D. Glen Elrod, MD
Tara Elrod, CDM
Mary Yanagawa, CDM

Phone: (907) 357-7781 Fax: (907) 745-6573

Last Name________________________________
First Name________________________________
Mailing Address____________________________
City______________________________________
State____________ Zip Code________________
Primary Language________ Race_____________
Home Phone_______________________________
Cell Phone________________________________
Date of Birth______________________________
Email Address:____

Social Security_____________________________________
Marital Status______________________________________
Employer Information:
Name____
Address____
City_______________________ State_________________
Zip Code___________________
Emergency Contact Name , Phone Number & Relationship:
____

Appointment Reminders will be made via text, would you like an appointment reminder? ☐ Yes ☐ No
Standard text messaging rates may apply depending on your cell phone plan.

Please furnish us with your insurance cards

Primary Insurance:
Insurance Name ___________________________
Address _________________________________
____
City _______________State______ Zip_________
Insurance Telephone # ______________________
Beneficiary relationship to Patient: Self/Spouse/Parent

Beneficiary/Insured Name_______________________________
GRP # ____________ID #________________________________
Beneficiary/Insured Telephone #__________________________
Beneficiary/Insured Date of Birth_________________________
Beneficiary/Insured Social Security _______________________
Employer Name____

Secondary Insurance:
Insurance Name ___________________________
Address _________________________________
____
City _______________State______ Zip_________
Insurance Telephone # ______________________
Beneficiary relationship to Patient: Self/Spouse/Parent

Beneficiary/Insured Name_______________________________
GRP # ____________ID #________________________________
Beneficiary/Insured Telephone #__________________________
Beneficiary/Insured Date of Birth_________________________
Beneficiary/Insured Social Security _______________________
Employer Name____

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 co-pays 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/Representative
Signature____Date_________________________________

Revised 09/2018

Phone (907) 357-7781 Fax (907) 745-6573

Billing Information

Arrangements 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 information 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 Funds Check: $25.00 Balances over 30-90 days: $2.00 No-Show: $50 and $100 for Dr. Elrod

*Balances that are 6 months or older will need to be paid in full to be seen.
*No-Show fees need to be paid prior to scheduling appointments.
*All patient payments including deductibles, co-pays, and self-pay payments are due at the time of service in order to be seen.

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
- Injectables-Unless pre-authorization with insurance
- Smartlipo

Insurance is a contract between you and your insurance company. We are NOT a party to this in most cases (we will inform you if we are a party to your insurance contract 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:_________________________

Revised 09/2018

HIPAA 3rd Party Release Authorization Form
45 CFR 164.508

The purpose of this form is to protect you. The Health Insurance Portability Accountability Act of 1996, or HIPAA, was created with the sole purpose and goal of protecting patients' medical records and financial information.

This form allows us to disclose information to a 3rd party for the following:

Patient Name and Date of Birth: ____
(Please note: A separate form is required to release information with regards to your baby.)

I, ____, authorize the staff of Larsen Billing Service to release my financial information or protected health information to the following people:

Spouse: ____

Partner: ____

Parent/guardian: ____

Other: ____

I authorize the staff of Larsen Billing Service to release only the following pieces of information as described below:

Name: ____ Relationship to you: _________________________________

Describe the specific information you are authorizing us to disclose: ____

____

I authorize the staff of Larsen Billing Service to send information, which may or may not contain my financial or protected health information, to the following 3rd party email address:

Patient Email: ____

This authorization expires on: (date) _______________

____ ______________________
Signature of Patient/Guardian Date

____
Provider's Name

Phone (888) 458-8015 Larsen Billing Service ~ PO Box 1046~ Layton, UT 84041

Revised 09/2018

780 S Snodgrass Dr. Palmer, AK 99645
Phone 907-357-7781 Fax 907-745-6573

RELEASE OF HEALTH INFORMATION

Please only sign top and bottom. This form is used when records are requested by IW&TCB, or a referring provider. Patient records are never released without permission.

I, (patient name and date of birth) ____, hereby authorize (custodian of records) ____, to release my individually identifiable protected health information in the manner described below. I understand that my information may be re-disclosed by the person or entity receiving my information from Integrated Wellness & Center For Birth, LLC, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my information from Integrated Wellness & Center For Birth, LLC. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.
This authorization expires on the following date or event: ____

Please send records to:

____

Please indicate what information you would like released:

☐ I would like this release to include all of my health information.

☐ I would like this release to include only health information that is necessary for a family member or friend to assist me with my care.

☐ Please limit use and disclosure of my health information to the following information:
____
____

I understand that I may revoke this authorization in writing at any time and that I have a right to receive a copy of this authorization, *this authorization was revoked on: ___________ (see attached revocation).*

______________________________ ______________
Signature of Client or Representative Date

____
Printed Name

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I have received a copy of document titled 'Integrated Wellness & Center For Birth, LLC. Notice of Privacy Practices.'

____________________________________ __________________

Signature of Client or Representative Date

____

Printed Name