Congratulations on your pregnancy! We look forward to following your pregnancy with you. At AWC, our mission is to provide first-class women's health care services, and we'd like to get started by providing some useful information for your first visit.

There are a few things that we will need for your upcoming appointment:

- Completed forms (enclosed)
- Photo ID
- Current insurance card

Please complete the attached forms and bring them with you to your first appointment.

While the OB Orientation visit is provided free of charge, there will be lab tests performed which are not. Labs typically cost about $858. A urine pregnancy test will be performed and billed for an additional fee of approximately $66 unless you bring a pregnancy verification form with you.

Anchorage Women's Clinic files insurance claims for most primary insurances. Medicaid or Denali Kid Care patients, your sticker/card is required at the time of check in or rescheduling will be necessary. If you have not provided insurance information, your account will be set up as self-pay and payment in full will be expected at the time of service. We recommend that you review your insurance coverage prior to your appointment as we cannot guarantee payment coverage by your insurance. Payments for co-pays or deductibles are expected at time of service.

Your first visit will take place in our Anchorage clinic. Please let us know if you would like to schedule your subsequent appointments at our Eagle River location. Your 1- 1-½ hour appointment will consist of mini sessions with our front desk, lab, billing department, and the orientation program given by one of our educators. Please note there may be a bit of down time between sessions. For this reason, you may want to make arrangements for child care.

Visitor/Patient parking is available near the main entrance off Providence Drive, or in Parking Garage 2, which is accessed off Providence Drive or Wellness Street. From any level of the garage, find the building entrance and then take the C-Tower elevator (or stairs) to Level 4.

We look forward to seeing you,

The Physicians and Staff of Anchorage Women's Clinic

ANCHORAGE WOMEN'S CLINIC
Notice of Privacy Practices for Protected Health Information

This notice describes how your Protected Health Information (called PHI) may be used and disclosed and how you can get access to this information. Please review it carefully.

AWC takes the privacy of your health information seriously. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

We are required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. We will act according to the terms of this Notice. We are required to notify you if we cannot accommodate a requested restriction or request and accommodate your reasonable requests regarding methods to communicate health information to you. We reserve the right to change this Notice of Privacy Practices and to make any new practices effective for all Protected Health Information that we keep. Any changes made to the Notice of Privacy Practices will be prominently displayed, available at our offices and posted on our web site (www.anchoragewomensclinic.com).

The clinic is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. We will attempt in good faith to obtain your signed Acknowledgement that you were offered a copy of this Notice to use and disclose your confidential medical information for the following purposes.

Treatment Purposes:

- A medical assistant or nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the provider determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given. **Exception: If you have paid a visit in full and have requested the information not be shared with your insurance carrier, we will not disclose that particular visit.**

Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment and improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review and legal services. We will share information about you with such insurers or business associates as necessary to obtain these services.

Other Disclosures and Uses:

Examples of other types of disclosures and uses of your PHI are listed below (note that this is not an exhaustive list). If you would like additional information on these, please contact us.

- Communication with Family
- Notification of persons responsible for your care
- FDA, related to adverse events
- Threat to health or safety
- Law Enforcement as required by law; Judicial proceedings
- Abuse & Neglect
- Public Health
- Health Oversight to agencies for health oversight activities

We will not sell your PHI without your written authorization. We will not use your PHI for marketing purposes without your written authorization. Patients do have a right to 'opt out' of such marketing information. Except where required by law, we will not disclose your psychotherapy notes without your written authorization.

Other uses and disclosures, besides those identified in this Notice, will be made only with your written authorization and you may revoke the authorization as stated under "Your Health Information Rights."

