



# AVANTE MEDICAL CENTER, LLC

915 W. NORTHERN LIGHTS BLVD

ANCHORAGE, AK 99503

907.770.6700

**Hello and welcome to your first visit as a patient at Avante Medical Center!**

Enclosed in this packet are forms that need to be completed prior to your visit. Please take the time to fill them out as completely as possible and bring them to your first visit.

**Our providers are very conscientious of your valuable time, and make a strong effort to run on time with their appointments. The time spent during your initial visit is best utilized when the paperwork is completed prior to your arrival. To optimize your time with them, we ask that you come 15 minutes early to have your vital signs taken, and have your paper work already filled out. If you cannot have your paperwork filled out prior to your appointment, please come 25 minutes early.**

**We cater to many patients with allergies and environmental sensitivities. Please avoid wearing perfume or cologne to your appointment.**

## Insurance Billing Information

**\*Make sure to bring your insurance information card to your appointment and please fill out the insurance billing information sheet in this packet as completely as possible.\***

We ask that you take time to contact your insurance carrier prior to your visit to find out if they cover Naturopathic care if you are seeing Drs. Markian Babij, Natalie Wiggins, Gary Ferguson, or Torrey Smith. If your carrier will cover these services, we will be happy to bill them for you. If your insurance company does not cover our services, you will be responsible for the fee at the time of service. *Insurance Billing is a service we provide, not an expectation.*

We serve a large community. If you are unable to keep your appointment, please call us in time for another patient to schedule.

We look forward to seeing you.

The Staff at Avante Medical Center

## **Insurance Billing and Collection Guidelines**

As a service to our patients, we bill primary insurance when possible. This is performed as a courtesy. Here are some very important things to know about Avante Medical Center and Insurance Billing:

**Medicare**- It has been the decision of our Nurse Practitioners at Avante to “**opt out**” of Medicare and naturopaths are not eligible. Therefore, all services provided at our facility cannot be submitted, either by the patient or Avante Medical Center, to Medicare. However, if you have a secondary coverage, please see the Insurance Benefits section listed below.

**Insurance Benefits**- It is important to know your coverage **before** coming in for an appointment. Although we bill most insurance carriers, our providers are listed independently and therefore may not be contracted with your insurance company. Avante Medical Center does not preauthorize benefits; **it is the patient's responsibility**. Please contact your insurance carrier prior to your visit and fill out the answers to the questions on the following page. **This information will be required at check in.**

**Appointment**- Please come to your appointment with your insurance card and with the Insurance Billing Information Sheet completely filled out. After your appointment we will collect any outstanding deductible, co-pay, and/or coinsurance for covered services. All non-billable services (i.e. IVs, supplements, NAETs, lab kits and injections) will require payment in full at the time of service. Due to most common insurance policies, we are unable to schedule two appointments for the same day. If you would like to see multiple providers in one day, you will be responsible for paying in full for one of your visits.

**Payment Due at Visit**—The amount of payment due at the time of visit depends upon your insurance plan and your preparation. Avante Medical Center will collect in full at the time of visit if you do not have an insurance card, or have not completed the attached insurance form. If you have met your deductible, have completely filled out the attached insurance form, and verified \*ND coverage, we will bill primary insurance. If your insurance company denies your claim, or pays less than expected, you will be responsible for paying the balance, in full, within 60 days of the date of service. In the event of patient nonpayment and/or a delinquent account, please see our collections policy.

**If you have questions regarding this policy, please call and speak with our billing department (907-770-6700) prior to your scheduled appointment.**

Please read and sign below:

I have read and understand all of the information above. In signing below, I authorize Avante Medical Center to release any information required to process claims and that my insurance benefits are to be paid directly to Avante Medical Center. I understand that although my insurance might be billed, I am financially responsible for the services provided.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* if applicable

**Avante Medical Center, LLC**  
**Insurance Billing Information**

**Do you have Medicare, Medicaid or Tri-Care? \_\_\_\_\_ Yes \_\_\_\_\_ No If so, circle which one**

Name of patient \_\_\_\_\_ DOB \_\_\_\_\_

Primary Person Insured \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Insurance Co \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Group or Plan # \_\_\_\_\_ Insurance Co. Phone # \_\_\_\_\_

Address \_\_\_\_\_

**SECONDARY INSURANCE \* (We do not bill secondary insurance in most cases)**

Primary Person Insured \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Insurance Co \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Group or Plan # \_\_\_\_\_ Insurance Co Phone # \_\_\_\_\_

Address \_\_\_\_\_

Please contact your insurance carrier prior to your visit and fill out the answers to the questions below. If these questions are not completed we will collect in full at the time of visit, but will still bill your insurance as a courtesy:

1. Is the type of provider you are seeing covered on your insurance plan? (i.e. - naturopathic doctor, ANP, opted out ANP, etc...) \_\_\_\_\_

2. Does the plan require you see a contracted provider & how does it affect your coverage?  
\_\_\_\_\_

3. What month does your deductible start, how much is it, and how much is met?

Month: \_\_\_\_\_ \$: \_\_\_\_\_ Currently met: \_\_\_\_\_

4. What is your coinsurance (the percentage you pay) and/or copay? \_\_\_\_\_



## Collection Fee Notice

In the event my account is forwarded to a collection agency by Avante Medical Center, I understand that I will be responsible for any fees and or interest that are accrued.

