FRONTIER HEALTH AND WELLNESS: PATIENT REGISTRATION FORM

Frontier Health and Wellness will utilize the information provided to complete your patient profile, provide your provider with necessary demographic information and allow our contracted billing service to contact and bill your insurance provider(s).

Today's Date:	Client: ○ Adult ○ Child	If client is a child, then include guardian's name above				
Primary Care Provider (Clinic Name):						
Client's last name: First: Middle:	○ Mr. ○ Miss ○ Mrs. ○ Ms	Marital status Single / Mar / Div / Sep / Wid ☐ ☐ ☐ ☐ ☐				
Is this your legal name? ○ Yes ○ No	If not, what is your full legal name?	Any other Former name(s):	Birth date:	Age:	Gender ○ M ○ F ○ Prefer not to disclose	
Physical address:	Social Security no.:	Best phone # to reach you: ( )				
Mailing Address:	City:	State:	ZIP Code:			
Occupation/Grade:	Employer/School:	Employer/School phone number: ( )				
Preferred Pharmacy Name	Pharmacy Address	Pharmacy Phone Number				
I choose this clinic because (please indicate your referral source): ☐ Family/Friend ☐ Location ☐ Search Engine ☐ Another Provider ☐ Hospital ☐ Insurance Plan ☐ Other						
Other family members seen here:						

INSURANCE INFORMATION

(Please give your ID and insurance card to the receptionist. so we can make a copy for our records)

Person responsible for bill:	Birth date: / /	Address (if different):	Best phone # to reach you: ( )
Is this person a patient here? ☐ Yes ☐ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Please note that this clinic is NOT set up to receive payments from Medicaid/Medicare/Denali Kid Care.

Is this client covered by insurance (other than Medicaid/Medicare/Denali Kid Care)? ☐ Yes ☐ No			
Please indicate primary insurance company:	Group no.:	Policy no.:	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Co-payment: $
Client's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Client's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Frontier Health Services or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Consent to Treat and Consent to Financial Responsibility

Frontier Health and Wellness (on behalf of its contracted providers)

_____ (Initial)*Guarantee of Outcomes:* I recognize that no guarantee of a specific outcome has been provided. Payment of a service fee does not guarantee or imply specific results from any services provided to the patient. This includes but is not limited to therapy, medication treatments, exams or procedures for a patient of a Frontier Health and Wellness contracted provider.

_____(Initial)*Divorce/Custody:* In the event of a divorce/multi-home families, Frontier Health and Wellness will need a copy of the custody documentations from court. Frontier Health and Wellness providers provide services and seek involvement of both parents/interested parties within reason of a custody plan. Please note that the default position of any provider without a signed parenting plan is to assume 50/50 legal and physical custody of each parent. If legal custody is 50/50 shared then Frontier Health Services providers will require one parent to be the primary contact/sponsor for any employee contacts and billing purposes. This will not prevent the other parent from participation in patient care and accessing treatment recommendations or documentation. In the absence of custody paperwork, the default position is to assume that both parents maintain 50/50 custody.
Primary Parental Contact: _____.

_____(Initial)*Assignment of authorization to negotiate on your behalf regarding insurance benefits and payment:* In consideration of any and all treatment services rendered or to be rendered by Frontier Health and Wellness and its contracted providers, to the extent permitted by law, I hereby permanently assign, handover and set over to Frontier Health and Wellness and its providers providers all my rights, title and interest to medical reimbursement, containing, but not restricted to, the right to name a beneficiary, add dependent eligibility and to have an individual policy sustained or allotted in agreement with the terms and reimbursements under any insurance policy, compensation certificate or other health benefit indemnification reimbursement otherwise payable to me for those services rendered by Frontier Health and Wellness providers in the interim of the claim for care provided by Frontier Health and Wellness contracted providers.
Such irrevocable allocation and assignment shall be for the recovery on said policy or insurance, but shall not be construed to be an obligation of Frontier Health and Wellness or its providers to pursue any such right of reclamation. I authorize the insurance company or tertiary client to pay directly Frontier Health and Wellness contracted providers all reimbursements due for services received.

_____ (Initial)*Assurance of Compensation:* I understand and agree that the payment of the financial obligation for services rendered by Frontier Health and Wellness contracted providers will paid. I agree whether signing as a guarantor or as a patient, that in consideration of the services to be provided to the patient, to be hereby jointly and individually obligated to pay the account of Frontier Health and Wellness' contracted providers in accordance with the regular rate and terms of each of Frontier Health and Wellness' contracted providers. Should the account be referred for collection by an attorney or collection agency, I agree to pay all of the amount not referred for collection by an attorney or collection agency, I agree to pay all of the amount not paid when owed. If legal custody is shared contact/guarantor for any staff contacts and billing purposes. 50/50 by both parents, then Frontier Health and Wellness and its contracted providers will require one parent to be the main contact/guarantor for any staff contacts and billing purposes.

