Providence Medical Group Mat-Su Behavioral Health
2250 S Woodworth Loop, Suite 202
Palmer, AK 99645
Tel: (907) 921-5050 Fax: (907) 761-5801

Providence

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name: ________________________First Name: __________________________ M.I.:___________
SSN: ________________________ Marital Status: M / S / D Sex: M / F DOB: ____________________
Address: _______________________________________City __________________ State ____ Zip ________
Home Phone: __________________ Cell Phone: ____________________ Work Phone: _________________
Email: ____

EMPLOYMENT: Please indicate if unemployed, a student, disabled, or retired _________________________
Employer's Name: __________________ Status: FULL TIME / PART TIME Occupation: ________________

EMERGENCY CONTACT:

Name: ________________________ Relationship To Patient: _________________ Phone: ________________

PRIMARY CARE PROVIDER:____

PARENT/GUARDIAN/RESPONSIBLE PARTY: Who is responsible for the bill?

Last Name: ___________________________ First Name: __________________________ M.I.:___________
Relationship to Patient: ____
Marital Status: M / S / D SSN: _________________________ DOB: _____________________ Sex: M / F
Address: _______________________________________ City __________________ State ____ Zip ________
Home Phone: __________________ Cell Phone: ____________________ Work Phone: _________________
Employer's Name & Address: ____

PRIMARY INSURANCE

Policy Holder: _______________________________ Relationship to Patient: ___________________________
SSN: __________________________________ Date of Birth: _________________________ M_____F_____
Insurance Name & Address: ____
Policy #: _________________________ Group #: _____________________ Effective Date: _______________
Employer Name & Address: ____

SECONDARY INSURANCE

Policy Holder: _______________________________ Relationship to Patient: ___________________________
SSN: __________________________________ Date of Birth: _________________________ M_____F_____
Insurance Name & Address: ____
Policy #: _________________________ Group #: _____________________ Effective Date: _______________
Employer Name & Address: ____

Has any member of your immediate family been treated by Providence Medical Group Mat-Su Behavioral Health Clinic before? ___ If yes, under what name? ____

Patient/Parent/Legal Guardian Signature_________________________________ **Date**____________________

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CONSENT FOR TREATMENT

In order to provide effective treatment, a number of considerations must be agreed upon before beginning. Please read and sign below. If you have any questions, please ask.

I____, request and agree to receive behavioral health services from Providence Medical Group Mat-Su Behavioral Health. I voluntarily consent to such care and services as deemed medically necessary by mental health professionals with the understanding that I have the right to be fully informed regarding diagnosis and treatment options and to be fully involved in my treatment plan.

I understand that I have the right for my personal information to be kept private and that information may be discussed between staff members here at Providence Medical Group Mat-Su Behavioral Health only to the extent that ensures quality care. I understand that my rights to privacy are limited by State and Federal law; and only in an emergency or if required by law records will be released without my consent. These circumstances include but are not limited to known or suspected abuse or neglect of a minor or a vulnerable adult; threat of suicide or harm to another person; compliance with court orders and subpoenas; and other emergency situations.

I understand that my active engagement is a necessary ingredient for treatment success. I agree to attend all my scheduled appointments and to cancel as quickly as possible if circumstances arise that keep me from attending my appointment. I understand that I will be charged for appointments cancelled or rescheduled with less than sufficient notice and that a pattern of missed or canceled appointments jeopardizes my continuing treatment at Providence Medical Group Mat-Su Behavioral Health.

Signature____ Date_________________________________

If patient is a child, who has legal custody and medical decision-making authority?

Name [Print]: ______________________________________Relationship to Child: ________________________

Signature____

Legal Guardian____________________________________ Telephone Number____________________

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HIPAA ACKNOWLEDGEMENT

NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge I was offered a copy of the Providence Health Systems in Alaska Notice of Privacy Practices.

Signature of Acknowledgement___________________________________ Date__________________

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CLINIC POLICIES

CONFIDENTIALITY: We respect your right to confidentiality and what you share with us will be kept in strict confidence. By law, we are required to report instances of child abuse or intent to harm yourself or others. We cannot speak with anyone about your health condition or care without your specific written permission. Please ask the front desk staff for a release of information if you want us to be able to speak with your family member or outside provider about your care.

Patient/Parent/Legal Guardian Initials _______________

CANCELLATIONS/NO SHOW: We are glad to make a reminder call or text prior to each appointment, but you are responsible for keeping your appointments. If you are unable to attend an appointment, we need at least 24 hours' notice so that we can offer that time to someone on our wait list. If you regularly miss or cancel appointments with less than 24 hours' notice, we may no longer be able to provide you with services in our clinic.

Patient/Parent/Legal Guardian Initials _______________

TELEHEALTH: If you are seen through telehealth for an appointment, you must be present in the state of Alaska. If you are outside of Alaska, please call our office in advance to cancel the appointment.

Patient/Parent/Legal Guardian Initials _______________

FINANCIAL: As a courtesy, we will bill your insurance for you if you provide an insurance card(s) and/or proof of coverage at the time of service. If you have a change of insurance, please notify us as soon as possible. Deductibles and co-pays are expected at the time of service. It remains your responsibility to pay in full any balance not covered by your insurance. You are ultimately responsible for payment of services. If you do not make a payment or make financial arrangements to settle your account within thirty (30) days after receiving your statement, you may be sent to collections. We accept cash, check, Visa, MasterCard, AMX and Debit.
Self-paying patients: I understand that I am responsible for my bill and that payment is expected at the time of service unless prior arrangements have been made.

Patient/Parent/Legal Guardian Initials _______________

GUARANTEE OF PAYMENT/ASSIGNMENT OF BENEFITS: In order to bill my insurance, I understand they will have access to records generated from services provided by PMG Mat-Su Behavioral Health. I authorize the exchange of information necessary for payment of services. I authorize payment directly to PMG Mat-Su Behavioral Health for services rendered to me regarding my illness and/or treatment. I also understand that I am responsible for any amount not covered or deemed over usual and customary by my insurance carrier or agency.

Patient/Parent/Legal Guardian Initials _______________

MEDICATION REFILLS: Patients are encouraged to contact their preferred pharmacy for prescription refills. You may also call the PMG Mat-Su Behavioral Health Clinic Medical Assistants to request prescription refills. However, if calling the clinic please allow up to three (3) business days for a prescription refill authorization. Refills will not be authorized on the weekend or holidays.

Patient/Parent/Legal Guardian Initials _______________

QUESTIONS: If you have any questions concerning Providence Medical Group Mat-Su Behavioral Health please contact our office at (907) 921-5050 and we will be happy to assist you.

Providence Medical Group Mat-Su Behavioral Health Clinic Policies have been reviewed, understood, and agreed to by me.

Patient Name:[Print] ____ Date:___________________________

Patient/Parent/Legal/Guardian Signature: ____