Polar Pediatrics
Monique O # M.D.
Phone (907) 522-KIDS (5437)
Fax (907) 522-5435
www.polarpediatrics.com

NEW PATIENT INFORMATION SHEET

Patient Information			**Account#**
Last Name:		First Name:	MI:
Birth Date:	Sex: M F	Social Security#	
Child resides with (check one):	Both Parents	Mother Father	Other:
Home Phone:			
Mailing Address:			
City:	State:		Zip:
Physical Address:			
City:	State:		Zip:
Email:			
Other Children in Household:			
1.) Name: Birth Date:	Sex: M F	2.) Name: Birth Date:	Sex: M F
3.) Name: Birth Date:	Sex: M F	4.) Name: Birth Date:	Sex: M F

Responsible Party	Relation to Child:	
Last Name:	First Name:	MI:
Birth Date:	Social Security#:	
Mailing Address:		
City:	State:	Zip:
Home Phone:	Daytime Phone:	Other:
Email:		

Other Legal Guardian	Relation to Child:	
Last Name:	First Name:	MI:
Birth Date:	Social Security#:	
Mailing Address:		
City:	State:	Zip:
Home Phone:	Daytime Phone:	Other:
Email:		

Emergency Contact		
Last Name:	First Name:	
Address:		
City:	State:	Zip:
Home Phone:	Daytime Phone:	Other:

Pharmacy Information
(Please indicate which pharmacy you prefer to have your prescriptions filled.)

Please Fill Out Page Two

NEW PATIENT INFORMATION SHEET
PAGE TWO

Primary Insurance Information		
Insurance Name:		
Insurance Address:		
Policy Holder:		
Birthdate:	Social Security#:	
Policy#:	Group#:	CoPay Amount:
Employer:	Occupation:	Deductable Amount:

Secondary Insurance Information		
Insurance Name:		
Insurance Address:		
Policy Holder:		
Birthdate:	Social Security#:	
Policy#:	Group#:	CoPay Amount:
Employer:	Occupation:	Deductable Amount:

Medicaid or Denali Kid Care #

Assignment and Release I, the undersigned, certify that I have provided complete and accurate information on behalf of my family. I assign directly to Polar Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Polar Pediatrics to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.	
Responsible Party Signature:	**Date:**

HIPPA Privacy Acknowledgement I have received and been given the opportunity to review the Notice of Privacy Practices for Polar Pediatrics.	
Responsible Party Signature:	**Date:**

Polar Pediatrics
"""Monique N. Ej kf , MD
New Patient History

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Concerns you would like addressed today:

Past Medical History:

Past Hospital Stays:

Past Surgeries:

Allergies to Medications:

Other Allergies:

Family Medical History:

Who lives at home:

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Office Financial Policies

1. OFFICE VISITS: Applicable fees are payable at the time of service unless current information is on file. Polar Pediatrics accepts cash, checks, MasterCard and Visa as forms of payment.

_______ (Initials)

2. MEDICAID: Medicaid patients need to provide a current coupon or sticker at the time of check-in. If a sticker cannot be provided, **the appointment will either be rescheduled or the guardian accompanying patient will be considered personally responsible for the bill.** Newborn infants will be given four weeks to be approved by Medicaid.

_______ (Initials)

3. DENALI KID CARE: Patients with Denali Kid Care need to present a current ID card at time of check in. If a card cannot be provided, the appointment will either be rescheduled or the guardian accompanying Patient will be considered personally responsible for the bill. Newborn infants will be given four weeks to be approved by Denali Kid Care.

_______ (Initials)

4. LATE APPOINTMENTS: Patients arriving more than fifteen minutes late will be rescheduled.

_______ (Initials)

5. MISSED APPOINTMENTS: When a patient "no-shows", other patients who are ill are denied that time slot. As courtesy we ask that you please give 24 hours notice to reschedule or cancel your appointment. Patients who repeatedly miss appointments may be dismissed from our practice.

