Integrated
WOMEN'S WELLNESS
&
CENTER FOR BIRTH

D. Glen Elrod, M.D.
950 E. Bogard Rd., Ste 212, Wasilla, AK 99654
Phone: (907) 357-7781 Fax: (907) 357-7786

Last Name:_____ Social Security:_____

First Name:_____ Marital Status:_____

Mailing Address:_____

City, State, Zipcode:_____

Employer Name: _____

Employer Address:_____

City, State, Zipcode:_____

Home Phone:_____ Work Phone:_____

Emergency Contact Name: :_____

Emergency Contact Phone: :_____

Birth Date_____

Please furnish us with insurance cards if available

Primary Insurance:

Primary Insurance Carrier Name: _____

Cardholder's Name: _____

Address:_____GRP#_____ID#_____

City: _____ State: _____ Zip: _____

Primary Cardholder's Telephone #_____

Primary Cardholder's Date of Birth: _____

Insurance Phone: _____ Cardholder's Social Security:_____

Relationship to Patient: Self_____Spouse____Parent_____Employer's

Secondary Insurance:

Secondary Insurance Carrier Name: _____

Cardholder's Name: _____

Address:_____GRP#_____ID#_____

City: _____ State: _____ Zip: _____

Secondary Cardholder's Telephone #_____

Secondary Cardholder's Date of Birth: _____

Insurance Phone: _____ Cardholder's Social Security:_____

Relationship to Patient: Self_____Spouse____Parent_____Employer's

Assignment & Release

I understand that I am financially responsible for all charges whether or not paid by insurance. It is customary to pay deductibles and copays at the time services are rendered unless other arrangements have been made in advance. I hereby authorize the above named provider to release to my insurance company or its representative, all information including the diagnosis and treatment or examination rendered to me during the period of such medical or surgical care. I also authorize and request my insurance company to pay directly to the above named provider the amount due him in my pending claim for basic medical, major medical, and/or surgical treatment or services by reason of such treatment or services rendered to:

Patient Signature: _____ **Date:** _____

Billing Information

Integrated Women's Wellness & Center for Birth
(907) 357-7781

If you do not have insurance or have insurance that will not cover your visit, payment is expected at the time services are rendered. Arrangement for payments should be made prior to the appointment.

Alaska Medicaid recipients are required to present proof of coverage on the first visit of each month and a $3.00 copay, if applicable, at each visit.

We will accept assignment of benefits for most insurance companies if:

1. You provide our office with all the billing information for your particular insurance, coverage, deductibles or copays.
2. You have met your deductible and are being seen for a covered service.
3. You agree to pay your co-payment at the time services are rendered.
4. You agree to pay the balance of all charges and fees within 30 days after the insurance company has paid or 90 days after services are rendered whether or not your insurance has paid on your account. Failure to pay off your account within 90 days from the date of services could result in your account being sent to a debt collection agency and you will be responsible for all collection agency cost.

Fees: Insufficient Fund Check: $25.00 Balances over 30-90 days: $2.00

There are some instances or services provided when we will ask for full payment. These include:

- Catastrophic insurance coverage or non covered services.
- Depo Provera injections for birth control reasons.
- Implanon or IUD products or insertion services.
- Infertility testing or services.

Insurance is a contract between you and your insurance company. We are NOT a party to this in monst cases (we will inform you if we are a party to your insurance contact and will handle claims according to our agreement with the insurance company, if one exists). Our agreement to file your claim is a courtesy and you are ultimately responsible for all charges.

I have read and understand the above information.

Responsible Party

Signature_____ Date:_____

Privacy Practices Acknowledgement

Integrated Women's Wellness & Center for Birth
950 E. Bogard Rd., Ste 212
Wasilla, AK 99654

At my first visit in to the office I have the right to request and review the Notice of Privacy Practices. This document states that I understand that my health information is protected by HIPPA and that all information is considered confidential.

Name:_____

Signature:_____

Date:_____