Borealis
Heart Specialists

Thank you for choosing Borealis Heart Specialists to look after your heart health. We look forward to seeing you in the office soon!

To prepare for your upcoming appointment and to be seen in the office by the provider, you **MUST HAVE** the following items:

1. GOVERNMENT ISSUED ID
2. ALL OF YOUR INSURANCE CARDS (IF YOU HAVE MORE THAN ONE INSURANCE)
3. PRESCRIPTION MEDICATION BOTTLES

Please bring the completed forms with you to your appointment along with your government issued ID, insurance card(s) and prescription medication bottles. Please arrive 15 minutes early for your appointment. We look forward to meeting you!

Borealis
Heart Specialists

New Patient Registration

Patient Information

Last Name	First Name		Middle Initial
SSN	DOB		Gender
Mailing Address	City	State	Zip code
Main Phone Number	Alternate Phone Number		E-mail Address
Employer	Employer Phone Number		
Preferred Pharmacy			

Guarantor/Responsible Party Information (if other than patient)

Last Name	First Name		Middle Initial
SSN	DOB		Gender
Mailing Address	City	State	Zip code
Main Phone Number	Alternate Phone Number		E-mail Address
Employer	Employer Phone Number		
Employer Address			

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New Patient Registration (cont.)

Contacts

Emergency Contact Name	Relationship to Patient
Phone Number	Alternate Phone Number
Primary Care Provider (PCP) Name	Phone Number
Referring Provider	Phone Number

Insurance Information

PRIMARY	**SECONDARY**
Insurance Company Name:	Insurance Company Name:
Policy ID #:	Policy ID #:
Group #:	Group #:
Policy Holder Name:	Policy Holder Name:
SSN:	SSN:
DOB:	DOB:
Relationship to Patient:	Relationship to Patient:

*If you have tertiary insurance coverage, please let us know when you check into your appointment. Please have the current insurance card available to scan in.

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Consent for Care and Treatment

You have the right, as a patient, to be informed about your condition and the diagnostic, medical and/or surgical procedures recommended by your provider to make an informed decision as to whether to proceed with the suggested procedures and treatment. At this point in your care, no specific treatment plan has been recommended. This consent form provides us with your permission to perform medical examinations and diagnostic testing necessary to identify the appropriate treatment plan and/or procedure for any identified or probable condition(s).

By signing below, you are indicating that (1) this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any procedure ordered for you. If you have any concerns regarding the recommended diagnostic test or treatment, we encourage you to ask questions.

Acknowledgment

I voluntarily request a physician, advance practice professional, and other healthcare providers to perform the reasonable and necessary examination diagnostic testing and treatment for the condition that has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures, are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I acknowledge that I have been given sufficient information to make an informed decision regarding my care and treatment. I am aware of the potential benefits, side effects, and contraindications of the procedures recommended by my physician. I acknowledge that I have had the opportunity to discuss possible risks and hazards of these procedures with my physician. All my questions have been answered to my full satisfaction.

I understand that I have the right to consent to, or refuse, treatment at any time. I understand that there is no implied or stated guarantee of success or effectiveness of the recommended procedures.

I certify that I have read and fully understand the above statements and consent fully and voluntarily agree to its contents.

Patient/Representative Signature Date

Printed Name Relationship to Patient

Authorization to Disclose Protected Health Information (HIPAA)

In accordance with the *Health Insurance Portability and Accountability Act of 1996*, Borealis Heart Specialists may not use or disclose your health-related information except as specified in its Notice of Privacy Practices without prior written authorization. To authorize disclosure of your health-related information in the following situations, please complete and sign this form.

Patient Name:	**DOB:**

*Please initial below

_____ I hereby authorize Borealis Heart Specialists to disclose **my scheduling/appointment** information to the person(s) listed below.

_____ I hereby authorize Borealis Heart Specialists to disclose **my clinical information** to the person(s) listed below.

_____ I hereby authorize Borealis Heart Specialists to disclose **my billing information** to the person(s) listed below.

Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:
Name:	Phone Number:	Relationship to Patient:

Appointment Confirmations

*Please check the applicable option below.

I hereby authorize Borealis Heart Specialists to confirm upcoming appointments for me by:

Phone Call Text Message

Patient/Representative Signature Date

Printed Name

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Terms and Conditions of Use of E-mail Communications and Text Messages

E-mail/text communications to/from patients concerning diagnosis or treatment may be printed in full and made part of the patients' medical record. Because e-mails are part of the medical record, individuals authorized to access the medical record, such as clinical staff and billing personnel, will have access to the communications.

