

FRONTIER HEALTH AND WELLNESS

Yearly Patient Information and Policy Update

Please review and sign the following FHW yearly patient update on behalf of itself and contracted providers

- Frontier Health Services – Dr. David Hjellen
- Beyond Barriers – Victoria Swatek (FKA Victoria Hutton), LPC
- BoreTide Behavioral Health – Kelly Moore, PMHNP
- Tina M. DeMure LLC, Tina DeMure, PMHNP

Demographics and Insurance

Check any of the below information that has changed within the last year

- | | | |
|-----------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Legal Name | <input type="checkbox"/> Physical <u>or</u> Mailing Address | <input type="checkbox"/> Child Custody Status |
| <input type="checkbox"/> Contact Email | <input type="checkbox"/> Insurance Information | <input type="checkbox"/> Marital Status |
| <input type="checkbox"/> Primary Phone Number | <input type="checkbox"/> Preferred Pharmacy | |

If you checked any of the boxes above, complete a new *Frontier Health and Wellness Registration Form*

Contact Preferences/Update

May FHW and/or its contracted providers contact you by phone, email, or send a text to you to confirm appointments? Yes No

What is your preferred method of contact? (check) Phone Call Email SMS (messaging rates apply)

You may check one or all of the above options for receiving appointment reminder notifications

Does FHW and/or its contracted providers have your permission to leave confidential information via voicemail regarding you/your child (e.g. appointment dates/time/provider, prescription/medication information, referral information)?

Yes, you do authorize FHW and/or its contracted providers to leave confidential information via voicemail on the number(s) I have provided below

No, you do not authorize any confidential information be left via voicemail on any phone number FHW has on file.

If yes, please confirm the phone number(s) authorized to receive confidential voicemail.

Primary Phone:_____ Secondary Phone:_____

Please leave blank if you DO NOT WISH to receive confidential voicemails

_____(initial) I understand I have a right to review the following documents from Frontier Health and Wellness (FHW) prior to signing this document. FHW has provided me access to the following documents on behalf of itself and its contracted providers.

- | | | |
|------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Consent to Treat and Financial Responsibility | <input type="checkbox"/> Electronic Communications Policy | <input type="checkbox"/> _____ (initial) I have had the |
| <input type="checkbox"/> Notice of Privacy Practices | <input type="checkbox"/> Email Communications Policy | opportunity to review and |
| <input type="checkbox"/> Telemedicine Consent | <input type="checkbox"/> Medication Policy | update/rescind any ROI's I have |
| <input type="checkbox"/> Separation of Responsibilities | <input type="checkbox"/> Release of Information (ROI) Updates | signed and put on file within the last |
| | | year |

Copies of the forms listed above, representing FHW and its contracted providers, are available at the FHW Front Desk and on the FHW website. FHW and its contracted providers reserve the right to change/update any of the above listed forms. I have the right to obtain revised copies of these forms at the FHW Front Desk, by accessing the FHW website, or calling the FHW Office and requesting a revised copy be sent to me.

Contact Options

Phone: 907-222-6606

email: contact@fhwak.com

website: www.fhwak.com

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Medical Update

Within the last year have you had any newly:

- ☐ Documented medical conditions (Check One) Yes No

If answered yes, please explain:

- ☐ Documented allergies (Check One) Yes No

If answered yes, please list allergy and reaction:

- ☐ Prescribed medications from any other provider(s) (Check One) Yes No

If answered yes, please list medication name, dosage, and frequency:

Agreement:

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

All 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