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: _____

Referral Source: _____

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

Primary reason you want to be seen: _____

_____

Who is your current medical provider? _____

If applicable, when were you last seen? _____

What were you seen for? _____
(***Please sign a medical records release so we can obtain your records***).

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

_____

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:_____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date of request: _____

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ___ Zip code: _____

I authorize (Clinic or Provider name) _____ to release the following medical records to Solstice Medicine & Wellness:

_____ Complete Medical Record	_____ All Chart notes between _____
_____ All labs and Imaging	_____ Flow Sheets(Vital signs/ Height/Weight)
_____ Medication List	_____ Mental Health Record
_____ STD/HIV Status	_____ Other: _____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the staff member of Solstice Medicine & Wellness. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Patient Signature: _____ Date: _____

MEDICAL HISTORY

Name: _____ DOB:_____

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)

_____

_____

_____

_____

_____

_____

_____

Please list the date you have received any of the following preventative health items :

Colonoscopy: _____ Tetanus/Tdap: _____

Shingles Vaccine: _____ TB Skin Test (PPD): _____ positive or negative?

Pneumovax: _____ Eye Exam: _____ Location: _____

Flu Shot: _____ Chest Xray: _____

Female History:

Age of first menstrual period: ____ Date of last menstrual flow: _____ Current birth control: _____

Describe your cycle: Light ___ Moderate ___ Heavy ___ Regular ___ Irregular ___ Painful ___ #of days: ___

Number of pregnancies: ___ Live Births: ___ Last pap smear date: _____ (Normal ___/ Abnormal ___)

Date of Bone Density Scan: _____ Date of last Mammogram: _____ Location: _____

SOCIAL HISTORY

OCCUPATION: _____ How many hours do you work per week: _____

Highest level of education: _____

Marital Status: _____ Are you sexually active? _____ # of Children: _____

Do you eat a balanced diet? _____ Do you partake in special diet trends? Which ones? _____

Do you exercise routinely? _____ What type of exercise and frequency? _____

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? _____

Are there guns in your home? _____ Are they secured/locked? _____

Do you use a seatbelt while driving? _____

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: _____)

___ 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:_____)

Other:_____

_____

_____

Medical Providers/ Specialists participating in your past or current medical care (name/specialty/location):

_____

_____

Surgical or Hospitalization history:

(Please list all surgeries, dates, any complications. List any hospitalizations, length of stay and reason)

_____

_____

_____

_____

_____

Family History:

Have any of your blood relatives had any of the following:

___ Heart disease ___ Stroke ___ Diabetes ___ High Blood Pressure ___ High Cholesterol
___ Mental Health Illness ___ Substance Abuse ___Cancer (site: _____)

What medical conditions do/did these relatives have:

Father: _____
Mother: _____
Paternal Grandfather: _____ Grandmother: _____
Maternal Grandfather: _____ Grandmother: _____
Brothers: _____ Sisters: _____

REVIEW OF SYSTEMS

Do you <u>currently</u> have? (check all that apply)

GENERAL ___ Fatigue ___ Fever ___ Weight Gain ___ Weight Loss ___ Night Sweats	**SKIN** ___ Dry skin ___ Nail Changes ___ New Lesions/ Moles ___ Rash ___ Acne	**EYES** ___ Visual Changes ___ Double Vision ___ Eye Redness ___ Wear Glasses ___ Wear Contacts	**EAR** ___ Hearing Problems ___ Wear Hearing Aids ___ Ear Ringing ___ Ear Pain
NOSE ___ Nasal congestion ___ Nose Bleeds ___ Sinus Pain ___ Sinus congestion ___ Deviated septum	**MOUTH** ___ Dry Mouth ___ Oral Ulcers ___ Sore Throat ___ Hoarseness ___ Mouth/Dental Pain	**NECK** ___ Neck Pain ___ Swollen Glands ___ Enlarged thyroid ___ Thyroid Nodule	**ALLERGY:** ___ Runny nose ___ Itchy eyes ___ Seasonal allergies ___ Drug allergies ___ Food allergies
RESPIRATORY ___ Cough ___ Shortness of breath ___ Difficulty breathing ___ Wheezing ___ Decreased exercise tolerance ___ Sputum Production ___ Coughing up blood	**CARDIOVASCULAR** ___ Chest pain ___ Palpitations ___ Leg swelling ___ Leg pain while walking ___ Night awakening due to trouble breathing ___ Fainting ___ Varicose Veins	**GASTROINTESTINAL** ___ Abdominal pain ___ Nausea ___ Vomiting ___ Diarrhea ___ Constipation ___ Change in bowel habits ___ Trouble swallowing ___ Blood in stool ___ Loss of appetite	**URINARY** ___ Painful urination ___ Increased frequency ___ Urgency ___ Blood in urine ___ Change in urinary stream ___ Incontinence ___ Nighttime urination
MUSCULOSKELETAL ___ Joint pain ___ Joint swelling ___ Joint stiffness ___ Muscle pain ___ Muscle weakness ___ Leg cramps ___ Back pain ___ Neck pain ___ Arm/ Leg pain	**NEUROLOGICAL** ___ Headaches ___ Migraines ___ Dizziness/ vertigo ___ Lightheadedness ___ Incoordination ___ Tremor ___ Numbness/tingling ___ Seizures ___ Memory problems	**PSYCHIATRIC** ___ Depression ___ Anxiety ___ Panic attacks ___ Insomnia ___ Mood disturbance ___ Change in sleep pattern ___ Hallucinations ___ Suicidal thoughts	**ENDOCRINE** ___ Fatigue ___ Appetite changes ___ Heat intolerance ___ Cold intolerance ___ Hot flashes ___ Increased thirst ___ Increased urination ___ Hair changes ___ Dry skin
HEMATOLOGY ___ Easy bleeding ___ Easy bruising ___ Prolonged bleeding ___ Enlarged lymph nodes ___ Current Anticoagulation therapy	**SLEEP** ___ Snoring ___ Stop Breathing or choke/gasp during sleep ___ Difficulty falling asleep or staying asleep ___ Teeth Grinding	**FEMALE** ___ Vaginal pain ___ Vaginal discharge ___ Vaginal dryness ___ STD exposure ___ Menstrual problems ___ Sexual dysfunction ___ Hormonal problems ___ Menopause	**MALE** ___ Difficulty starting/ stopping urinary stream ___ Urethral discharge ___ Testicular pain ___ STD exposure ___ Sexual dysfunction ___ Prostate problems

OTHER: _____

_____