_____**(Initial) Court Proceedings:** Frontier Health and Wellness contracted providers provide clinical services and do not conduct Forensic or Custody evaluations. FHW contracted providers will independently decide, on a case by case basis, to take part in court actions or provide opinions on court issues. Initialing this line indicates my agreement that neither I, nor my representative will subpoena Frontier Health and Wellness or its contracted providers for matters related to this case.

Consent to Treat and Consent to Financial Responsibility

Frontier Health and Wellness (on behalf of its contracted providers)

_____(Initial)***Cancellation Policy and Agreement:*** Appointments should be canceled within 48 hours or more to avoid a 50% missed appointment fee; an email, or a message for cancellation that is left on the Frontier Health and Wellness voicemail or your providers voicemail 48 hours or more before the appointment will qualify as appropriate notification. The 50% fee will need to be paid at or prior to the next scheduled appointment. Insurance companies DO NOT cover missed appointment or late cancellation fees. The client/family will be solely responsible for all missed appointment or late cancellation fees and will need to provide payment by cash, check or credit card to their provider or their providers contracted billing company. Frontier Health and Wellness contracted providers reserve the right to extend the fee to 100% of the appointment fee when a pattern of missed appointments occurs involving two or more missed appointments.

_____(Initial)***Confirmation Calls:*** I understand that all confirmation calls, emails or texts are a courtesy that Frontier Health and Wellness may provide on behalf of my provider(s), but the absence of a confirmation call does not negate the cancellation policy agreement.

_____(Initial) ***Medical Record Requests:*** Frontier Health and Wellness staff will work to manage these requests on behalf of each provider. These requests will be handled in a reasonably expeditious fashion and in accordance with Alaska statues. *Please note that court orders do not require a release of information from the patient or guardian.*

Record requests from health care facilities, mental health clinics, hospitals, academic centers and other related institutions will require a fully completed and signed Frontier Health and Wellness contracted provider Release of Information (ROI) to be on file. These releases can be found on the FHW website or one can be provided to you during your office visit. If you have any questions on how to fill the document out please contact the FHW front desk.

There are very few instances that a refusal of release medical records may occur. Although we reference three such instances here, others may occur as well.

1. Records that contain information subject to substance abuse or health issues without appropriate ROI on file will not be sent.
2. The release of the records breaches patient confidentiality or HIPAA regulations.
3. The release of records has the potential to endanger the health or safety of a patient or member of the community.

Once the records request has been reviewed and approved, the staff at Frontier Health and Wellness has 3-5 business days to complete the request on behalf of your provider. If for any reason this request is denied the patient and requester will be notified of the denial within 3-5 business days.

_____ **(Initial) Emergencies:** In the case of a psychiatric/psychological emergency (e.g. harm to self or others), patients are instructed to call 911 or, if able, go to The Providence Psychiatric Emergency Room in Anchorage; 3200 Providence Drive Anchorage, AK 99508. I understand that Frontier Health and Wellness or its contracted providers do not provide emergency or after hours call services or medical care and will use the above listed resources in the event of any psychiatric/psychological emergency.

Consent to Treat and Consent to Financial Responsibility

Frontier Health and Wellness (on behalf of its contracted providers)

_____ **(Initial) Electronic Communication and Phone Contact:** I understand that electronic communication; whether through email or the client portal; phone calls, refill requests and other associated correspondence with an FHW contracted provider are all tasks that require time and resources. Due to this, the above mentioned correspondence is often a billable service.

Note: Insurance coverage of these types of services is inconsistent and varies by coverage plan. Please check with your insurance company to determine what level of coverage you have regarding these types of electronic, telephonic, remote and non-face-to-face services.

_____ **(Initial) Frontier Health and Wellness; Contracted Providers:** I understand that Frontier Health and Wellness is a medical management company that contracts with clinical care providers. Each physician/ clinician that provides treatment at FHW is an independent contractor. Each provider is responsible for their treatment, clinical management and billing submissions. Since our providers submit their own billings under their own entities, all insurance submissions, Explanation of Benefits and bills will be under those individual entities. Please consult the Frontier Health and Wellness provider information page or the FHW website for information on each providers individual entity.

I have read the above Consent to Treatment and Consent to Financial Responsibility document from Frontier Health and Wellness on behalf of its contracted providers. I understand and accept all the terms set forth above. All of my questions and concerns have been answered and addressed by Frontier Health and Wellness staff or my provider prior to signing and submitting this document.

Printed Name of Patient or of Legal Guardian	Relationship to Patient
Signature Patient or of Legal Guardian	Date

FRONTIER HEALTH AND WELLNESS

Please review and sign the following Privacy Policy on behalf of our contracted providers

Notice of Privacy Practice – Privacy Policy

Your Right to Privacy and the Policies at Frontier Health and Wellness

This *Notice of Privacy Practice* describes how Frontier Health and Wellness and it's contracted providers may use and disclose your protected health information to carry out treatment, collecting payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

Frontier Health and Wellness (FHW) and it's contracted providers is committed to protecting the privacy of your personal health information. Federal regulations provide an additional framework for maintaining the privacy of protected health information while providing individual's with notice of Frontier Health and Wellness' and it's contracted providers legal duties and privacy practices with respect to protected health information.