E-mail/text communications may be forwarded internally to staff members and others involved in the patients' care, as necessary, for diagnosis, treatment, reimbursement, healthcare operations, and other related matters. These communications will not be forwarded to independent third parties without the patients written consent, except as authorized or required by law.

Although every effort will be made to read and respond to e-mail/text communications promptly, there is no guarantee that these communications will be read and responded to within any particular time frame. In an urgent or emergency-situation, the patient should call their healthcare provider or go to the emergency room.

E-mail communications and text messages are at risk in many situations including, but not limited to, the following circumstances:

- E-mail communications and text messages can be circulated, forwarded, and broadcast to unintended recipients.
- E-mail communications and text messages can be intercepted, altered, forwarded or used without authorization or detection; errors can occur in the transmission process.
- E-mails are not disposable. Even after the sender and recipient have deleted copies of the email, back of copies may exist on a computer or in cyberspace.
- Employers and online services may have the right to inspect and keep communications that pass through their system.
- E-mail communications are easier to falsify than handwritten or signed hardcopies. In addition, it is impossible to verify the identity of the sender, or to ensure that only the recipient can read the e-mail once it has been sent.
- E-mail communications can introduce viruses into a computer system and potentially damage or disrupt a computer.
- E-mail communications and text messages can be used as evidence in court.

If the patients e-mail/text communications require or invite a response and the patient has not received a response within a reasonable period of time, it is the patients responsibility to determine whether the intended recipient received the communication and when the recipient will respond.

E-mail/text communication should not be used to communicate sensitive medical information such as that relating to HIV, mental health or substance abuse.

The patient is responsible for notifying the office staff of any type of information that the patient does not want to be sent by e-mail or text messages.

Borealis Heart Specialists is not responsible for loss of information due to technical failures associated with the patients e-mail or text messaging software or Internet service provider.

In the event the patient does not comply with the conditions here in, the patient's privilege to communicate by e-mail or text messages may be terminated.

The patient shall adhere to the guidelines below for communicating via e-mail or text message:

- Limit or avoid using an employer's or other third-party computer.
- Notify the office staff of any changes to the e-mail address or cell phone number for text messages.
- Insert topic of e-mail communication in the subject line and patients name in the body of the e-mail.
- Take precautions to preserve privacy and confidentiality by, for example, using screensavers and protecting your computer passwords.
- Exercise caution when using mobile devices in public places where others may eavesdrop on these communications.

_____I hereby consent to have Borealis Heart Specialists' staff communicate with me via **e-mail or text messages**. I understand and acknowledge that Borealis Heart Specialists cannot guarantee the privacy, security or confidentiality of information transmitted via e-mail or text messaging.

By signing this form, I certify that I have read and understand this form and I voluntarily agreed to uses and disclosures of information as described. Furthermore, I understand that I may revoke this authorization at any time by submitting a written notice to Borealis Heart Specialists.

Patient/Representative Signature Date

Printed Name Relationship to Patient

Borealis Heart Specialists
1200 Airport Heights Dr. Building E, Suite 200

P: (907) 262 4278 F: (877) 653 0649

OFFICE FINANCIAL POLICY

BOREALIS HEART SPECIALISTS
Alvaro E Rosales, MD, FACC

As a courtesy to you, we will file your insurance. Those portions of treatment or services that are not estimated to be covered by your insurance company (including patient co-pay and deductible) are expected to be paid at the time of service unless other arrangements have been **agreed upon in writing**. This office can make no guarantee of the insurance payment estimates. If, after 60 days, your insurance company has not paid the balance due on your account, you will be billed directly. Our staff makes every effort to maximize your medical insurance benefits and will gladly answer any questions you have regarding this service. Ultimately, **YOU ARE** responsible for your account and knowledge of your insurance policy. Accounts remaining unpaid after 90 days may be turned over to collections. To assist you with financing, we accept all major credit/debit cards, cash, and check payments.

Missed Appointments for Procedures and Imaging

No charge will be made for rescheduling an appointment provided at least 24-hour notice is given. We reserve the right to charge a minimum of $50.00 for appointments broken or cancelled without this advanced notice. Please remember your appointment has been reserved specifically for you.

Returned Checks

There will be a $25.00 handling fee for returned checks.

By singing below, I certify that I have read, understand, and agree to this financial policy. Upon request, a copy of this Office Financial Policy will be provided to you.

