Annual Patient Registration Update

Aleutian Pribilof Islands Association

Anchorage (907) 276-2700 **Anchorage Behavioral Health** (907) 222-9764
Atka (907) 839-2232 **Nikolski** (907) 576-2204 **St. George** (907) 859-2254
Unalaska Primary Care (907) 581-2742 **Unalaska Behavioral Health** (907) 581-2751

Patient/Client Information

Clear Form

First Name: Middle: Last:

Date of Birth: SSN: Gender: ☐Male ☐Female ☐Non-Binary ☐Identify as: _____

Address: City: State & Zip:

Please check preferred number for contact:

☐Home Phone:_____ ☐Mobile Phone:_____ ☐Work Phone:_____ Ok to send appt reminders by text? ☐

Can APIA leave a confidential voice message? ☐Yes ☐No

Email: Internet Access? ☐Yes ☐No Ok to send email? ☐

(Emails are not encrypted)

Number of People that live with you: Number of Children under 18 in Household:

Marital Status: (check one) ◯Never Married-Single ◯Married ◯Cohabitating ◯Divorced ◯Separated ◯Widowed

For Minors: Are there any custody arrangements? ◯Yes ◯No If yes, please describe:_____

Additional Parent/Guardian Information (Responsible Party) ☐Same as Patient

First Name: Middle: Last:

Address: City: State & Zip:

Please check preferred number for contact:

☐Home Phone:_____ ☐Mobile Phone:_____ ☐Work Phone:_____

Email: Date of Birth: Employer:

Employment

Employment Status:

☐Active Military Duty ☐Full Time ☐Part Time ☐Disabled ☐Retired ☐Student

☐Subsistence or Seasonal ☐Unemployed looking for work ☐Unemployed ☐Homemaker

Employer:

Address: City: State & Zip:

Health and Treatment Information

If Female, Are you pregnant? ◯Yes ◯No

Are you an IV Drug User? ◯Yes ◯No

Have you ever been in the hospital or residential treatment for substance abuse or mental health reasons? ◯Yes ◯No

Have you been in the hospital in the last 6 months for medical problems caused by substance abuse? ◯Yes ◯No

Legal History: Number of Arrests in the past 30 days (If none, enter "0") ___

Emergency Contact Information

Emergency Contact:		Relationship:
Address:	City:	State & Zip:
Home Phone:	Mobile Phone:	Email :

Insurance Information (Please Provide your ID card)

Please list **ALL** members (people) in the household.
(spouse, child, foster child, grandparent, aunt, uncle, etc.)

Full Name	Relationship	Age

Total Annual Household Income Estimate:

This information will help us screen if you are eligible to apply for the APIA Sliding Fee/Discount Schedule.

◯Under $15,000 ◯$15,000-$30,000 ◯$31,000 -$41,000 ◯$42,000-$52,000 ◯$53,000-$63,000

◯$64,000-$74,000 ◯$75,000-$85,000 ◯$86,000-$96,000 ◯$97,000-107,000 ◯Above $108,000

Medicare: ☐Yes ☐No ☐Primary ☐Secondary Effective: Exp Date: #:

Medicaid: ☐Yes ☐No ☐Primary ☐Secondary Effective: Exp Date: #:

Denali Kid: ☐Yes ☐No ☐Primary ☐Secondary Effective: Exp Date: #:

Private Insurance: ◯Yes ◯No (please provide your ID card)	Insurance Company:	
Policy Holder:	Policy #:	Group #:
Other Insurance: VA Benefits: ☐Yes ☐No	Policy #:	Group #:

☐I DO NOT have any other insurance coverage from any other source other than the above mentioned

Self Pay/Guarantor:		Relationship:
DOB:	Phone:	Address:
City:	State/ Zip:	Effective Date:

Physical Health

Have you had any significant illness or injury in the past 12 months? ◯Yes ◯ No

If yes, please describe:

Are you taking any new medications? ◯Yes ◯No Please list:

Medical Referral: Would you like to be contracted by the Medical RN? ◯Yes ◯No
Or a referral for a physical exam? ◯Yes ◯No

What was the date of your last Physical Exam? Flu Shot: PPD (TB Screen):

Advance Care Planning

I have an Advance Health Care Directive, also known as a living will, Durable Power of Attorney, POLST or Comfort One:
◯Yes ◯No ◯Pt Less than 18 yrs. ☐Unable to Access: Reason_____ Last date reviewed:_____

I have a Psychiatric Advance Directive: ◯Yes ◯No ◯Pt Less than 18 yrs. ☐Unable to Access: Reason_____

If no, would you like information regarding Advance Health Care Directives? ◯Yes ◯No

Consent

Consent: I hereby certify that all information provided is true and correct to the best of my knowledge and I give my consent for APIA to administer–assessments and/or–treatments to perform behavioral health or medical services. APIA operates as an integrated health system and may refer patients as necessary.

I _____(printed name) authorize APIA Behavioral Health Providers to disclose general mental health, housing, drug or alcohol use information to APIA staff for the purpose of program evaluation and grant reporting. I understand I may be contacted to complete a questionnaire over the telephone or by email. I understand that I may revoke this authorization at any time preventing future use. Unless I revoke my consent earlier, this consent will expire automatically one year from active services at APIA.

Assignment of Medical Insurance Benefits: I hereby agree to full responsibility for all expenses incurred by or on account of this patient and assign to APIA, Inc. any and all insurance benefits due to me to the full extent of my financial obligation and said providers. This is certification and authorization is valid until otherwise revoking in writing.

I consent to full financial responsibility for services rendered at APIA, Inc.

Signed: _____ Date: _____

Guardian: _____ Date: _____