As a general rule, Protected Health Information is kept confidential unless authorization to release it is provided to FHW. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical/mental health or condition and related health care services.

Frontier Health and Wellness and it's contracted providers must provide all people it serves with written notice of its privacy practices no later than the date of first service delivery, or as soon as possible after emergency treatment. Frontier Health and Wellness and it's contracted providers must obtain written acknowledgement that you have received this notice, or written documentation specifying reasons for not obtaining such acknowledgement.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, you may obtain the revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

If you have any questions about this Notice please contact the administration of Frontier Health and Wellness at:

4241 B Street Suite 305
Anchorage, Alaska 99508

FRONTIER HEALTH AND WELLNESS

Please review and sign the following Privacy Policy on behalf of our contracted providers

What to expect:

The purpose the services being sought by a Frontier Health and Wellness (FHW) contracted provider is to address mental health or behavioral concerns that you may have. When meeting with contracted providers at FHW we will discuss many sensitive issues. Your provider will ask questions, listen to you and suggest a plan for addressing these concerns. It is important that you feel comfortable talking to your providers about these sensitive issues. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their provider. Privacy, also called confidentiality, is an important and necessary part of good medical care.

As a general rule, Frontier Health and Wellness and its contracted providers will keep the information you share with us confidential, unless we have your consent to disclose the information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with us during any appointment. In some situations, providers are required by law or by the guidelines of our profession to disclose information whether or not we have the client's permission. Some of these situations are listed below.

Confidentiality cannot be maintained when:

- You tell your provider you plan to cause serious harm or death to yourself, and your provider believes you have both the intent and ability to carry out this threat in the very near future. Under these circumstances your provider is obligated to take steps to inform an authority and/or family member of what has been disclosed and how serious this threat appears to be. The goal here it to ensure that you are protected from harming yourself. If this were to occur, your provider would make an effort to inform you before disclosing this information to anyone.

- You tell your provider you plan to cause serious harm or death to someone else who can be identified, and your provider believes you have the intent and ability to carry out this threat in the very near future. In this situation, your provider must inform an authority AND inform the person whom you intend to harm. If this were to occur, your provider would make an effort to inform you before disclosing this information to anyone.

- You tell your provider you are engaging in behaviors/activities that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, the provider will need to use their professional judgment to decide whether an authority should be informed. If this were to occur, your provider would make an effort to inform you before disclosing this information.

- You tell a provider you are being abused - physically, sexually or emotionally. In this situation, your provider is required by law to report the abuse an authority. If this were to occur, your provider would make an effort to inform you before disclosing this information.

- You are involved in a court case and a request is made for information about your treatment. If this happens, your provider will not disclose information without your written agreement *unless* the

court requires your provider to do so. Even under these circumstances your provider will do all they can within the law to protect your confidentiality, and if your provider are required to disclose information to the court, they will make an effort to inform you that this is happening.

Communicating with other family members:

Except for situations such as those mentioned above, contracted providers at Frontier Health and Wellness will not disclose information you share with your provider to family members. However, if risk-taking behavior becomes serious and represents imminent danger to you or others, then your provider will need to use professional judgment to decide whether to disclose this information. If your provider feels that you are in such danger, they will make an effort to tell you before disclosing this information.

- The exception to this is if you have signed a Release of Information (ROI) for your provider to communication with an individual. Please know that if you signed an ROI for your provider to speak with another person regarding your treatment, that release is considered valid for one year or until you officially revoke the consent. To revoke an ROI consent it must be done in writing and given to either an FHW staff member or directly to your provider.

Communicating with other providers:

Your provider may need to communicate with another one of your providers so that the best care can be provided to you. Your provider will get written permission in the form of an ROI in advance so that information can be shared with additional providers.

There are also outside contractors, staff and other contracted providers directly associated with FHW who may need limited access to parts of your medical record to provide support to the care your provider is giving (such as an insurance company, the receptionist, a billing company, etc).

If you have any additional questions or concerns, please direct them to Frontier Health Services Administration before continuing to the signature portion of this document.

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FRONTIER HEALTH AND WELLNESS

Please review and sign the following Privacy Policy on behalf of our contracted providers

Signature Page

Please initial each section and sign below indicating your understanding and agreement with the Frontier Health and Wellness Privacy Policy:

_____ **(initial)** I consent to the release of my healthcare information to the contracted providers and staff at Frontier Health and Wellness (including, but not limited to receptionists, billing contractor [currently Alaska Billing Services], my insurance company, etc) to a level that is required for that individual or entity to aid in my medical care.

_____ **(initial)** I understand that when my provider is obligated to release my protected healthcare information that the provider will make an effort to inform me first, but that doing so is not a requirement or a guarantee.