Your Health Information Rights

The health and billing records we maintain are the physical property of the clinic. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our clinic - we are not required to grant the request, but we will comply with any request granted.
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full)—we must comply with this request.
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information.
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our clinic. Access to your health records will not include information to which your access is restricted by law. We may charge a reasonable fee for providing a copy of your health records or a summary of those records at your request, which includes the cost of copying, postage and preparation or an explanation or summary of the information. Electronic copies are also available on CD.
- Appeal a denial of access to your protected health information, except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our clinic. We may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for the clinic;
  - Is not part of the information that you would be permitted to inspect and copy; or,
  - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our clinic.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our clinic. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures made to you or made at your request; disclosures made pursuant to an authorization signed by you; to family members or friends relevant to that person's involvement in your care or in payment for such care. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our clinic, except to the extent information or action has already been taken.
- You have the right to be notified of any breach of your information that occurs.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Privacy Officer for AWC at 907-561-7111**.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Practice Administrator. You may also file a complaint with the Department of Health and Human Services (DHHS) by contacting the Regional Office for Civil Rights in Seattle, WA.
We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

AWC
Anchorage Women's Clinic
ANCHORAGE AND EAGLE RIVER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have been offered
Print Patient Name
a copy of Anchorage Women's Clinic Privacy Practices.

_____ _____
Signature Date

_____ _____
Patient Legal Representative Signature (if applicable) Relationship to Patient

_____ _____
Print name of Legal Representative Date

For Office Use Only

We attempted to obtain written acknowledgement of offer of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____
_____
_____
_____

www.anchoragewomensclinic.com
3260 Providence Drive Suite 425 Anchorage Alaska 99508 Phone 907.561.7111 Fax 907.770.7891

Anchorage Women's Clinic
ANCHORAGE AND EAGLE RIVER

Patient Name:_____

Access to Personal Health Information
Family and Friends

I authorize Anchorage Women's Clinic, LLC to discuss my personal health information, "PHI", with the following individuals:

1._____Relationship:_____

2._____Relationship:_____

By signing below you agree that Anchorage Women's Clinic, LLC may discuss "PHI" with the above individual(s). This will remain in effect for one year from the date signed below.

If you wish to cancel this you must do so in writing directed to:

HIPAA Compliance Officer
Anchorage Women's Clinic, LLC
3260 Providence Dr. Suite 425
Anchorage, AK 99508

Please call 907-561-7111 if you have additional questions.

Signature:_____ Date_____

Date of Birth:_____

PATIENT NOTICE OF BILLING PRACTICES

Anchorage Women's Clinic (AWC) is committed to providing quality medical services to our patients and clearly defining our financial policy. If you have any questions, please ask one of our staff members to assist you.

PAYMENT AT TIME OF SERVICE

Medical Services provided by AWC are payable at the time of service. We accept the following:

- Cash, Visa, MasterCard, Discover, Personal Checks, Money Orders, and Debit Cards. *Checks returned for insufficient funds (NSF) will be assessed a $30 fee.*

_____ *(initial)* I understand that I am responsible for payment of co-pays, deductible, and co-insurance at time of service.

I understand past due amounts must be paid in full prior to the scheduling of any future appointments, unless prior arrangements have been made and approved by management.

Self-Pay Patients (No Insurance) - Payment is due, in full, at time of service.

ADDITIONAL CHARGES (*Charges that may be billed after you leave the office)*

_____ *(initial)* I understand that there may be charges for services rendered which do not appear on my account at check-out. This is because some services may require additional laboratory tests or follow-up, and some OB-related charges may not be present in my chart until reviewed by another provider.

_____ *(initial)* If I am a nutrition, massage, and/or counseling patient, I understand that if I no-show for future appointments and/or have not cancelled more than 24 hours in advance, I will be charged a **$90 no-show fee**.

INSURANCE BILLING

_____ *(initial)* I authorize AWC to release any medical information required by my insurance company for the processing of any medical claims filed on my behalf.

AWC bills most major insurances, with the exception of TRICARE (except as secondary), VA, and auto insurance policies.

LAB SERVICES

_____ *(initial)* I understand that LabCorp is AWC's primary lab for routine tests.

I understand Providence is AWC's primary lab for pathology and immediate/urgent tests.

If your insurance company requires use of a different lab, please notify our staff so that an annotation can be made in your chart.

