Dr. Ankita M. Ambasht
3300 Providence Drive Suite 114
Anchorage, AK 99508
Phone: 907.770.6200
Fax: 907.770.6202

Patient Registration

Name:_____ DOB:_____ SSN:_____ Gender:_____

Mailing Address: _____ City:_____ State:____ Zip:_____

Physical Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____ May we leave a detailed message on your voicemail? **YES** or **NO**

Employer:_____ Occupation:_____Marital Status:_____

Where did you hear about us/who referred you? _____

Preferred Pharmacy:_____ Phone:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Parent/Guardian Name (if under 18):_____ Phone:_____

Would you like someone other than yourself to have complete access to your medical records? If so, list below:

Name/Relationship:_____ Name/Relationship_____

Primary Insurance:_____ Policy #: _____ Group #:_____

Are you the primary subscriber? **YES** or **NO** If **NO**, please provide subscriber's information below.

Subscriber Name:_____ DOB:_____ SSN:_____

Secondary Insurance:_____ Policy #: _____ Group #:_____

Are you the primary subscriber? **YES** or **NO** If **NO**, please provide subscriber's information below.

Subscriber Name:_____ DOB:_____ SSN:_____

Please initial the following: Rev. 3/22

_____**Financial Policy (policy printed on back):** I have reviewed the clinic financial policy and understand I am ultimately responsible for any charges incurred. All fees including deductible, co-pay/co-insurance, and non-covered services are due at the time of service. I understand the clinic's no-show and late cancellation policy and agree to pay any associated fees incurred.

_____ **Physical/Preventative Visit:** I understand that if I am here for a preventative visit, the evaluation and management of EXISTING and NEW health issues is NOT covered under the visit. These include management of chronic conditions and prescriptions refills. Addressing these issues will generate additional charges subject to deductibles, copays, or coinsurance.

_____**Non-covered Services:** Any care not paid for by existing insurance coverage will require payment in full at the time of service or upon notice of insurance claim denial. Since patient agreements with insurance carriers are private, the clinic does not routinely research whether a service is covered. It is the patient's responsibility to find out beforehand if a service is covered.

_____ **Privacy Notice:** I acknowledge and agree that I have reviewed a copy of Ambasht Family Medicine's Notice of Privacy Practices. The clinic will provide additional copies whenever requested, and it is also available on the practice's website.

_____ **Information Release:** I hereby authorize Ankita Ambasht, MD and her staff to release any information to my insurance carriers, referring doctors, and referring labs concerning my illness and treatment and authorize all claims and payments

Signature:_____ Date:_____

CLINIC FINANCIAL POLICY

Thank you for choosing this clinic for your health needs. We wish to make you aware of our expectation of your financial responsibility. Your medical insurance is a contract between you and your insurance company. As a courtesy, we will bill your insurance for services rendered; however, **you are primarily responsible for any charges that you have incurred** as a patient with our clinic. It is your responsibility to notify our office of any changes including your address, and any changes to your insurance and billing information. Please review and sign the following financial policy prior to your office visit.

1. **Co-payments, deductibles, and fees.** All fees including co-pays, deductibles and non-covered services not covered by insurance policy are due at the time of the service.
2. A **valid credit card** (Visa or Master Card) authorization should be on file. Any balance left after insurance company has processed the claims will be automatically charged to your credit card and a copy of the transaction will be mailed to you. **The card information is stored on secure servers.**
3. **Insurance**. You must provide us with a current insurance card at each visit. If you do not present a current valid insurance card, you will be responsible for payment at the time of the service. You will receive reimbursement from our clinic if your insurance pays at a later date. **It is your responsibility to check with your insurance company prior to your visit to find out the percentage of services covered and bring proof of deductible met**. Insurance plans consider some services to be non-covered, in which case you are responsible for payment in full.
4. **Referrals and prior authorizations**. If your insurance company requires a referral and/or pre-authorization, you are responsible for notifying the office staff, so we may assist you in obtaining it. **Referrals and prior authorizations are your responsibility as a patient to initiate.** Failure to obtain the referral and/or pre-authorization may result in paying lower or no payment from the insurance company, and the balance will be your responsibility.
5. **Self-pay accounts**. Patients who have no insurance coverage will be responsible for the entire cost of the services rendered at the time of service. Special arrangements may be considered on an individual basis and this needs to be discussed in advance.
6. **Minors and dependents**. Parents and guardians are responsible for payments for their dependents at the time of service rendered.
7. **Missed appointments**. In fairness to other patients and the doctor, our policy is to charge for missed appointments without at least 24 hours' notice. The fee for a missed office visit appointment is $75 and a fee of $100 will be charged for missed procedural appointments. This fee is not covered by your insurance plan and it is your responsibility. Excessive abuse of scheduled and rescheduled appointments may result in termination of care and discharge from the practice.
8. **Prompt payments**. Balances are due within the 30 days of your first statement. You will receive three statements over 90-day period. If you have not made payments on your balance within 90 days period and you have not established the payment plan or met with the billing manager, the account may be sent to a collection agency or a small claim may be filed.
9. **Collection accounts**. In the event that an account is referred to collections, a 35% collection fee will be added to the amount due. The individual financially responsible for the account will be responsible for all collection costs including attorney or court fees. The patient accounts that are sent to collections will be asked to seek care with another provider.