_____ **(initial)** Although I know I have the legal right to request a copy o my medical record, I acknowledge that under rare circumstances my provider may decide to remove or didact certain elements if there is a reasonable expectation that releasing this information to me will put myself or others at risk.

_____ **(initial)** I have read the *Notice of Privacy Practice* policy fully and have all of my questions answered fully prior to signing this document. I have been given adequate time to study the information and find the information to be specific, accurate, and complete.

Client Signature:

Client Signature _____ Date_____

Provider Signature _____ Date_____

Electronic Communication Policy
FRONTIER HEALTH AND WELLNESS
On Behalf of its Contracted Providers

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, Frontier Health and Wellness (FHW) in collaboration with its contracted providers has prepared the following policy.

The use of various types of electronic communications is common in our society, and for many individuals this is the preferred method of communication, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of medical care. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethical, legal and professional standards.

Email Communications

We use email communication, only with your permission, and only if there is not another option of communication that provides you with greater privacy and security. That means that email exchanges with FHW and its contracted providers should be used sparingly and limited. It is the preference of FHW and its contracted providers that all electronic communication be managed and sent through your secure Patient Portal.

Emails to FHW or its contracted providers regarding clinical matters should be avoided as they are not secure and if you must use electronic communication FHW and its contracted providers request the use of your Patient Portal messaging system. The you still choose to send an email regarding a clinical matter the email can be saved for reference during the next appointment. If the client chooses to include a clinical question in their email they may be answered by your provider, however it is understood that:

- email communication is not a secure medium
- email does not allow for the degree of precision and effective communication that face to face encounters do
- email communication can be easily misinterpreted or misunderstood, that it is practically impossible to provide an answer to any question which covers all possible outcomes and or risks

If you need to discuss a clinical matter with your provider, please feel free to call so they can discuss it on the phone or; if possible, wait so you can discuss it during your next appointment. The Patient Portal, telephone or face-to-face communication is much more secure as a mode of communication. FHW and its contracted providers work hard to protect your privacy and wish to maintain communication through the safest means possible.

Note: There is a billing protocol in place for electronic communication and phone call responses. Please review your Consent to Treat and Financial Responsibility document for more detailed information.

Text Messaging

Appointment related text messaging reminders are provided at Frontier Health and Wellness and its contracted providers as a courtesy (see Consent to Treat and Financial Responsibility form for details). Due to text messages being an impersonal and insecure mode of communication, FHW and its contracted providers do not text social or treatment related messages to clients/families nor do we respond to text messages from anyone in treatment. Please do not text message FHW staff or any of its contracted providers.

Social Media

Frontier Health and Wellness (FHW) or its contracted providers do not communicate with, or contact, any clients through social media platforms, such as Twitter and/or Facebook. This is because these types of casual social contacts can create significant security risks for you and your provider.

Any communications with clients online have a high potential to compromise the professional relationship as well as your protected health information. In addition, please do not try to contact FHW staff or its contracted providers in this way. We will not respond and will terminate any online contact even if it is accidental.

FOR CLIENT RECORDS

Electronic Communication Policy
FRONTIER HEALTH AND WELLNESS

Websites

Frontier Health and Wellness (FHW) has a website that you are free to access. It is used for professional reasons to provide information to others about FHW and its contracted providers. You are welcome to access and review the information that we have on our website and, if you have questions about it, we should discuss this during your next appointment.

Web Searches and Reviews

Frontier Health and Wellness (FHW) and its contracted providers will not use web searches to gather information about you without your permission. This is felt to violate your privacy rights; however, we understand that you might choose to gather information about FHW or its contracted providers in this way. There is an incredible amount of information available about individuals on the Internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about contracted providers or other staff at FHW through web searches, or in any similar fashion, please discuss this with us during our appointment so that we can address its potential impact on your treatment.

Recently it has become commonplace for clients to review their healthcare provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of Frontier Health and Wellness or any contracted provider with whom you are working, please share it with us so we can discuss it and its potential impact on your treatment. Please do not rate our work with you while we are in treatment together on any of these websites. Doing so can potentially damage your providers ability to work with you.

If you have any questions about this policy, please feel free to discuss this with us in person.

I have read the above Electronic Communications Policy document from Frontier Health and Wellness. I understand and accept all the terms set forth above. All of my questions and concerns have been answered and addressed by Frontier Health and Wellness or my provider prior to signing and submitting this document.

_____ _____

Printed Name of Patient or of Legal Guardian Relationship to Patient

_____ _____

Signature Patient or of Legal Guardian Date

FRONTIER HEALTH AND WELLNESS

Email Communication Agreement

This agreement is written on behalf on Frontier Health and Wellness and its Contracted Providers

As a supplement to your in-office appointments, Frontier Health and Wellness (FHW) and its contracted providers can use email to communicate. Set forth below are policies outlining when and how email should be utilized to maintain your privacy and to enhance communication as well as a place for you to acknowledge your consent for its use. Your decision to utilize email is strictly voluntary and your consent may be rescinded at any time. Email will be accessible by all staff members associated with FHW and its contracted providers. Email is typically reviewed **once daily during business days**. Email can be used to relay information but the preferred method of communication is through your patient portal messaging system. When communicating through email, please include a clearly identified question if you would like a response. Not all emails will be responded to. FHW and its contracted providers reserve the right to use clinical judgment regarding the response to any given email and the need to provide a response (for example, in some cases a response may be postponed because the next appointment is close enough that the response may be considered redundant).