Avante Medical Center requires payment in full within 60 days of the date of service. In the event of patient nonpayment and/or a delinquent account, the billing office will attempt to notify you before any charges are applied to your card. Leaving a credit card on file has advantages such as:

1. If you leave town for a period of time or do not receive your mail and have a balance due, we can run your credit card, which will insure your account does not go to collections.
2. You can call in a payment, request a mail order for supplements and ask us to use your card on file.

In the event the credit card declines on a **delinquent** account balance (over 60 days), the account will be forwarded to a collection agency with all appropriate fees included.

I understand that although my insurance may be billed, I am financially responsible for the services provided at Avante Medical Center. I understand that payment in full is due within 60 days of the date of service. I understand that in the event of my nonpayment and/or delinquent account, Avante Medical Center will run the balance on my credit card. If my credit card declines and my account is delinquent, the balance, which will include any applicable collection fees, will be forwarded to a collections agency.

CC Number \_\_\_\_\_ Exp \_\_\_\_\_ EVS \_\_\_\_\_  
(Visa/MasterCard Only) (last 3 digits on back)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I have read and understand Avante Medical Center's Collection Policy

Signature \_\_\_\_\_

Date \_\_\_\_\_



## Face Sheet

Chart Number \_\_\_\_\_

Date \_\_\_\_\_

### PATIENT INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home # \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Fax \_\_\_\_\_

E Mail Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_

\_\_\_\_\_ Occupation \_\_\_\_\_

### SPOUSE / PARENT / LEGAL GUARDIAN INFORMATION:

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Employer/Address: \_\_\_\_\_

Occupation \_\_\_\_\_ Work # \_\_\_\_\_

### EMERGENCY INFORMATION:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ None

Whom may we thank for referring you? \_\_\_\_\_



## Missed Appointment Policy

### **There is a new policy in effect related to missed appointments.**

Avante Medical Center, LLC will charge \$100 for missed appointments and cancellations received less than 24 hours prior to appointment time, except for cases of medical emergency. If you make the cancellation call to Avante after hours or weekends, please leave the cancellation message with the answering service.

If you disagree with being charged the \$100 fee, please ask for an Appeal Form, complete the information and the Avante Clinic Director will respond.

At Avante, we strive to perform the best care and services to our ability. We work very hard to care for and respect your time and needs. We thank you for your assistance in supporting our staff and providers with this signed agreement.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Avante Medical Center, LLC

915 W. Northern Lights Blvd. Anchorage, AK 99503 907.770.6700

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Other health care providers \_\_\_\_\_

What brings you into the office today? \_\_\_\_\_

What are your expectations? \_\_\_\_\_

Prescription (RX) meds \_\_\_\_\_

Non-RX meds (incl. supplements) \_\_\_\_\_

Medication allergies \_\_\_\_\_

Food/Other allergies \_\_\_\_\_

Past surgical history \_\_\_\_\_

**HEALTH SCREENING EXAMS** Please circle all you have had and the approximate date/year of the test

Chest X Ray \_\_\_\_\_ EKG \_\_\_\_\_ Stress Test \_\_\_\_\_ Echocardiogram \_\_\_\_\_ Colonoscopy/Sigmoidoscopy \_\_\_\_\_

CT scan: \_\_\_\_\_ MRI \_\_\_\_\_ Other \_\_\_\_\_

**WOMEN:** PAP Smear \_\_\_\_\_ Mammogram \_\_\_\_\_ Pelvic Ultrasound \_\_\_\_\_ **MEN:** Prostate exam \_\_\_\_\_ PSA Blood test \_\_\_\_\_

**FAMILY HISTORY** Have any blood relatives been diagnosed with the following (Please circle and name relative)

Alcoholism \_\_\_\_\_ Cancer \_\_\_\_\_ Mental Health Problems \_\_\_\_\_

Alzheimer's \_\_\_\_\_ Depression \_\_\_\_\_ Migraines \_\_\_\_\_

Arthritis \_\_\_\_\_ Diabetes \_\_\_\_\_ Osteoporosis \_\_\_\_\_

Autoimmune disorders \_\_\_\_\_ Heart Disease \_\_\_\_\_ Thyroid Problems \_\_\_\_\_

Bleeding Disorders \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Colon/Digestive \_\_\_\_\_

Cataracts/Glaucoma \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Stroke \_\_\_\_\_

