



Patient Name: _____ Date of Birth: _____

Authorization to Disclose Medical Records to Anchorage Women's Clinic

I, _____ authorize Dr. _____

And/or Staff of: _____

Address: _____

Phone: _____ Fax: _____

to release all of my medical records pertinent to my OB/GYN care as indicated and initialed below to the following:

Name: Anchorage Women's Clinic, LLC

Address: 3260 Providence Dr. Suite 425 Anchorage, AK 99508

Phone: 907-561-7111 Fax: 907-770-7891

Records are to be Faxed Mailed Collected

All my medical records relative to my Obstetrics or Gynecological care
 Other. Please state part(s) released: _____

The following items **MUST** be initialed to be included in the use or disclosure of other records:

HIV/AIDS related health information and/or records.

Mental health information and/or records

Genetic testing information and/or records

Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

Psychotherapy notes (If this authorization is for the psychotherapy notes, then it cannot be combined with any other authorizations.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to AWC. Unless revoked earlier, this authorization will expire in 180 days from the date of signing below or upon _____.

I also understand that if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Printed Name: _____ Date: _____

Signature: _____ SSN: _____



Anchorage Women's Clinic values your input. In order to make our clinic better for you, our valued patient, we ask that you take a minute to answer a few quick questions and tell us what you think. Each quarter, we review this information and try to make positive changes. Thank you for your participation!

Patient Age: _____ After check in, how long did you wait to be seen? _____

Who is your provider? _____ How did you select your provider? _____

Did someone refer you to our clinic? Y / N

If so, will you let us know who it was so we can thank him/her? _____

Please circle the number that best represents your experience.

REGISTRATION	Very Poor	Poor	Fair	Good	Very Good
Were we professional on the telephone?	1	2	3	4	5
Did we answer the phone promptly?	1	2	3	4	5
Were we helpful when you checked in?	1	2	3	4	5
Was the registration process easy?	1	2	3	4	5
Were you informed of delays?	1	2	3	4	5
Amount of time you had to wait	1	2	3	4	5
Comments: _____					

FACILITY	Very Poor	Poor	Fair	Good	Very Good
How comfortable was the waiting room?	1	2	3	4	5
How clean was the clinic?	1	2	3	4	5
How was the decor?	1	2	3	4	5
Comments: _____					

VISIT/TEST/TREATMENT	Very Poor	Poor	Fair	Good	Very Good	
Was your clinician or provider friendly/pleasant?	1	2	3	4	5	
Did your provider answer your concerns/questions?	1	2	3	4	5	
Was your input was included in your treatment?	1	2	3	4	5	
If you had lab work, was the experience comfortable?	1	2	3	4	5	
Do you feel your condition has improved?	1	2	3	4	5	
Did you find OB education informative?	N/A	1	2	3	4	5
Were you offered educational materials pertinent to your condition or treatment?	N/A	1	2	3	4	5
Comments: _____						

-Over-



AWWC
Anchorage Women's Clinic
You take care of everyone else, let us take care of you.

WEBSITE	Yes	No
Were you aware Anchorage Women's Clinic has a website?		
Have you ever visited our website?		
Was our site easy to navigate?		
Did you find the information you were looking for?		
Did you find the site visually appealing?		
Did you pre-register or print necessary forms via our website?		
Comments: _____		

Reason for visit: Please check those that apply.	
GYN Issues	
Massage	
OB	
Preventative care: (Annual Exam/PAP/Birth Control/Vaccines)	
Ultrasound	
Other	

What is important to you? Please check appropriate box.	Not Important	Somewhat Important	Important	Most Important
I can get appointments promptly				
Location of the office				
My provider's personality				
Office helps with my insurance				
Office provides me with educational materials or pertinent information				
Pleasant staff				
The knowledge my provider has				
Warm/friendly environment				
Other – please list				

Was there anything we forgot to ask about that you'd like to share with us?

Would you like us to contact you regarding anything in this survey or about your recent visit? Y / N

Name: _____

Phone: _____



Patient Notice of Billing Practices

Medical Services provided by AWC are payable at the time of service. We accept the following:

- Cash, Most Major Credit Cards, Personal Checks, Money Orders, and Debit Cards
- Payment plan options are offered for large patient balances through *Care Credit*. (Please ask someone in billing for additional information)
- Copayments and amount due for non covered services (including deductible) will be expected at time of service.