WHEN MAY I USE EMAIL TO COMMUNICATE?

EMAIL MAY BE USED FOR:

- Medication refill requests (Please refer to our website FHWAK.com or your client portal for a refill request submission for this when possible)
- Appointment requests (Please refer to your client portal for scheduling changes when possible)
- Other matters not requiring an immediate response

Please note - FHW and its contracted providers do not suggest email be primary method of communication due to the security risks. The preference is for patients to utilize their secured patient portal and or the telephonic communication to reach their providers as this is secure and maintains your confidentiality.

WHEN SHOULD I NOT USE EMAIL TO COMMUNICATE?

EMAIL SHOULD NEVER BE USED:

- In an emergency
- If you are experiencing any desire to harm yourself or others
- If you are experiencing a severe medication reaction
- If you need an immediate response

WHAT ARE MY OBLIGATIONS?

- I agree to let Frontier Health and Wellness (FHW) and/or my provider know immediately if my email address changes.
- If I do not receive a response from FHW or my provider within my expected time frame, then I will contact FHW or m provider by telephone if a response is needed.
- I will use email communication only for the purposes stated above.
- I will advise FHW and/or my provider in writing should I decide that I would prefer not to continue communicating via email
- I understand that email may only be used to supplement my appointments with my provider and not as a substitute for them.
- To avoid possible confusion, I will not use internet slang or short-hand when communicating via email
- There is a billing protocol that exists for email and phone communication. Under most circumstances emails and phone calls are a billable forms of communication.

WHAT ARE THE ADVANTAGES TO USING YOUR PATIENT PORTAL OR EMAIL?

- Unlike trading voicemail messages, email allows you to see exactly the question the doctor is responding to and to have a written record of that exchange for future reference.
- The patient portal messaging system or email allows for the rapid transmission of forms or other paperwork such as information regarding your medications/condition.

FOR CLIENT RECORDS

FRONTIER HEALTH AND WELLNESS

Email Communication Agreement

WHAT ARE THE RISKS OF USING EMAIL?

RISKS OF COMMUNICATING VIA EMAIL INCLUDE BUT ARE NOT LIMITED TO:

- Email may be seen by unintended viewers if addressed incorrectly.
- Email may be intercepted by hackers and redistributed.
- Someone posing as you could access your information.
- Email can be used to spread computer viruses.
- There is a risk that emails may not be received by either party in a timely matter as it may be caught by junk/spam filters.
- Emails are discoverable in litigation and may be used as evidence in court.
- Emails can be circulated and stored by unintended recipients.
- Statements made via email may be misunderstood thus creating miscommunication and/or negatively affecting treatment.
- There may be an unanticipated time delay between messages being sent and received.
-

WHAT HAPPENS TO MY EMAILS?

- Emails will be printed out and maintained as a permanent part of your medical record.
- As part of your permanent record, they will be released along with the rest of the record upon your authorization or when the doctor is otherwise legally required to do so.
- Messages may be seen by FHW staff or their contracted providers for the purpose of filing or carrying out requests (e.g., appointment scheduling) or when your provider is away from the office.

WHAT STEPS HAS FRONTIER HEALTH SERVICES TAKEN TO PROTECT THE PRIVACY OF MY EMAIL COMMUNICATIONS?

- Frontier Health and Wellness (FHW) and its contracted providers have security software installed on all office computers.
- All office computers are password protected.
- FHW staff and contracted providers have educated on the appropriate use and protection of email.
- FHW staff and contracted providers do not access patient email from public Wi-Fi hotspots.
- FHW staff and contracted providers do not allow family members access to personal work computers.
- FHW staff and contracted providers will not forward patient email to third-parties without your express consent.
- FHW staff and contracted providers will verify email addresses before sending messages.

WHAT STEPS CAN I TAKE TO PROTECT MY PRIVACY?

- Do not use your work computer to communicate with Frontier Health and Wellness or its contracted providers as your employer has a right to inspect emails sent through the company's system.
- Do not use a shared email account to transmit messages.
- Log out of your email account if you will be away from your computer.
- Carefully check the address before hitting "send" to ensure that you are sending your message to the intended receiver.
- Avoid writing or reading emails on a mobile device in a public place.
- Avoid accessing email on a public Wi-Fi hotspot.
- Make certain that your email is signed with your first and last name and include your telephone number and date of birth to avoid possible mix up with patients with same or similar names.