**SOCIAL HISTORY**

Marital Status: single married divorced widowed separated domestic partner

Do you live: alone with children spouse roommate significant other (male / female)

Do you have children? Ages \_\_\_\_\_

Do you exercise? What kind/how often: \_\_\_\_\_

Do you sleep well? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

How is your energy level? \_\_\_\_\_

Do you smoke/chew? Y N How much? \_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_

Have you traveled outside the United States? \_\_\_\_\_

Have you received a blood transfusion in the past? Yes No What is your blood type? \_\_\_\_\_

What is your occupation? \_\_\_\_\_ How many hours a week \_\_\_\_\_

**NUTRITIONAL HISTORY**

Typical Breakfasts \_\_\_\_\_

Typical Lunches \_\_\_\_\_

Typical Suppers \_\_\_\_\_

Typical Snacks \_\_\_\_\_

How much per day or week: coffee \_\_\_\_\_ tea/kind \_\_\_\_\_ soda/kind \_\_\_\_\_

water: \_\_\_\_\_ tap filtered Other daily/weekly beverages \_\_\_\_\_

Do you crave anything? \_\_\_\_\_ Do you avoid anything? \_\_\_\_\_

Any food sensitivities or allergies \_\_\_\_\_

**GENERAL SYMPTOMS**

- tired, no energy
- frequent colds, illnesses
- poor memory
- poor concentration
- headaches
- dizziness
- fainting
- poor sleep
- night sweats

**SKIN & HAIR**

- rashes
- eczema
- hives/itching
- eruptions/boils
- dry/rough skin
- bruise easily
- nails weak/peel easy
- dry hair
- split ends
- hair loss

**EYES & EARS**

- blurry vision
- dry eyes
- sensitive to light
- itchy eyes
- earaches
- ear infections
- loss of hearing
- lots of wax
- ringing in ears

**LUNGS**

- asthma
- wheeze
- cough frequently
- short of breath with activity
- bronchitis/ pneumonia history
- exposure to chemicals/fumes

**CARDIOVASCULAR**

- fast heart rate
- irregular heart rate
- tightness in chest
- swollen feet/ankles
- leg pains with walking
- loss of hair on legs
- fainting
- high blood pressure
- history of heart attack
- varicose veins
- dizzy or weak when stand up

**NOSE, MOUTH & THROAT**

- re-occurring sinusitis
- runny nose
- post nasal drip
- chronic congestion
- sore throats
- canker sores
- cold sores
- bleeding gums
- toothaches
- hoarse voice
- dry mouth
- poor taste/smell

**GASTROINTESTINAL**

- loss of appetite or thirst
- difficulty swallowing
- nausea or vomiting
- not tolerating fats/greasy foods
- heartburn
- use antacids
- gas/burping/belching
- upper stomach bloating
- feel bad if skip meals
- diarrhea or loose stools
- dark stools or blood in stool
- mucous in stool
- undigested food in stool
- constipation
- # of Bowel Movements/day**
- hemorrhoids
- anal itching/bleeding

**URINARY**

- urinate frequently at night
- urinate frequently during day
- pain with urination
- bedwetting
- incomplete urination/dribbling
- narrowing/weakness of stream
- change in color/odor of urine
- kidney or bladder infections
- kidney stones

**PSYCHOLOGICAL**

- history of counseling/therapy
- preoccupations
- nervous breakdown
- paranoia
- depression
- anxiety
- panic attacks
- anger issues/bad temper
- irritable
- suicidal thoughts

**MUSCULO-SKELETAL**

- muscle pain
- painful/stiff joints
- loss of strength/muscle wasting
- tremors/twitches cramps
- Other \_\_\_\_\_

**MEN**

- discomfort or pain in genital area
- discharge from penis
- sores/rash on penis
- diminished sexual desire
- difficulty maintaining erection
- impotent
- genital herpes

Other \_\_\_\_\_

**WOMEN**

- Age of first period \_\_\_\_\_
- Number of days of flow \_\_\_\_\_
- Length of cycles \_\_\_\_\_ days
- Blood flow: light moderate heavy
- Birth control: \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_
- Number of children \_\_\_\_\_
- Number of miscarriages \_\_\_\_\_
- Do you have your uterus? Y N
- Do you have your ovaries? Y N
- History of abnormal pap smear? Y N
- Describe Premenstrual symptoms:

\_\_\_\_\_

How many days before period do you experience these symptoms? \_\_\_\_\_

Do you have:

- irregular periods
- pain with or prior to periods
- difficulty with conception
- difficulty with orgasm
- diminished sexual desire
- ovarian cysts
- fibroids
- endometriosis
- vaginal infections
- genital herpes
- sexually transmitted infection
- painful intercourse
- hot flashes
- night sweats
- cry easy
- vaginal dryness
- breast tenderness
- irritability