Patient's Signature: _____ Date: _____

PRINT Patient's Name: _____

Office Policies

We are delighted that you have chosen to and trust us with your care, and we welcome the opportunity to serve you. We are committed to working closely with you and your primary care physician to deliver the most effective treatment available. As part of this commitment, it is important that you have a clear understanding of our office and financial policies.

Office Hours

Monday – Friday from 8:00am to 5:00pm.

Emergency Situations

In the event of an emergency during office hours, our staff will notify the appropriate healthcare provider and he or she will return your call promptly. If the office is closed, please call 9-1-1or go directly to the emergency room nearest to you.

Appointment Scheduling

Appointments are scheduled between 8:00am and 5:00pm, Monday through Friday. If you need to cancel or reschedule your appointment, please notify our office during normal office hours, at least 24 hours prior to your appointment. It is very important that you arrive for each visit on time, for you to have adequate time with your provider. If you are more than 15 minutes late you may be asked to reschedule. Occasionally, the doctor's schedule and hospital emergencies necessitate a change in your appointment. When this occurs, we will do our best to contact you so that you may avoid an extended wait or unnecessary trip.

Cancellation Policy

Please be aware that if you fail to notify us to cancel your appointment at least one business day in advance, you may incur a $50 cancellation or no-show fee. Such fees are not covered by health insurance; therefore, you will be responsible for paying this fee. After three missed appointments, without prior notification of cancellation, Borealis Heart Specialists will no longer be able to provide services to you. We kindly ask that you call our office as far in advance as possible to cancel/reschedule your appointment.

Prescriptions

1. For Refills, please contact your pharmacy and they will send us a refill request. (2) If they have not received the new medication within 48 business hours, please call the office at (907) 262 4278. (3) If you have zero refills left on medications, please contact the office when you have a week left of your medication and allow us 72 business hours to process the request. (4) If you run out of your medication, please have the name of your pharmacy, medication name, dose of the medication, and how often you are taking it, and allow us 72 business hours to process the request.

Refunds

If there is an overpayment for services rendered, we will refund the amount to you once all claims are settled on the account and no payment is due on any other claim.

Returned Checks

There will be a $25 return check fee for checks returned by the bank. You will be required to pay all fees associated with this check, in cash, prior to scheduling a new appointment.

Account Balances

If there is a balance on your account, we will send you a monthly statement. Balances are expected to be paid in full upon receipt of the statement. Payments not received within 30 days of receipt of the statement are considered past-due. Accounts with balances outstanding for 90 days will be referred to a

collection agency. If your account is sent to a collection agency, you may be subject to separate collection agency fees and penalties.

Disputes

Any disputes of your account should be submitted in writing, within 30 days of receipt of the monthly statement. You will be notified of the outcome within 14 business days of receipt of your submission.

Confidentiality of Medical Records

Borealis Heart Specialists is committed to protecting the privacy and confidentiality of your medical information. Please review our Notice of Privacy Practices which describes our legal duties, the different ways that we are permitted to use and disclose your protected health information, and your rights to access and control the information. All records that we create or receive concerning your health or medical condition and the services rendered are confidential and cannot be disclosed without your prior written authorization, except as otherwise permitted by law.

Records Request

To authorize the release of your medical information to a specific person or entity, you must submit your request in writing. If you want a copy of your medical records for your personal records, please inform the front office staff. For all Records Requests, please allow between 7 to 10 business days for the request to be completed. By law, we are required to retain your medical records for seven years. If you request a letter/form, be completed for you or on a family member's behalf, such as short-term disability or creditor forms, please schedule an appointment with the provider to discuss the paperwork and what is needed.

Complaints and Grievances

To file a complaint, kindly fill out our complaint form and submit it to the practice manager. Within 14 days of submission of your complaint, you will receive written notice of the results of our investigation and actions taken to resolve your grievance.

By signing this form, I certify that I have read and fully understand the above statements and consent fully and voluntarily agree to its contents.

Patient/Representative Signature Date

Printed Name Relationship to Patient

MEDICATION REFILL REQUEST POLICY

For all medications, please contact your pharmacy to request the refills. The pharmacy will in turn fax us the request. It is the patients' responsibility to request refills in a timely manner.

At Borealis Heart Specialists, we always strive to provide the fastest service possible. But please allow **48 hours** for processing of your refill request. Due to high patient call volumes, the time is required to ensure proper documentation and verification of the medication.

_____

PRINT patient name

_____ _____

Patient Signature Date