FOR CLIENT RECORDS

FRONTIER HEALTH AND WELLNESS

Email Communication Agreement

CONSENT TO EMAIL USE

Frontier Health and Wellness (FHW) and its contracted providers initiate email communication only with your permission and only for, scheduling, administrative and billing purposes unless we have made another agreement. That means that email exchanges with FHW or its contracted providers should be limited to matters such as setting and changing appointments, billing matters and other related issues. The preferred and recommended method of any of these topics is through your patient portal as that is the only way to ensure your messages are secure. Emails to our providers regarding clinical matters should be avoided as they are not secure. If the client chooses to send an email regarding a clinical matter, then the email can be saved for reference during the next appointment. If the client chooses to include a clinical question in their email, then these questions will typically be answered via email, however, it is understood that email communication is not a secure medium and that sending a question through this medium authorizes FHW or its contracted providers to provide our reply through the same medium (unless a request not to reply is included in the body of that email). It is also understood that email does not allow for the degree of precision and effective communication that face to face encounters do. Further it is understood that email communication can be easily misinterpreted or misunderstood, that questions cannot be fully answered and answers cannot cover all possible risks or outcomes. If you need to discuss a clinical matter with your provider, please feel free to call us so we can discuss it on the phone or wait to discuss it during your next appointment. A telephone or face-to-face conversation is a much more secure mode of communication. There is a billing protocol in place for email and phone call responses.

Electronic correspondence, phone calls, refill requests and associated correspondence are all tasks that require time and resources, as such they are often billable services.

Note: Insurance coverage of these types of services is inconsistent. Please check with your insurance company to determine what level of coverage you have regarding these types of online, remote and non-face-to-face services.

By signing below, I consent to the use of email communication between myself and contracted providers/staff at Frontier Health and Wellness (FHW). I recognize that there are risks to its use, and despite FHW's and its contracted providers best efforts, they cannot guarantee confidentiality. I understand and accept those risks and the policies for email use outlined in this form. I further agree to follow these policies and agree that should I fail do so, FHW and/or its contracted providers may cease to allow me to use email as a means of communication regarding my care/account. I also understand that I may withdraw my consent to communicate via email at any time by notifying FHW or my provider in writing.

Patient Name (print) _____ Date _____

Guardian (print) - When applicable _____ Date _____

Patient/Parent/Guardian (signature) _____ Email Address _____

Frontier Health and Wellness
Informed Consent for Telehealth Services

on behalf of its contracted providers

PATIENT NAME: _____ LEGAL GUARDIAN NAME: _____ (IF APPLICABLE)	PATIENT'S DATE OF BIRTH _____/_____/_____	TODAYS DATE: _____/_____/_____

PROVIDER NAME(Please Circle): Dr. Hjellen V. Hutton, LPC K. Moore, NP T. DeMure, NP

LOCATION: 4241 B ST. SUITE 305, ANCHORAGE, AK 99508

Introduction:

Telehealth involves the use of electronic communications to enable your provider to meet with you at a separate location to continue ongoing medical/clinical care. The information discussed may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. The telehealth platform used by FHW and its contracted providers is HIPAA Compliant and the protection of your personal health information is our utmost priority.

Expected Benefits:

- Alternate access to medical care by allowing a patient to remain within his/her home (or at a remote site) while still being able to meet directly with their provider.
- Increased access to medical/clinical evaluations and management during times of restricted mobility.
- The ability to maintain and adhere to the state mandated social distancing during the COVID-19 pandemic.

Possible Risks:

As with any medical/clinical treatment, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making by the physician and additional face-to-face visits may be required to effectively manage patient care.
- Delays in medical/clinical evaluation and treatment could occur due to deficiencies or failures of the electronic equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. FHW or its contracted providers will not record telehealth sessions to provide additional safeguards against any such privacy breach.
    - FHW or its contracted providers will not be able to mange the privacy and security of your environment while participating in a telehealth appointment and request that you take all necessary precautions to protect your personal health information by securing your surroundings prior to your appointment.
- In rare cases, a lack of face-to-face treatment may result in judgment errors due to lack of environmental controls.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telehealth interaction, and may receive copies of this information.
4. I understand that in person medical/clinical care may be available to me, and that I may choose to see the doctor face to face in lieu of telehealth. I will, however, follow all Federal, CDC, State of Alaska and Municipality of Anchorage guidelines and mandates in regards to the containment of the COVID-19 Virus.
    a. I understand that FHW and its contracted providers reserve the right to refuse face-to-face services if myself or anyone I have been in close contact with has been/is currently ill or is experiencing symptoms of the COVID-19 virus.
    b. I understand that in the event that any member of the FHW staff or its contracted providers is ill or experiencing symptoms of the COVID-19 virus my regularly scheduled face-to face appointment may be moved to a telehealth appointment to maintain the health and safety of all patients.
5. I understand that I may still be expected to pick-up a hard copy of my medication prescription if the medication I am being prescribed is mandated by the DEA to be delivered direct to the pharmacy.

Patient Consent To The Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care.