MEDICAID

AWC currently accepts Medicaid (Denali Kid Care and Denali Care). Proof of eligibility is due at time of service. Please understand we are required by law to collect your co-pay at time of service. ***AWC does not back-bill for any services or labs rendered prior to patient receiving Medicaid approval.***

MEDICARE

We accept new Medicare patients for problem-specific visits by referral only. Existing patients who convert to Medicare may still be seen for routine care. Medicare co-pays are due in full at time of service. Any services not covered by Medicare are the patient's responsibility.

PATIENT CREDITS

Patient credits will be refunded once all visits have been responded to by insurance. No refunds will be issued while there are future appointments scheduled.

Obstetrical patients will have any credits applied to future visits and/or to their delivery. Once the delivery has been responded to by insurance, any remaining credit will be refunded.

There is a $25 stop payment/re-issuing fee for any lost refund checks.

COLLECTIONS

Payment for services rendered by Anchorage Women's Clinic is the responsibility of the patient, regardless of insurance status. If you are having difficulty paying your bill, please call our billing department.

Patients who refuse to remit payment or make financial arrangements will have their account reviewed for collection action and will be considered for dismissal from AWC. If account is transferred to an outside collection agency, you will be assessed an administrative fee in addition to the outstanding AWC bill.

I have read the above payment options and understand my financial responsibility to Anchorage Women's Clinic. If I have additional questions, I understand that I may speak with a billing representative prior to my appointment.

_____ _____

Patient or Guardian Signature Date Signed

AWC
Anchorage Women's Clinic
ANCHORAGE AND EAGLE RIVER

Patient Rights & Responsibilities

The team at Anchorage Women's Clinic is dedicated to promoting excellent women's health care service to every woman, every time. As a patient at Anchorage Women's Clinic (AWC) **you have the right to:**

1. Be afforded considerate and respectful care in a safe environment, and free from mental, physical, sexual and verbal abuse, neglect and exploitation.
2. Medical care without discrimination as to race, religion, national origin, sex or sexual orientation, disability, source of payment or age.
3. Be fully informed, in layman's terms, concerning your health, diagnosis, treatment options and prognosis. You have the right to helpful information and answers to your questions.
4. Make decisions about your care and to include or exclude family members or others when making decisions.
5. Be furnished with the name of the physician(s) and staff helping with your care.
6. Accept or refuse any treatment by the clinic to the extent permitted by law and to be informed of the medical consequences of such acceptance or refusal.
7. Designate a representative to make health care decisions on your behalf.
8. Privacy, which shall be respected to the extent consistent with providing adequate medical care to the patient, with the efficient administration of the clinic and with applicable law. (See AWC's Notice of Privacy Practices.)
9. Discuss concerns you may have when, from time to time. your provider may ask another provider, medical assistant or a medical student to accompany them in the exam room.
10. Change providers or transfer your care.
11. Refuse to participate in any research program should one be offered.
12. Examine your bill and receive an explanation of the charges, regardless of the source of payment of such bill. An itemized bill will be furnished upon request.
13. Review your medical record, and obtain a copy for a reasonable fee.
14. Be involved in your care.
15. Receive translation or other communication assistance.
16. Have any concerns, complaints and grievances heard and addressed without fear of reprisals.

www.anchoragewomensclinic.com
3260 Providence Drive Suite 425 Anchorage Alaska 99508 Phone 907.561.7111 Fax 907.770.7891

Your Responsibilities

Anchorage Women's Clinic has the right to expect responsible behavior from its patients and their families. We expect that you will:

1. Provide us with correct and complete information about past illnesses, hospitalizations, medications, allergies and any other matters relating to your health.
2. Inform us if you do not understand information or instructions given to you by the staff or if you think you will be unable to carry out any particular instruction.
3. Report any unexpected changes in your condition or concerns about your care.
4. Follow the care, treatment and service plans that have been developed for you by your healthcare team.
5. Keep all appointments and advise us when you are unable to keep an appointment
6. Arrive 10 minutes prior to your scheduled appointments to allow time for the review of any paperwork or visit-related information, and to ensure that the same level of personalized care is provided to all our patients.
7. Repetitive cancellations, no-shows or lateness may result in discharge from the clinic.
8. Be considerate of other patients, their visitors and their property.
9. Be considerate of AWC staff and our property. *Please note that we have a zero tolerance policy regarding any verbally, physically or mentally abusive or threatening behaviors to any AWC staff, providers or other patients. Such behaviors will be grounds to terminate your care and therapeutic relationship with AWC providers.*
10. Share any concern you may have if your provider asks another provider, medical assistant or medical student to accompany them in the exam room. This would occur when the provider requires support and/or we have a student training at our clinic.
11. Provide complete and sufficient information necessary for insurance processing of your bill.
12. Assume the financial responsibility of paying for all services rendered either through your insurance or by taking personal responsibility to pay for any services that are not covered by insurance.