Private Insurance

We compliment our services with insurance claims submission. In many cases we are a Preferred Provider. Most private policies are billed as a courtesy to our patients. We allow a 30-day grace period for your insurance to respond to our claims. If the insurance does not respond to our claims within 30 days, the balance becomes due in full. If you have two insurances, we allow 30 days for the primary insurance payment and 30 days for the secondary insurance payment. If payment is not received from your insurance companies, the full balance is requested from the patient.

Medicare/Medicaid

We are currently accepting both Medicare and Medicaid. If you have either insurance and there is a co-payment required, it will be collected when services are rendered. Please understand that we are required to collect *at time of service*. Applicable waivers will be provided for signatures at appointment.

Tricare

As of January 1st, 2006 we no longer accept Tricare. This means that we will not bill Tricare nor will we accept their adjustments. We are happy to continue our relationship with our Tricare patients but will need to obtain payment in full when services are rendered.

Patient Credits

Patient credits will be refunded once all visits have been responded to by insurance. Obstetrical patients will have any credits on their visits applied to future visits or to their delivery. Once the delivery has been responded to by insurance, any remaining credit will be refunded. Any total balance or credit under \$10.00 will not be billed or refunded. These will be adjusted off as small balance write off.

Out of State Patients

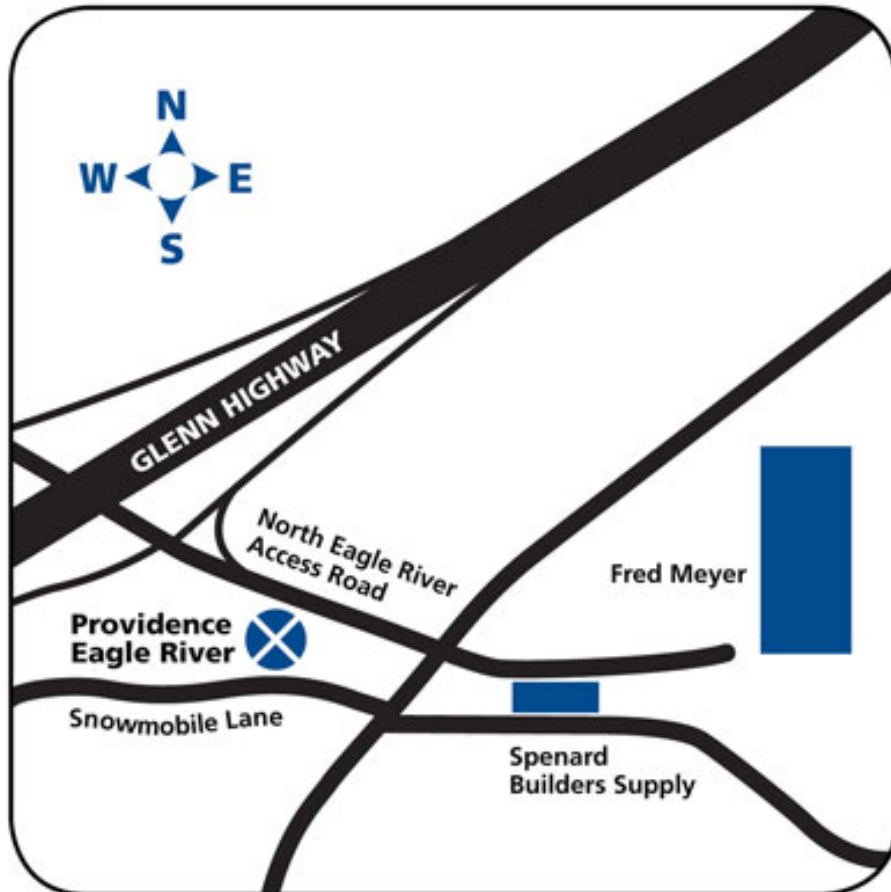
Those patients who are here visiting Alaska and require our services will be required to make full payment when they are seen. We will provide you a receipt that you may use to submit to your insurance for reimbursement.

