welcome to our clinic...

Urgent Care Medical Clinic, P.C.

5437 E. Northern Lights Blvd #1
Anchorage, AK 99508
907-333-8561 | Fax 907-333-8560

9150 Jewel Lake Rd. Ste B
Anchorage, AK 99502
907-248-8561 | Fax 907-248-8563

Patient Name: Last First MI	Date of Birth:	Social Security #	Gender: M or F
Home Phone:	Mobile:	Email:	
Mailing Address: city, state zip			
Residence Address: city, state zip			
Employer Name & Address:			
Occupation:	Business Phone:		
Spouse Name (or Parent):	Date of Birth:	Social Security #	
Employer Name & Address:			
Occupation:	Business Phone:		
If Patient is a minor, give parent or guardian's name. Who may authorize treatment of this minor for this or future visits?			
Primary Insurance Carrier (please provide insurance card and photo ID to be copied for billing)			
Policy Holder's Name:	ID#:	Date of Birth: / /	
Secondary Insurance Carrier (insurance card and photo ID also required)			
Policy Holder's Name:	ID#:	Date of Birth: / /	

Whom may we thank for referring you?		
Name of nearest relative or friend not living with you:	Relationship to patient:	Phone:
If you cannot be reached by phone, how would you like to be contacted? (i.e. email, home or work voicemail, letter, etc.)		

Payment in full is expected for all first-time patients and those who have not met their insurance yearly deductible: Please remember that insurance is considered a method of reimbursing the patient for paid to the facility and is not a substitute for timely payment. It is your responsibility to pay any deductible amount, co-payment or other balance not paid for by your insurance. By signing below, I authorize payment of medical benefits to Urgent Care Medical Clinic P.C. I understand that I am responsible for all charges regardless of coverage. It is also my request for Urgent Care Medical Clinic P.C. to release any medical or other information necessary to process my Claims.

Signature (patient, parent or guardian): _____ Date: _____

Print name: _____

thank you!

patient health history

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Please list all medication allergies:

Please list medications you are taking currently:

Is there anything we need to know about your religion or culture in order to care for you?

Please mark with an "X" all of the following that you have EVER had:

_____ Acid reflux
_____ Atrial fibrillation
_____ Alcohol/substance abuse
Type & amount _____
_____ Anemia
_____ Arthritis
_____ Asthma
_____ Blood clots
_____ Cancer
_____ Chest pain
_____ Chronic headaches
_____ Chronic gastrointestinal problems
_____ COPD
_____ Diabetes
_____ Dizziness or fainting
_____ Ear or hearing problems
_____ Eye problems
_____ Gynecologic problems
_____ Fractures
_____ Gallbladder disease/gallstones
_____ Gout
_____ Head injury
_____ Heart attack
_____ Heart disease
_____ Hernia
_____ Hepatitis C
_____ High blood pressure
_____ High cholesterol
_____ HIV
_____ Kidney/bladder problems
_____ Knee, hip, or back injury
_____ Male: prostate/genital problems
_____ Mental health disorder
_____ Parkinson's disease
_____ Rheumatic fever
_____ Sexually transmitted disease
_____ Skin conditions
_____ Sleep apnea
_____ Stomach ulcers
_____ Stroke
_____ Swollen ankles
_____ Thyroid problems
_____ Tobacco use
Type & amount _____
_____ Tuberculosis

Please describe any serious illness, health problem, surgery, or injury not listed above:

Please describe any signficant family medical history:

Circle only those conditions that you are CURRENTLY having now:

Constitutional
Fever
Chills
Fatigue
Weight loss/gain

Eyes
Change in vision
Eye pain
Eye discharge/tearing

HEENT
Ear aches
Ringing in ears
Sinus problems
Sore throat

Cardiovascular
Chest pain
Swelling of legs
Palpitations

Respiratory
Wheezing
Shortness of breath
Cough

Gastrointestinal
Diarrhea
Constipation
Nausea/vomiting
Bloody stool
Abdominal pain

Genitourinary
Blood in urine
Pain with urination
Urinary incontinence
Urinary frequency/urgency
Low back pain
Genital discomfort/discharge

Skin
Rash
Ulcers
Infection

Endocrine
Abnormal thirst
Tremors
Cold/heat intolerance

Hematologic
Unexplained bruising/bleeding
Enlarged lymph nodes

Musculoskeletal
Muscle weakness
Muscle cramps
Joint discomfort/swelling

Psychiatric
Depression
Mood swings
Anxiety
Suicidal thoughts
Homicidal thoughts

Patient name: _____ DOB: _____ Date: _____

Urgent Care Medical, LLC

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UCMC FINANCIAL POLICY

Thank you for choosing Urgent Care Medical Clinic, LLC. We value our patients and are committed to providing you with quality convenient health care. The following is a statement of our financial policy. If you have any questions, please ask one of our staff members to direct you to our billing company and/or office manager.

