Solstice Medicine and Wellness, LLC
Dr. Gina Escobar, Internal Medicine
Karolina Priebe, Nurse Practitioner
475 Riverstone Way Suite 2
Fairbanks, AK 99709
Phone: (907) 456-6334
Fax: (907) 456-6336
Email: solsticemedi@alaska.net

Date: _____

Name: _____ Date of Birth: _____

Phone Number: Home _____ Cell _____ Work _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Payment Method: Cash _____ Insurance _____ If Insurance, What Type: _____

Surgery Details:

Type of surgery: _____

Date of surgery: _____

Surgeon/ Location: _____

Anesthesia (local/general): _____

Do you have any special requirements? Such as latex allergies, disabilities, wheelchair, etc.

_____

MEDICAL HISTORY

ALLERGIES/ ADVERSE REACTIONS

(List all allergies- medications/food/environmental/ other substances- and type of reaction:

_____

_____

_____

CURRENT MEDICATIONS AND SUPPLEMENTS

(including prescription, over-the-counter medication, supplements/ herbal remedies- taken daily and on as needed basis. Please list name, dosage and frequency)

_____

_____

_____

_____

_____

_____

_____

Medical conditions/ Have you ever had or currently have:

___ Anxiety
___ Depression
___ Insomnia
___ Anemia
___ Asthma
___ Congestive Heart Failure
___ COPD/ Emphysema
___ Pneumonia
___ Tuberculosis
___ Sleep Apnea (___use CPAP)
___ Seasonal Allergies
___ Diabetes (or prediabetes)
___ GERD/ Reflux/ Esophagitis
___ Gallbladder disease
___ Cancer (site: _____)
___Other: _____

___ High blood pressure
___ High Cholesterol
___ Heart Attack
___ Clotting disorder
___ Varicose Veins
___ Blood clots in legs/ lungs
___ Kidney disease
___ Kidney stones
___ UTI
___ Seizure Disorder
___ TIA
___ Stroke
___ Thyroid disease (type: _____)
___ HIV/ AIDS
___ Hepatitis

___ Headaches
___ Chronic migraines
___ Arthritis
___ Rheumatoid arthritis
___ Back Problems
___ Fractures (site:_____)
___ Gout
___ Ulcers (GI)
___ PCOS
___ Prostate enlargement/ BPH
___ Low testosterone/ erectile dysfunction
___ Osteoporosis
___ Bowel disorder (Type: _____)
___ Liver disorder (Type: _____)
___ Skin disorder (Type:_____)

Surgical history: (Please list all past surgeries, dates, any complications):

_____

_____

_____

_____

SOCIAL HISTORY

OCCUPATION: _____

Do you consume alcohol? _____ How many per week? _____ What kind? _____

Do you smoke? _____ How many a day? _____ Have you ever smoked? _____ When did you quit (month/year)? _____

Do you consume caffeine? _____ How many a day? _____ What type? _____

Do you use recreational drugs? _____ How often? _____ What type? _____

Solstice Medicine & Wellness LLC
Authorization to Bill Insurance

SECTION 1: PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ SS#: _____ Daytime Phone: (_____)_____

SECTION 2: INSURANCE INFORMATION

Please notify the front desk staff if your visit is related to an injury or accident

I. Does your insurance have alternative medicine benefits? Yes No

Who is your Primary Care Provider?: Dr. _____ Clinic Phone #: (____)_____

Clinic Address: _____ City:_____ State: _____ Zip Code: _____

Does your plan require you to have a referral from you Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic?:_____

II. Primary Insurance

Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Relationship to the policy holder: _____ Policy Holder's Gender (circle): Male Female

III. Secondary Insurance

Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Relationship to the policy holder: _____ Policy Holder's Gender (circle): Male Female

SECTION 3: GUARANTOR INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services r ender ed to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____

Guarantor's Signature **Date**

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize **Solstice Medicine & Wellness, LLC** to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X_____ _____

Patient's Signature (or patient's representative signature) **Date**

Solstice Medicine and Wellness, LLC
Financial and Payment Policies

A clear understanding of **your financial responsibility** for the medical care and services provided to you is essential. **Please read this form carefully and have any questions answered prior to signing**.