Our preference is ALWAYS to work with our patients directly; however, any balances that remain unpaid may be forwarded to Cornerstone Credit Services. Accounts referred to Cornerstone Credit Services are assessed additional fees. These fees are assessed by Cornerstone and are in addition to your clinic charges. Should you have a question regarding a collection balance due, we will direct you to a Cornerstone representative for resolution. Additional fees may be applied upon referral.

***I have read the above payment options and understand my financial responsibility to this organization.
If you have additional questions, please ask to speak to a billing representative, prior to your appointment.***

Patient or Guardian Signature

Date Signed



From Anchorage:

1. Glenn highway to North Eagle River Exit
2. Turn right from off ramp on to North Eagle River Access Road
3. Turn right at the Light
4. Take 1st right on to Snowmobile Lane
5. We are located in the Providence building 2nd floor suite 201

From Valley:

1. Glenn highway to North Eagle River Exit
2. Turn left from off ramp on to North Eagle River Access Road
3. Turn right at the Light
4. Take 1st right on to Snowmobile Lane
5. We are located in the Providence building 2nd floor suite 201

www.anchoragewomensclinic.com

3260 Providence Drive Suite 425 Anchorage Alaska 99508 907.561.7111 Phone 907.770.7891 Fax

8/2/2010 eaglerivermap.doc

Patient Name: _____ Date of Birth: _____ Date: _____

Health History Form

Are you a new patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been seen at AWC before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what year? _____	Where you referred by another provider? <input type="checkbox"/> Yes <input type="checkbox"/> No If so Whom: _____
Primary Care Physician: _____		Other Providers: _____
<u>Current Medications and /or Vitamins:</u> _____ _____ _____		
Allergies: _____ Latex: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Past History

<u>Surgeries with Dates:</u> _____ _____				
<u>Illnesses & Injuries (Physical & Mental) with Dates:</u> _____ _____				
<u>Immunizations & Dates:</u>	Rubella:	Tetanus TD/Tdap:	HPV:	Other:
Flu:	TB/PPD:	Pneumonia:	Meningococcal:	

Gynecological History

<u>Last Menstrual Period:</u>	<u>Age Menses Started:</u>	<u>Length of flow:</u>	<u>Interval Between Periods:</u>
<u>Any Recent Changes:</u> _____			
Ever Had Sex: <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Active Now: <input type="checkbox"/> Yes <input type="checkbox"/> No	Partners Are: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	
<u>Any Abnormal Pap Smears, Colposcopy and/or Leeps (Please include dates and/or years):</u> _____		<u>History of STD's (Please include date and/or years):</u> _____	
<u>Current Method of Contraception:</u>		<u>Previous Contraceptive History:</u>	

Obstetric History

No. of pregnancies:	Live Births:	Premature Births:	Miscarriage/Abortion:	Live Children:
<u>No.</u>	<u>Birth Year</u>	<u>Weight of Baby</u>	<u>Baby's Sex</u>	<u>Weeks Pregnant</u>
				<u>Type of Delivery (Vaginal, Cesarean, Etc.)</u>
1.				
2.				
3.				
4.				Put Additional on back
Any Pregnancy complications? <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension/High Blood Pressure <input type="checkbox"/> Preeclampsia/Toxemia <input type="checkbox"/> Depression <input type="checkbox"/> Other				

Family History (If you mark one please state who)

<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other

Social History

Marital Status: _____	Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Packs/Day: _____	Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No How Often: _____	Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____
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Dear New Patient:

Thank you for choosing Anchorage Women's Clinic for your gynecological needs.

It is important to bring your current insurance card with you. If you have a co-payment please be prepared to pay at the time of your visit. The cost of your medical care will vary depending upon the level of care required as determined by your physician. Procedures and laboratory tests may result in additional fees from AWC and the lab. Payment for all non-covered services (not including lab charges which are billed separately by the lab) is due when services are rendered.

The pages following this letter need to be completed and mailed, faxed or hand delivered to AWC marked ATTN: **GYN Intake** prior to your appointment. Your information will be loaded into your Electronic Medical Record in advance of your appointment. Your previous records pertaining to your Ob/GYN care need to be reviewed prior to your appointment. Please be sure to include those records with your registration paperwork.