Private insurance

As a courtesy to our patients, we bill most insurance plans. You must provide copies of your insurance card(s) with photo ID at the time of service. If you are unable to provide copies of insurance card(s) and/or proof of insurance and photo ID, you are responsible for payment in full at the time of service.

Please keep in mind you are responsible for any *out-of-network fees, deductibles, co-pays, and any non-covered services as determined by your insurance company*. Please call your insurance prior to your visit for insurance benefit details. UCMC will also bill your secondary insurance as a courtesy with insurance card(s) and/or proof of insurance provided at the time of service.

Below is a list of PPO contracted insurance companies:

- Aetna
- Blue Cross Blue Shield
- Federal Blue Cross Blue Shield
- EBMS
- Medicare Part B
- Alaska Medicaid

Any other types of private insurance UCMC will bill as a courtesy. Please keep in mind you are responsible for any *out-of-network fees, deductibles, co-pays, and any non-covered services as determined by your insurance company*.

For insurance plans listed below, payment is due at the time of service. A superbill with diagnosis codes will be provided for you to submit to your insurance directly.

- Kaiser Permanente
- Out of state Medicaid
- HMO private insurances
- HMO Medicare
- Travel insurance
- Foreign exchange student insurance
- CAMA
- Care Credit

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Self-Pay or Un-Insured

We accept patients without insurance with the following payment rules. In general payment is expected at the time of service, unless other financial arrangements are made in advance. A Truth and lending agreement must be signed and paid the amount agreed upon monthly to keep account in good standing. We accept checks, credit cards (except American Express and Discover) and cash.

Medicare

We are happy to see patients with Medicare part B for urgent care type health needs, *except Medicare HMO insurance.* The office policy requires a copy of your Medicare Part B card with proper ID at the time of service, as any inaccuracy will deny coverage and payment. You are required to pay your co-pay at each office visit. You may be asked to sign an advanced beneficiary notice or ABN prior to any labs, injections, minor procedures, and orthopedic supplies given during your visit.

Medicaid

We are happy to see patients with Medicaid for urgent care type health needs, *except out of state Medicaid insurance.* The office policy requires a copy of your updated Medicaid card with proper ID at the time of service, as any inaccuracy will deny coverage and payment. You are required to pay your co-pay of $3.00 at each office visit for patients 18 years of age and older.

Please keep in mind Medicaid is the "payer of last resort". This means that if you have private insurance in addition to Medicaid, Medicaid will be secondary. *Without your private insurance information you will be considered Self-Pay, payment in full will be due at the time of service.*

Motor Vehicle Accidents

Urgent Care Medical Clinic will bill for motor vehicle accident claims. In order to bill for a MVA, Urgent Care requires the claim number from the insurance company, a valid address to send the claim to, and a copy of your personal medical insurance cards (if available, please provide a copy of the motor vehicle insurance card).

If you prefer to submit the claim yourself, we will provide you with a copy of the bill that you can submit to your insurance company or other third party.

Tricare Beneficiaries

Urgent Care Medical Clinic is happy to see patients with Tricare and their families for urgent care type health needs with Military ID provided. We are not in-network with Tricare, therefore you will be asked to pay 20% of the balance at the time of visit. We will submit the remaining balance to Tricare as a courtesy. Please keep in mind you are responsible for any *out-of-network fees, deductibles, and any non-covered services as determined by your insurance company.*

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Work related injuries

We accept patients for initial evaluation of work related injuries. As an employee you are responsible to report any injury to your employer. Your employer is required to provide you with payment information. You must provide us with that payment information. Without the information or if insurance denies your claim, you become responsible for payment of services rendered.

Additional Charges

Please keep in mind we strive to provide the highest quality of care for every individual here at UCMC. That being said, please be advised there may be additional charges based upon review of chart notes and/or lab results that may not appear on superbill when checking out from UCMC facility.

Returned Checks

A charge of $25 will be billed to your account on all returned checks

Refund Policy

If a refund is due to an overpayment or credit balance, our billing company will verify there are no balances owed to UCMC. Once determined a refund is owed to policy holder, we will send a check. Please keep in mind this process takes time, and any information you have (explanation of benefits) you may bring to our clinic and/or send to our billing company to possibly expedite this process. *You may call Advance Professional Services at (907) 677-2990 to REQUEST a refund, but UCMC is the company that will issue the refund check.*

UCMC Billing Company

Advance Professional Services
P.O. Box 221221
Anchorage, AK 99522-1221
(907) 677-2990

By my signature below, I acknowledged I have read and understand the above financial policy.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Patient Printed Name DOB