AMBASHT
FAMILY MEDICINE

Rev. 04/22

Medical History

Name: _____ DOB: _____

Briefly describe the reason for your visit today: _____

_____

List all current medications (include over-the-counter medications and supplements)		
Medication Name	Dose	Frequency

Which of the following do you currently have or have had in the past?

- ☐ Acid Reflux
- ☐ Anxiety
- ☐ Arthiritis
- ☐ Asthma
- ☐ Cancer (specify): _____
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated cholesterol
- ☐ Heart disease
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Migraines
- ☐ Thyroid Disease
- ☐ Other: _____

List any allergies AND reactions to each: _____

_____

List any surgeries and when: _____

_____

Do you use tobacco products? ☐No ☐Yes – type/amount/how long: _____

Do you drink alcohol? ☐No ☐Yes – type/amount/how long: _____

Do you use marijuana? ☐No ☐Yes – how often/how long: _____

Do you use recreational drugs? ☐No ☐Yes – type/amount/how long: _____

If you used any of the above in the past, describe prior use and when you quit:

_____

_____

_____

Relevant Family Medical History	
Family Member:	**Illnesses/Conditions:**
Father	
Mother	
Pat. Grandfather	
Pat. Grandmother	
Mat. Grandfather	
Mat. Grandmother	
Brother(s)	
Sister(s)	
Son(s)	
Daughter(s)	
Other: _____	
Other: _____	

Height: _____ Weight: _____ Last physical: _____ Last tetanus shot: _____

Screening:	Year Last Performed:	Findings: Normal or Abnormal?
Colonoscopy		
Mammogram		
Pap Smear		
Eye Exam		

For Female Patients Only:

When was your last period? _____

Have you been pregnant in the past? **YES** or **NO**

How many total pregnancies? ____ Number of full-term deliveries: _____
Number of pre-term deliveries: ____ Number of miscarriages/abortions: ____

What is your current method of birth control? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is my responsibility to inform the clinic of any changes in medical status. I understand that Ambasht Family Medicine, LLC reserves the right to refuse service to anyone.

Signature: _____ Date: _____

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CREDIT CARD AUTHORIZATION FORM

Rev. 03/22

ALL INFORMATION WILL REMAIN CONFIDENTIAL				
CARD HOLDER NAME:				
CREDIT CARD NUMBER:			**CVV (3 DIGITS):**	
EXPIRATION DATE:		**CARD TYPE:**	☐ **VISA**	☐ **MASTERCARD**
BILLING ADDRESS:				

AMOUNT TO CHARGE: We will charge the balance of the charges to your card after insurance has processed each claim. This includes any on-site laboratory services provided by Harbir S. Makin, MD. You can cancel this auto pay authorization any time by giving us a written notice and mailing it to Ambasht Family Medicine, 3300 Providence Drive Suite 114, Anchorage AK 99508.

By signing below, I authorize Ambasht Family Medicine, LLC and Harbir S. Makin, MD to charge the balance on my account to the credit card listed above, and I agree to pay for the services in accordance with the issuing bank cardholder agreement.

Card Holder Signature: _____ Date: _____

Card Holder Name: _____