_______ (Initials)

6. COLLECTIONS: Should collections become necessary I agree to pay all collection agency fees.

_______ (Initials)

7. INSURANCE: As a courtesy to our patients we bill primary insurance (we do not bill secondary insurance carriers) for office visits. In order for us to provide this service, we need documentation of insurance. This includes a copy of the insurance card, yearly deductible amount, and maximum yearly allowable for preventative care; any co-pay requirement. and coverage effective dates. Our receptionist will provide you with a form on which to provide the necessary information.

   If we bill insurance, the patient remains responsible for 1) the deductible amount, 2)any co-pay, 3) any unpaid balance after 90 days, and 4) that portion of our charges not covered by insurance (unless collection of the uncovered portion is prevented by contract, such as a preferred provider agreement). .

   For new patients, we will continue to request payment at the time of service until we have all requested information on file.

_______ (Initials)

8. RETURNED CHECKS: Our NSF (Non Sufficient Funds) fee for returned checks is $25.00. If your check is returned for non-sufficient funds, then we will no longer accept personal checks as payment on your balance due. You can pay by credit card, cash or a cashier's check.

________ (Initials)

Signature ________________________________Date _____________

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Release of Information

I **hereby authorize Polar Pediatrics to REQUEST information FROM:**

____

____

(facility name and address)

Regarding the following patient:

Patient Name: ____ DOB: _______________

Other Names Used: ____

Records to be released:
Date(s) of service: ____

Check all that apply:

Consultation Report	Laboratory Reports	Office Visits
Discharge Summary	Operative Report	Other: ________________
Emergency Room Visit/Report	Pathology Reports	
History and Physical	X-Ray Report	

Purpose: Continuing Care

This authorization expires on the following date, event or condition: ___________________________ .
If I do not specify any expiration date event or condition, this authorization expires in one year.

Statement of Authorization:

- I understand that, except for research related Polar Pediatrics will not condition my treatment on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Monique M. Karaganis, M.D.
- A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to a third party.
- I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

____ Date:________________
Signature of Patient/Legally Authorized Representative

____to a MINOR (reason patient unable to sign)
Relationship

The information contained in this transmission is privileged and confidential. It is intended only for the use of the individual or entity named above. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT YOU ARE NOT AUTHORIZED TO REVIEW THE FOLLOWING PAGES AND THAT ANY DISSEMINATION, DISTRIBUTION, OR COPY OF THIS COMMUNICATION IS STRICTLY PROHIBITED. If you have received this communication in error, please notify us immediately by telephone (collect) and destroy the original message. Thank you for much!

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail,

U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

1. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

2. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

3. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

4. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

5. We agree to provide patients with access to their records in accordance with state and federal laws.

6. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

7. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____date____________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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ALASKA DIVISION OF Public Health

Prevention Promotion Protection

Patient Eligibility Screening Record
Vaccines for Children (VFC) Program

VFC eligibility screening must be conducted whenever a child age 18 years or younger receives state-supplied vaccine. Although screening must take place during EACH immunization visit to ensure the child's eligibility status has not changed, documentation on this form is required only during the initial visit of a VFC-eligible child and during any subsequent visit in which it is determined the child's eligibility status has changed. The screening record may be completed by the parent/guardian/individual of record or by the health care provider. Verification of responses is not required. This form (or similar information) must be maintained in the child's medical record.

Primary Provider's Name: Polar Pediatrics - Monique Karaganis M.D.

Initial Screening Date: _____/_____/_____ Child's Date of Birth _____/_____/_____

Child's Name: ______________________________
Last Name First MI

Parent/Guardian/
Individual of Record: ______________________________
Last Name First MI

Does this patient qualify for the VFC program? □ Yes □ No

If yes, check one eligibility box:

- □ Medicaid
- □ American Indian/Alaska Native
- □ Uninsured
- □ Underinsured (health insurance does not cover cost of vaccines)

Eligibility Changes

Although VFC eligibility status must be reviewed EVERY time a vaccine is administered, documentation is required on the table below ONLY when changes in VFC eligibility occur.

Date mm/dd/yyyy	**VFC Eligibility Status** *(place an "x" under the appropriate category)*				
	Medicaid	**American Indian/ Alaska Native**	**Uninsured**	**Underinsured***	**Does not meet eligibility criteria**

* To be supported with VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center.