



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
PEDIATRIC HEALTH HISTORY FORM

Child's name _____ Date of birth _____ Age _____

Height _____ Weight _____ Ethnicity _____

Your Name _____ Relationship to child _____

Address _____ Contact phone # _____

Who does child live with? _____

Other healthcare providers _____

What are your child's health concerns, in order of importance?

1. _____

2. _____

3. _____

4. _____

PRENATAL HEALTH INFORMATION

Was the child a planned pregnancy? yes no Did mother receive prenatal care? yes no

What was the state of the parent's health *at conception*?

Mother: poor fair good excellent unknown Father: poor fair good excellent unknown

Mother's state of health *during* pregnancy: poor fair good excellent unknown

Mother's diet *during* pregnancy: poor fair good excellent unknown

Mother's age at birth _____ Total number of pregnancies _____ Total number of births _____

Mother's emotional state during pregnancy _____

Mother's occupation during pregnancy _____

Aware of chemical exposure during pregnancy? _____

Did mother use any of the following during pregnancy? (how much)

tobacco _____ alcohol _____ recreational drugs _____

prescription and/or over the counter medications _____

BIRTH HISTORY

Length of pregnancy _____ Length of labor _____ Weight of baby _____

Type of delivery: vaginal c-section induced anesthesia Complications? _____

Did child experience any of the following after birth? jaundice rashes seizures birth injuries birth defects

difficulty feeding other _____

CHILD'S HEALTH HISTORY

Illnesses (include measles/mumps/chickenpox) _____

Hospitalizations _____

Medications/past medications _____

Medication allergies _____

Any: ear infections fractures/trauma diaper rash cradle cap eczema bed wetting

diarrhea constipation fevers nosebleeds gas/stomach aches other _____

Are vaccines up to date? yes no (why not) _____

Vaccines given: MMR Hib chickenpox hepatitis A hepatitis B DPT influenza polio Other _____

Any reaction to vaccines? _____

CHILD'S DEVELOPMENT

How was child's health the first year? poor fair good excellent

What age did child: sit up alone _____ crawl _____ walk _____ talk _____ teethe _____

Describe child's sleep pattern (i.e. bed time, wake, difficulty falling asleep, naps, nightmares)

Child's personality and what you would change _____

Child's behavior at school _____

FEEDING HISTORY

How was child fed? breast bottle How long? _____ Type of formula? milk soy other _____

Any foods introduced before 6 months? _____ Any reaction? _____

Did baby experience colic? yes no How severe? _____

Any food allergies or intolerances _____ Any dietary restrictions? (religious, vegetarian) _____ Any vitamins/supplements _____

Typical diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages, include quantity _____

ENVIRONMENT

Is your child in: school daycare homecare other _____

Child's favorite activities/hobbies _____

How often does child: play video games _____ on a computer _____ read (not for school) _____

How often does someone read to child? _____ watch TV _____ (hrs per day/week)

Exercise (how much/kind) _____

Does anyone smoke in the house? yes no Are there animals in the house? _____

Age of home? _____ Type of heat _____ Any renovations/remodel? _____

Any toxic/hazardous exposure (home, parent's hobbies, parent's work) _____

Is child sensitive to: heat cold light dark other _____

Emotional climate of child's home _____

FAMILY HISTORY

Mother: Age _____ Any chronic illness _____

Father: Age _____ Any chronic illness _____

Siblings: Age/illnesses _____

Grandparents: illnesses/ if deceased, describe illness

MGM _____ MGF _____

PGM _____ PGF _____

Any fears for your child? _____

Is there anything that you feel is important to discuss that has not been covered? _____