I have read and acknowledge the above policy.

_____ _____

Patient or Guardian Signature Date Signed

You can communicate a concern or complaint through the **Contact Us** tab on our website (www.anchoragewomensclinic.com), by email manager@awcp.net or by calling 561-7111. If you feel your concern or complaint has not been addressed you may contact the Joint Commission (complaint@jointcommission.org).

AWC
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Name: _____ Date of Birth: _____ Today's Date: _____
Phone Numbers Home: _____ Work: _____ Cell: _____
Primary Care Provider: _____ Referred By: _____ Primary Language: _____
Insurance Preferred Hospital: Providence ☐ Alaska Regional ☐

Medication List/Pharmacy Information:

Please list all medications, vitamins & supplements you are currently taking or have been prescribed.

Name of Medication	Dose/Strength	How often do you take it?
1.		
2.		
3.		
4.		
5.		
6.		

Please list additional medications on the back of this form if needed

Allergies: List allergies to medications, food or environment including reaction:

_____

_____

Directives:

1. Any medical care limits due to religion or beliefs? ☐ Yes ☐ No
2. Are you an organ donor? ☐ Yes ☐ No
3. Do you have any other medical providers? ☐ Yes ☐ No
    a. If yes, who: _____
4. Do you already have a pediatrician? ☐ Yes ☐ No
    a. If yes, who: _____

Pregnancy Info:

1. First Day of Last Menstrual Period: _____
2. Was this a planned pregnancy? ☐ Yes ☐ No
3. Pre-pregnancy Weight: _____

Travel:

1. Have you or your partner traveled outside of Alaska in the last 6 months? _____
2. Do you have any travel plans during this pregnancy? _____

Current Weight: _____ Height: _____ AWC Only

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Anchorage Women's Clinic
ANCHORAGE AND EAGLE RIVER

Past Medical & Family History:

For yourself, provide details and dates. For family members, please check if yes. In the "other" column, please specify who the family member is, such as: Maternal Grandmother (MGM), Maternal Grandfather (MGF), Paternal Grandmother (PMG), or Paternal Grandfather (PGF).

☐ **Check here if you were adopted** ***(Please put N/A if any of the following do NOT apply to you)***

	Self	Mother	Father	Sibling	Child	Other
Cancer: Type						
Diabetes						
High Cholesterol						
High Blood Pressure						
Stroke						
Osteoporosis						
Heart Disease						
Asthma/Emphysema						
Thyroid Disease						
Liver Disease						
Drug Abuse						
Arthritis						
Heartburn/Ulcer						
Bowel Problems						
Depression						
Anxiety						
Hepatitis						
Eating Disorder						
Infertility						
Varicose Veins						
Uterine Anomaly						
Phlebitis						

History of Anesthesia Problems? ☐ Yes ☐ No **History of Blood Transfusions?** ☐ Yes ☐ No When: _____

Surgical History:

List any surgeries you have had	Date

Social History:

Tobacco Use:

Do you smoke cigarettes? ☐ Yes ☐ No ☐ Never Past Use: ☐ Yes ☐ No Quit Date: _____

If yes, _____ pack(s) per day for _____ years.