Our Anchorage clinic is located at 3260 Providence Drive within the Providence Alaska Medical Center in the "C" tower. When trying to find parking there are a couple of different options. Valet parking is located at the main entrance next to the Jesus statue parking garage behind the "A" building or parking in the parking lot. From the main lobby you will take the "C" elevators, which are located across from the gift shop, to the fourth floor and we are in suite 425. For our Eagle River location please see the map that comes with this packet.

Sincerely,

The Physicians and Staff of Anchorage Women's clinic



Patient Name: _____

Patient Account # _____

**Release of Personal Health Information
Family and Friends**

I authorize Anchorage Women’s Clinic, LLC to release my personal health information, “PHI”, to the following:

1. _____ Relationship: _____

2. _____ Relationship: _____

By signing below you agree that Anchorage Women’s Clinic, LLC may release “PHI” to the above individual(s). This release will remain in effect for one year from the date signed below.

If you wish to cancel this release you must do so in writing directed to:

HIPPA Compliance Officer
Anchorage Women’s Clinic, LLC
3260 Providence Dr. Suite 425
Anchorage, AK 99508

Your request will be processed within 48 hours unless otherwise specified. Please call 907-561-7111 if you have additional questions.

Signature: _____

Date _____

Date of Birth: _____



Position Statement: Treatment of Minors

When young women of minor age present to the clinic for medical care, including gynecologic care, it is our legal right to provide them with such care without consent of their parent or guardian, and our legal responsibility to provide that care confidentially. (We are legally required to reveal if a patient is in danger to herself or others, such as suicidal or homicidal intentions, or if there is evidence of statutory rape occurring, namely sexual activity between a girl 14 years or younger and a male 4 or more years older than she.)

This can produce a conflict, because the adults in the patient’s life often want, need, or deserve to know what the medical care for a minor consists of, while the young woman may or may not want them involved.

What we want more than anything is to help open up rather than harm the communication available between young women and the adults in their lives, and not to be considered an evil facilitator for having provided a young woman answers to her questions, medical advice to keep her safe, prescriptions she requests and safely be given, or referrals for other medical care she desires. Rather than creating a triangle out of the communication (as in “What did you tell my daughter? What did my daughter tell you?”), since we cannot reveal information without violating the confidence of our relationship with the patient, we hope that you discuss these important issues together, with/without us involved.

It is often helpful to realize that the common goal we all share is that the young woman who is our patient remains safe. Safe from: physical harm, unintended pregnancies, sexually transmitted diseases, and emotional harm. If we all communicate with that understanding, the exchange of information is often more adult, more respectful and flows more freely.

While we encourage adults to accompany young women to the clinic, we also would appreciate and usually need an opportunity to talk about confidential topics without the adult in the room at some point. This is not unusual: even pediatricians do this! Young women seeking care must realize that it is fraudulent for us not to bill for services we provide, and that the billing information, if routed through an insurance company, ends up with the person responsible for the medical bill. In other words, if screening tests for sexually transmitted diseases are performed (and they are recommended by the American College of OB/GYN’s for all sexually active women younger than 30 who have not had all the children they want, annually), they must be either paid for at the time of the visit or they will be billed to the responsible third party (insurance contracted by the parent or guardian).

Alternatives to care in our clinic for young women of limited financial means include clinics at the Municipality (eighth & L street), and Planned Parenthood (south Lake Otis).

Agreement to Treat

I, _____, am a parent or guardian of a minor patient, _____, And I have legal authority to make medical decisions for the patient. I have read the above Position Statement: Treatment of Minors prepared by the Anchorage Women’s Clinic (AWC). I understand that the AWC has a responsibility to maintain confidentiality, as outlined in the Position Statement, needs to be maintained. I understand there will be times when the minor will need to be alone with one or more AWC physicians when no other adults are in the room and that confidential topics may come up during these periods. I also understand that the AWC encourages open communication between parents and minor patients and hopes there will be discussions of these topics either with/without an AWC physician being present.

THEREFORE, In consideration of the AWC’s agreement to treat the minor patient named above, I, as the patient’s parent or legal guardian, hereby consent that the AWC may keep confidential any information received by the AWC from the patient that is deemed by the AWC to be confidential. I also agree that I will not make a claim or demand for the release of such information and hereby waive any right to do so, both on my own behalf and on behalf of the minor patient.

DATED: ____/____/____

(Parent/Guardian of the minor patient named above)

DATED: ____/____/____

(Minor patient named above)