Coho Family Medicine LLC.
Patient Registration Form

Social Security #_____Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____
Street

_____
City, State, Zip Code

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Circle One **Sex:** Male Female **Marital Status:** Single Married Divorced Other

Patient's Employer: _____

Employer's Address: _____
Street, City, State, Zip

Employer's Phone #:_____

How did you hear about us? (Circle one) friend, newspaper, yellow pages, dentist/doctor

BILLING AND INSURANCE INFORMATION

Name of Insurance Company: _____

Membership #:_____Group #:_____

Name of Policy Holder: _____ Date of Birth (policy holder):_____

SS# (policy holder):_____

Employer of Policy Holder: _____

Secondary Insurance: _____

Membership #:_____Group #:_____

Name of Policy Holder: _____ Date of Birth (policy holder):_____

IN CASE OF EMERGENCY

Name of local Friend or Relative (not living with you):_____

Relationship: _____ Number: _____

Signature of Person Completing This Form: _____Date:_____

Coho Family Medicine LLC. Dr. Steve Parker, MD
General Adult Medical

ame:_____ Date of Birth:_____

hief complaint:_____

DRUG ALLERGIES

_____
_____
_____
_____
_____

CURRENT MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

	father	mother	father's parents	mother's parents	siblings	children
Heart disease						
High blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/convulsions						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Mental illness						

HOSPITALIZATIONS OR SURGERIES

Reason	Date	Reason	Date

PAST MEDICAL HISTORY

- Headaches_____
- Shortness of breath_____
- Heart palpitations_____
- Heart murmur_____
- Chest pain_____
- Dizziness/fainting_____
- Peripheral vascular disease_____
- Allergies/hay fever_____
- Asthma_____
- Bronchitis_____
- Pneumonia_____
- Ulcer_____
- GI disorder_____
- Gall bladder disease_____
- Prostate disease_____
- Bowel irregularity_____
- Sexual/menstrual dysfunction _____
- Venereal disease_____
- Frequent infections_____
- Hepatitis_____
- Anemia_____
- Arthritis_____
- Nervousness_____
- Depression_____
- Gout_____
- Chronic rashes_____
- Rheumatic fever_____
- Mumps_____
- Rubella_____
- Polio_____
- Diphtheria_____
- Tetanus_____
- Other_____
- _____
- _____
- _____
- _____
- _____

ABITS

- Smoke Packs Daily_____ How long?_____ When stopped?_____
- Exercise routine _____
- Alcohol Type/amount_____

Coho Family Medicine LLC. , Dr. Steve Parker, MD

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize :

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

to release healthcare information of the patient named above to:

Dr. Steve Parker, Coho Family Medicine LLC
7200 E. Valley Circle, Suite B , Palmer , Alaska 99645
Phone :907-746-5577, fax :907-746-5578

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Coho Family Medicine LLC, Dr. Steve Parker, MD

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and reviewed a copy of Coho Family Medicine's HIPAA Notice of Privacy Practices.

Patient Name (Please Print) _____

PatientSignature_____Date_____

OR Signature of Personal Representative _____

Authority of Personal Representative to Sign for Patient (check one)

◯ Parent ◯ Guardian ◯ Power of Attorney ◯ Other _____

I would also like Coho Family Medicine to share my private medical information with the below listed individuals. This may be spouse, family member or friend. This means that Coho Family Medicine may communicate with your representative and pass on medical information related to all medical care unless limited by yourself.

Name: _____

Relationship: _____Phone:_____

Name: _____

Relationship: _____Phone:_____

Name: _____

Relationship: _____Phone:_____

** In accordance with Alaska State law and the Privacy rule of the Health Insurance Portablility and Accountability Act of 1996(HIPP), I understand that 1. This Authorization may incluse disclosure of information relating to drugs, alcohol, HIV or other health informaiton.I specifically authorize release of such information to the person(s) indicated. 2. I have the right to revoke this authorization any time by writing to the clinic.I understand I can revoke this authotrization except to the extent that action has already been taken based on this authorization. 3. I understand signing this is voluntary.My treatment , paymemt , enrollment in a health plan or eligibility for beneifits will not be conditioned upon my authorization of this disclosure. 4. Information disclosed under this authorization might be re -disclosed by the recipient and this re- disclosure may no longer be protected b y federal or state law. I release and hold harmless Coho Family Medicine LLC,and members andemployees therof, from any and all consequences of this release.

Coho Family Medicine LLC, Dr. Steve Parker, MD

Payment Policy

Coho Family Medicine uses R & R billing Services to handle all billings. Their offices are off site from the clinic. Because of this only co-pays or outstanding sent bills received are collected at this office .Charges from the days visit will be sent promptly in the mail. For patients without health insurance, we require$100.00 at the time of service. This might not cover the full charge of the visit and you will be billed accordingly. Overcharges will be refunded in a timely manner. If you need to make payment arrangement s, please let us know. Any balance over r6moths will be charged at a 20 % service fee.

Insurance As a service to you, we will file insurance claims for each of your insurance policies. You will need to furnish the clinic with all nessacary information. Please bring your insurance cards to very visit. It should be understood your insurance policy is an arrangement t between you and Coho Family Medicine LLC. You are responsible for full payment of your account regardless of the status of your insurance plan. ** Special note: many insurances do not pay for certain physicals. Because of this, at the time of visit, Coho Family Medicine LLC will collect $50.00 for sports physicals and $150.00 for DOT/CDL physicals. If your insurance policy covers them you may be entilted to a refund if you have met the requirements of your insurance company.

Fees for Services Fees for medical services are based on the cost of procedures performed the amount of professional skills involved, the amount of administration, record review required and the amount of time spent... Coho Family Medicine LLC's fees for professional service re determined in the same manner as those of other various physicians' offices throughout Alaska and the United States. Appropriate charges for the completion of various forms will apply. R & R billing will be glad to speak to you about our fees. Their phone # is 745-6440. We will be happy to estimate your charges; however due to the nature of diagnosing medical problems, it is sometimes difficult to be precise concerning total charges. If at any time you have questions about your charges, please let us know.

No Show Fee Not showing up for an appointment or failing to cancel significantly affects our ability to provide flexible times, and same day appointments. Because we respect your time and we want you to respect ours we have a "no show policy". There is an administrative fee of $25.00 for each "no show". Please call 24 hours in advance if possible to cancel an appointment.

Payment options we accept, cash, personal checks, visa and mastercard.Payments can be made over the phone, through the mail or in person. R & R Billing would be happy to assist you with any questions 745-6440. We want to be understanding and cooperative with everyone. Our staff will work with you in setting up payment arrangements if nessacary. However, for those patients who do not fulfill their obligations after 90 days, these accounts well be referred to a collections agency. If a patient has been referred to collections, future visits may be paid at time of service with cash or credit card.

"I understand that I am financially responsible for all charges whether or not paid by an insurance company. I know that it is my responsibility to notify Coho Family Medicine LLC of any changes to my account. This includes changes in Insurance, address, phone numbers, emergency contact, etc..."

Patient: _____ Date: _____