I hereby authorize Frontier Health and Wellness and its contracted providers to use telehealth in the course of my diagnosis and treatment.

Signature of patient or legal guardian _____ *Date:* _____

If Authorized signer, relationship to patient: _____

I have been offered a copy of this consent form (initial) _____

Prescription Refill and Medication Information
Frontier Health and Wellness
on behalf of its contracted providers

If you are seeing a Frontier Health and Wellness contracted provider who will be prescribing medications, please make sure you keep track of your medication supply so that you do not run out between appointments.

Medication Refill Policy

If you need a refill on a medication that you have previously received from your provider, please do so through one of the following options. Please know that refill requests can take up to 3 business days.

Preferred Option:

Log into your patient portal at https://www2.rxnt.com/phr/. Through the portal you can send your provider a direct message regarding the medication(s) that you are requesting. Please review your current medications as listed in your client portal and use that information to reference the correct medicine, dosage and supply you are requesting.

Secondary Option:

Visit the refill request page at FHWAK.com. Completing this Refill Request Form in full is the most effective way to make sure that we have all the needed information to process the refill.

Please Note:

- We can process refill requests by phone or email, but these are often delayed as necessary pieces of information are not always included.
- Saturdays, Sundays and holidays are not considered "business days" when calling in for refills. To account for any side effects and contraindications; please inform your provider of any NEWLY prescribed medications from other prescribers and of any newly diagnosed medication allergies.
- All refill requests must be directly through Frontier Health and Wellness or your provider
    - Refills requested through your pharmacy does delay the ability for the prescribing provider to be notified. Pharmacies often request out of date and discontinued medications for patients which also causes delay in the provider being able to complete an accurate refill.
    - FHW contracted providers cannot honor all pharmacy requests due to inconsistency and inaccuracy of patient medication information.

Access to Pharmacy Claim and Medication History

_____ By initialing you hereby agree to allow Frontier Health and Wellness (FHW) staff and its contracted providers to access your pharmacy claim and medication history in real time through SureScripts.

1. You are authorizing your provider OR an authorized agent working on behalf of Frontier Health and Wellness to view your pharmacy claims and medication history. This will

contain prescriptions and claims that have been submitted by other providers that are not affiliated with FHW

2. You have the right to revoke this consent at any time. Please submit in writing your desire to revoke consent for FHW and its contracted providers to access your pharmacy claims and medication history.

I have read the above Prescription Refill and Medication Information document from Frontier Health and Wellness on behalf of its contracted providers. I understand and accept all the terms set forth above. All of my questions and concerns have been answered and addressed by Frontier Health and Wellness or my provider prior to signing and submitting this document.

_____
Patient Name (Print)

_____
Guardian Name (Print) (When Applicable)

_____ _____
Patient/Parent/Guardian Signature Date

FRONTIER HEALTH AND WELLNESS

Collaborative Clinical Care for Alaskans

Acknowledgment of Separation of Responsibilities

At Frontier Health and Wellness (FHW) we operate as a clinical collaborative in conjunction with our highly skilled providers.

FHW is not a clinical or medical provider but an administrative company working in support of and on behalf of its contracted providers and their clients. Each contracted provider is responsible for the medical and clinical care that is provided to each patient. Providers with FHW each have their own State of Alaska Professional License and individual business license under which they practice. Since FHW's contracted providers are independent practitioners, they will submit billings to insurance or whichever payer source has been agreed upon under their individual practice names.

To better serve our clients please allow FHW staff to assist you in all your non-clinical needs. FHW is happy to assist with (but is not limited to) the following:

- New Intakes
- Scheduling
- Administrative questions
- Patient accounts
- Client portal set up
- Billing/accounts payable
- Medical records requests and management
- Acting as a liaison between contracted providers and clients

Frontier Health and Wellness Contracted Providers:

- Child, Adolescent and Adult Psychiatry Services: E. David Hjellen D.O. – Frontier Health Services
- Pediatric Clinical Therapy Services: Victoria Hutton MS, LPC, CAPT – Beyond Barriers Counseling
- Adult Psychiatric Services: Kelly Moore, Psychiatric Mental Health NP - BoreTide Behavioral Health
- Adult Psychiatric Services: Tina DeMure, Psychiatric Mental Health NP - Tina DeMure, LLC

Agreement:

_____*I have read the above document from Frontier Health and Wellness on behalf of its contracted providers.*

_____*I understand the Frontier Health and Wellness is not a medical or clinical provider and that all clinical decision making occurs outside of the authority of FHW. Furthermore; all diagnostic and treatment decisions exist between patient and provider and do not in any way involve FHW or its employees.*

All of my questions and concerns have been answered and addressed by Frontier Health and Wellness staff or my provider prior to signing and submitting this document.