Insurance coverage is a contract between YOU and YOUR INSURANCE COMPANY. Payment is not guaranteed and is based on your insurance contract. Please review your insurance policy or contact your insurance company for questions regarding coverage.

Regardless of insurance coverage, you are financially responsible for payment on your account, SMW bills insurance as a courtesy only.

Payment

We accept cash, Visa, Mastercard, and Care Credit. Established patients may pay by personal check.
All deductible, Co-pay, or Co-insurance amounts are due at each visit.
If you do not know your deductible, co-pay or co-insurance amount, a 20% co-pay will be collected each visit.
All patients must provide a current, valid insurance card or sticker at each appointment.

Refunds: Refunds are subject to final insurance payment and verification

NO SHOW/CANCELLATION: Subject to a $25 fee if less than 24-hour notice or no notice given.

NON-SUFFICIENT CHECK: A $35 fee per check. No exceptions.

Solstice Medicine and Wellness is NOT a financial lending institution

Delinquent Accounts: A $5 service charge will be added to patient balances and co-pays greater than 30 days overdue. A $10 service charge will be added to patient balances and co-pays greater than 60 days overdue. A $20 service charge will be added to patient balance and co-pays greater than 90 days overdue. Past due accounts greater than 120 days are subject to a collection agency. **SMW is not liable for any consequences arising from a collections agency's effort to secure payment.**

Payment arrangements can be made with the office staff or billing department of SMW if a patient is unable to pay their account balance. The patient will be required to provide a credit card to place on file to process on an arranged date for a set payment amount. **SMW is not liable for any consequences arising from overdraft fees or financial institution's fees or charges.**

HIPAA Compliance

SMW complies with current federal guidelines for HIPAA. A copy of our HIPAA policy is available for your review. "I understand that my signature on this form indicates that I have had an opportunity to review the SMW HIPAA policy and may be given a copy of the same, upon request."

I have read the above and have had all questions answered to my satisfaction.
This authorization shall expire one year from the date below

_____	_____	_____
Print Name	Signature	Date

_____	_____
SWM Staff/Witness	Date

Solstice Medicine and Wellness, LLC

HIPAA Consent for Patient Medical Information Release

Patient Name: _____ Date of Birth: _____

I authorize Solstice Medicine and Wellness, LLC to release my personal health information to family members or others involved in my care or assisting me with financial payment arrangements.

_____ Initial for myself

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Use the back of this form for additional people

Privacy Information: Please circle Yes or No for the following statements. By circling Yes for the following statements this office will leave voicemail or answering machine messages at your home, work, cell, or emergency contact on file that may include your protected health information and may be overheard by others not involved in your care.

Location	Call back message	Detailed message	Phone Number
HOME	YES NO	YES NO	
WORK	YES NO	YES NO	
CELL PHONE	YES NO	YES NO	
Emergency Contact	YES NO	YES NO	

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

This form will remain in effect for One Year from the date of signature. Any changes to this form must be submitted, by the patient, on a new form, signed, dated, and witnessed by a SMW staff member.

Solstice Medicine & Wellness, LLC
Notice of Privacy Practices
Acknowledgement of Receipt

Patient Name: _____ Date of Birth: _____
[Please print]

Solstice Medicine & Wellness, LLC, / Gina Escobar, MD is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call (907)456-6334.

***The Privacy Practices document is available online at solsticemedicine.com and posted in the front lobby of the clinic ***

I hereby acknowledge that I have reviewed and received a copy of Dr. Gina Escobar's Health Notice of Privacy Practices.

X _____ _____
Patient's Signature Date

X _____ _____ _____
Guardian/Representative Signature Relationship to Patient Date

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For Office Use only:

I hereby affirm that Gina Escobar, MD has made a good faith effort to obtain written acknowledgement from the above named patient.

Staff members initials:_____

0 Patient was offered form but refused to sign

0 Patient was physically unable to sign acknowledgement

0 Other:_____