Other tobacco use: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ E Cigarettes ☐ Never

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No # of drinks per week: _____ Quit for pregnancy? _____

Drug Use:

Do you use marijuana or other recreational drugs? ☐ Yes ☐ No If Yes, Frequency: _____

Have you ever used needles to inject drugs? ☐ Yes ☐ No If Yes, type and last use: _____

Have you ever been tested for Hepatitis C? ☐ Yes ☐ No If Yes, When: _____

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Social History:

1. Caffeine Use→ how many drinks daily? _____
2. Exercise → how often a week and what activity do you engage in? _____
3. Seatbelt Use → how often do you wear a seatbelt? _____%
4. Sun Exposure → do you wear sunscreen? _____ Do you use tanning beds? _____
5. Are you treated respectfully by your spouse/partner, family and friends? _____

Obstetric History: ☐ ***Check here if you have never been pregnant***

Please list type of delivery: Term= 37+ weeks Pre Term= <37 weeks, Spontaneous Miscarriage (SAB), Elected Abortion (EAB) or Ectopic Pregnancy.

Date of Delivery	# of Weeks	Labor Length	Baby's Weight	Sex (M/F)	Delivery Type (Vag or C/S)	Epidural/ Pain Med/ None	Name of Baby	Comments/Complications

Obstetric Initial Intake Information:

1. Positive home pregnancy test? ☐ Yes ☐ No
2. Occupation: _____
3. Type of work: _____
4. Education (Last Grade completed): _____
5. Number of children at home: _____
6. Father of Baby Name: _____ Birthdate:_____ Race: _____
7. Father of Baby Occupation: _____
8. Same father as your last pregnancy? ☐ Yes ☐ No

Pregnancy Dating:

First day of last menstrual period: _____ Certain or Approximate? **(Circle One)**

How often do you get your period: Every _____ Days.

How many days do you bleed: _____ Days. Are your periods regular? ☐Yes ☐ No

Were you on birth control when you became pregnant? ☐ Yes ☐ No Which Method? _____

Date of positive home pregnancy test: _____

Age of your first period: _____

Genetic History: *Genetic Screening includes Patient, Father of the Baby, or anyone in either family.*

	Yes	If Yes, Who		Yes	If Yes, Who
Will you be 35 years of age when baby is born?			Muscular Dystrophy		
Thalassemia: MVC <80			Cystic Fibrosis		
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)			Huntington Disease		
Congenital Heart Defect			Mental Retardation/ Autism		
Down Syndrome			*If yes, was person tested for fragile X?*		
Tay-Sachs (EG, Jewish, Cajun, French Canadian)			Other inherited genetic or chromosomal disorder?		
Canavan Disease			Patient or Father of Baby have child with other birth defects?		
Familial Dysautonomia			History of recurrent pregnancy loss?		
Sickle Cell Disease or Trait (African)			History of stillbirth?		
Hemophilia			History of multiple births?		

Infection History:

	Yes		Yes
Do you live with someone with TB or exposed to TB?		High Risk Hepatitis C?	
History of sexually transmitted infections?		History of Group B Strep?	
Have you or your partner ever been diagnosed with genital herpes?		Do you live in a house with cats? *If so, who changes litter box?* _____	
Rash or viral illness since last menstrual period?		Do you eat moose meat?	
Exposure to chemicals, X-rays and/or drug or alcohol use since LMP?		History of Parvovirus (Fifth Disease)	
High Risk Hepatitis B?		Have you had chicken pox or the vaccine?	
Immunized against Hepatitis B?			

Other Patient History:

	Yes	Provide details if appropriate:
History of Major Accident?		
History of Blood Transfusion?		
Do you have any tattoos? *If yes, was it done in a professional setting?*		
Do you have any piercings? *If yes, was it done in a professional setting?*		
Date of last pap smear?		
History of abnormal pap smear? *If yes, list date and treatment: Colposcopy, Cryotherapy, LEEP, repeat Pap smear, etc.*		
History of Uterine anomaly?		
History of Infertility?		
History of In Utero Des Exposure?		
History of liver disease?		
History of varicosities?		
History of Phlebitis?		
History of thyroid dysfunction?		

Do you have a history of physical abuse? ☐ Yes ☐ No
Do you have a history of sexual abuse? ☐ Yes ☐ No

Vaccines:	**Dates**	**Where was it administered?**
Tetanus		
Gardasil		
Flu Shot		
Pneumococcal		