkbox"/>	<input type="checkbox"/>	Stroke								
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems								
<input type="checkbox"/>	<input type="checkbox"/>	Vision Disease/Problems								
<input type="checkbox"/>	<input type="checkbox"/>	Any other relative with diseases or conditions of concern in this child's biological family?								
<input type="checkbox"/>	<input type="checkbox"/>	Are there any other relevant conditions?								

Signature: _____

Date: _____