_____ _____

Patient/Guardian Name **Child/Adolescent Name (if applicable)**

_____ _____

Patient Guardian Signature **Date**

Adult

Intake Checklist Presenting Problems and Symptoms

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Sad most of the day				
Not interested in activities that used to be fun				
Cannot fall asleep most of the time				
Sleeping more than usual				
Loss of energy				
Do not spend as much time with friends as usual				
Do not bathe or clean self regularly				
Eating more than usual				
Blaming self				
Acting angry much of the time				
Acting unusually happy much of the time				
At times needing little or no sleep				
An Increase in Intrusive and Unwanted Sexual Behavior				
Talking so fast it is hard to understand				
Tense, nervous, worrying much of the time				
Panic Attacks: heart pounding, can't breathe, sweating				

Client Name (Print)

Date

Recent = within the past 30 days In the past = greater than 30 days	**None**	**Recently**	**In the Past**	**Supported By: Please provide further explanation**
Saw or had something bad or scary happen				
Often remembering something bad or scary happening				
Having bad dreams over and over				
Easily upset when reminded of something bad or scary				
Staying away from or will not talk about things that remind you of something bad or scary that happened				
Jumpy or scared easily				
Doing things over and over without a clear reason i.e. washing hands, touching things, checking locked doors				
Having problems paying attention				
Easily distracted				
Often forgetful				
Often fidgeting with hands or feet				
Lots of physical movement				
Talking a lot				
Problems at work				
Often acting without thinking				
Often loses temper				

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Often found arguing				
Difficulties following rules or directions				
Bullying, threatening or intimidating others				
Starting physical fights				
Destroying property				
Stealing				
Lying				
Abandoning responsibilities				
Cruelty to others				
Fire setting				
Disciplinary actions at work				
Change in work performance				
Uncomfortable making eye contact with others				
Having problems communicating				
Repeating same movements over and over (i.e. wringing hands, rocking back and forth, snapping fingers)				
Difficulty noticing when others are trying to speak or interact with you				
No interest in making friends or interacting with others				

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Difficulties calming down when upset				
Unchangeable beliefs or ideas that others don't get/tolerate				
Hearing voices when no one is there				
Seeing things when nothing is there				
Voices tell you to harm self				
Voices tell you to harm others				
Talking with words that do not make sense to others				
People say you show little emotion on your face				
Refusal to maintain adequate body weight within normal range				
Very scared of gaining weight				
Others tell me I'm skinny but I still feel fat				
At times I eat way too much food				
People tell me I exercise way too much				
I take laxatives to lose weight				
I force myself to vomit				

FRONTIER HEALTH AND WELLNESS

Authorization to Obtain and Disclose Healthcare Information

This release is written on behalf of Frontier Health and Wellness and its contracted providers

FHW Contracted Providers: Frontier Health Services - Dr. E David Hjellen,
Beyond Barriers Counseling - Victoria Hutton, LPC
Bore Tide Behavioral Health - Kelly Moore, APRN
Tina DeMure LLC - Tina DeMure, APRN

This Release applies to both medical health information and mental health information

Patient Identification:

Client Name: _____ Date of Birth: _____

Client Previous Name (if applicable): _____

Name of Parent/Guardian (if applicable): _____

Address: _____

Cell Number: _____ Home Number _____ Work Number: _____

Release To/From: Name: _____ Phone: _____

Address: _____ **Fax:** _____

Release To/From: Name: Frontier Health and Wellness and its contracted providers Phone: 907-222-6606

Address: 4241 B Street Suite 305, Anchorage, Alaska 99503 Fax: 855-719-0457

Purpose of the Request:

☐ Personal (at the request of the client) ☐ Treatment ☐ Legal ☐ Insurance ☐ Government

Other (specify): _____

Information Authorized For Release:

Any Conditions/Diagnosis/Event/Timeframe Limits: ☐ No ☐ Yes

Specific limits (if checked Yes): _____

Please check the type of information to be released:

☐ Intake Evals (History & Physicals)	☐ Progress Notes (Last 5)	☐ Diagnosis/Procedure Note
☐ Discharge Summary	☐ Progress Notes (All)	☐ Photographs, Videotapes
☐ Mental Health Evaluations	☐ Medication Sheets (historical)	☐ Emergency Dept. Reports
☐ Neuropsychological Testing Reports	☐ Medication Sheets (current list)	☐ Radiology Films/Images
☐ Social Worker/Nursing Assessments	☐ Verbal Exchange of Information	☐ Radiology Reports
☐ Laboratory Test/EKG Results	☐ Education Reports	☐ Complete Health Record

☐ Other, (specify) _____

Receive by: ☐ **Mail** ☐ **Fax** ☐ **Pick-up** ☐ **Oral Exchange**

Not Obligated

This confirms that I am not signing this form under duress and am not obligated to sign this form to receive treatment. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

Expiration & Right to Revoke Consent

I understand that any time I may revoke this authorization by submitting a notice in writing to any provider listed on this form. Unless revoked earlier, this authorization will expire twelve months from the date on which it was signed, or upon the following **date or event**: _____

Re-Disclosure

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Signature: _____ **Date:** _____

If signed by legal representative/guardian, relationship to patient: _____

*

*