D. Glen Elrod, MD
1301 W. Parks Hwy. Ste. 101
Phone: (907) 357-7781
Fax: (907) 357-7786

INTEGRATED wellness

Last Name_____ Social Security_____
First Name_____ Marital Status_____
Mailing Address_____ Employer Information:
City_____ Name_____
State_____ Zip Code_____ Address_____
Primary Language_____ Race_____ City_____ State_____
Home Phone_____ Zip Code_____
Cell Phone_____ Emergency Contact Name , Phone Number & Relationship:
Date of Birth_____ Sex_____ _____
Email Address_____ _____

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 _____ Beneficiary/Insured Name_____
Address _____ GRP # _____ID #_____
_____ Beneficiary/Insured Telephone #_____
City _____State_____ Zip_____ Beneficiary/Insured Date of Birth_____
Insurance Telephone # _____ Beneficiary/Insured Social Security _____
Beneficiary relationship to Patient: Self/Spouse/Parent Employer Name_____

Secondary Insurance:
Insurance Name _____ Beneficiary/Insured Name_____
Address _____ GRP # _____ID #_____
_____ Beneficiary/Insured Telephone #_____
City _____State_____ Zip_____ Beneficiary/Insured Date of Birth_____
Insurance Telephone # _____ Beneficiary/Insured Social Security _____
Beneficiary relationship to Patient: Self/Spouse/Parent 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_____

INTEGRATED wellness
Phone (907) 357-7781 Fax (907) 357-7786

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 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 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 Fee: $100

*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.
***All cancellations MUST be made 24 hours in advance.**

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
- Nexplanon or IUD products or insertion services
- Infertility testing or services
- Injectables-Unless pre-authorization with insurance
- Medical Spa Procedures

Integrated Wellness & Center for Birth, and our Providers are in network with Premera BlueCross BlueShield, Multiplan, United Healthcare, TriCare, Medicaid, Medicare, Public Education Health Trust.

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:_____

INTEGRATED wellness

Patient Acknowledgment of Policies

Please initial, showing acknowledgement

All cancellations MUST be made 24-hours in advance. _____

All "no-shows" (providing less than 24-hours advance cancellation notice) result in a $100 fee. _____

All returned checks for insufficient funds will result in a $25.00 fee. _____

Balances that are 6 months or older will need to be paid in full or on an established and current payment plan 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. _____

Late show appointments past 7min of scheduled appointment will need to be rescheduled _____

Refills

Refill requests need to be provided at least 5 business days in advance of need. _____

Patient balance needs to be current (at a zero balance or on a current payment plan) prior to medication refill. _____

Controlled substance prescriptions require an in-person visit every 90 days. _____

Controlled substance prescriptions will be provided for one month at a time.

Controlled substance prescriptions (requiring a paper prescription) have a $15 fee due to administrative time associated with database search and physical prescription writing time. _____

I have read and understand the above information.

Responsible Party Signature_____Date:_____