



**Anchorage Location:**

3841 Piper Street Suite T-230 Anchorage, AK 99508  
Phone (907) 279-8800, Fax (907) 279-8810  
www.ACENTALaska.com

**Homer Location:**

South Peninsula Specialty Clinic  
4201 Bartlett St. Suite 201  
Homer, Alaska 99603

**PLEASE READ COMPLETELY**

Welcome to ACENT. We appreciate you choosing us for your comprehensive ENT care. Our Board Certified Otolaryngologists provide state-of-the-art care for a wide range of ENT, Hearing, and Cosmetic needs. We use the most advanced therapeutic and diagnostic modalities available to provide you with the very best care.

ACENT is conveniently located off Piper Street in the Providence Alaska Medical Center Campus. You will find our clinic on the second floor of the T- Tower between the elevators and the Sky Bridge that leads to the main Providence Hospital. Visit our website at [www.ACENTALaska.com](http://www.ACENTALaska.com) for more information about our providers, staff, and services lines including Hearing at ACENT and FACES Medical Spa at ACENT.

In a sincere effort to maintain patient satisfaction while honoring the need to maximize effectiveness and efficiency of our work processes, we have implemented procedures which we hope will let us provide you with the best quality medical care we can.

**New Patients/First Appointment**

***\*\* We encourage all patients to complete or update all paperwork by utilizing our Patient Portal located on our website. Our staff can easily email you information about your upcoming appointment along with a hyperlink and the needed security code to access the portal.\*\****

- **Please arrive 15 minutes prior to your appointment and bring the following with you:**
- **Completed Patient Registration Form (or complete in the office)**
- **Completed Patient History Form (or complete in the office)**
- **Current list of medications**
- **Insurance Card/Billing Information**
- **Current Photo Identification**
- **A list of questions you may have**
- **Copay (Patients are responsible for their copay at time of checkout )**

A current identification photo will be taken at your initial visit for your patient record in addition to helping us meet privacy and verification requirements. At your initial visit your provider will review your medical history and may discuss with you any needed diagnostic testing that may be required to help in your diagnosis or treatment. In the specialty field of Otolaryngology, CT, Referrals for Audiology, Allergist or Oncologist, Pathology or MRI, may be suggested and are continual throughout your care. Any diagnostic testing or procedure is an additional charge to your office visit. Diagnostic test results will be reviewed during your follow up appointment with your provider, results will not be mailed.

**Returning Patients or Follow-Up Appointments**

At each follow-up appointment you will be asked to update your Medical and Billing information, even if you were seen the prior day. This is in an effort to help determine any issues or problems since your previous visit. Please have a current list of medications to compare, update, and verify the list we have in our office. Please let us know if you need any prescriptions refilled at this time.



### **Office Calls/Prescription Refill Requests**

Your questions or concerns are important to our providers and will be submitted through the Registered Nurse or Certified Medical Assistant that works directly with your provider. When calling the clinic with a question, please listen carefully for the option for the Clinical team. If we can't answer your call immediately, our goal is to return calls the same day or within one business day. Multiple calls in one day will cause a delay in the Nurses or Medical Assistants ability to return your call. Any message left after 4:00 p.m. will be returned the following business day. Secure messages may also be sent via our Patient Portal on our website.

Routine prescription refill requests must be received at least two business days in advance so that your chart may be reviewed by your provider. It is best to have your pharmacy fax us directly a refill request several days before you are out of medication. Most prescription refills will be sent electronically to your pharmacy and may take up to an hour to process. Please expect a delay if requests are called in over a weekend or after business hours. Some prescriptions can take up to two business days to fill, so please be patient before contacting us a second time. It is our policy that we do not provide refills on some medications without provider approval, which may require an office visit. All prescriptions picked up in our office will require photo identification verification by our staff.

### **Appointments/Late Arrivals/Cancellation Policy**

Our goal is for you to be seen at your scheduled appointment time, but sometimes delays are unavoidable. Regularly scheduled office visits allow us to better assist you in identifying and managing your medical care. We utilize an automatic phone reminder system that will call you 24 hours in advance of your appointment. It is your responsibility to update us of any changes in phone numbers, emails, etc. We kindly ask that you provide notice if you need to reschedule or cancel an appointment so that we may offer your appointment to another patient. You may cancel by calling 907-279-8800 or during the time of your confirmation reminder call. It is our policy that three no show or missed appointments within one year, may result in a discharge of your care from our practice. In addition, a late arrival or arriving without the required information or documentation may require a rescheduling of your appointment. As a courtesy to all of the patients in the clinic, a patient who arrives 10 minutes later than their scheduled appointment may require rescheduling.

### **Medical Insurance Billing**

We offer medical insurance billing in our clinic as a courtesy to our patients. It is the patient or guardian's responsibility to know your insurance policy and be familiar with your coverage. Each insurance company has individualized rules for determining payment for medical services. Your healthcare coverage is a contract between **you the patient and your insurance company**. If your insurance plan requires a referral from your primary care physician, or a Prior Authorization, it is your responsibility to have this completed prior to your visit. You should always contact your insurance company if you have any questions regarding coverage or payment of your services. In the unforeseeable event your health plan determines a service or supply "not covered," you will be responsible for the unpaid balance on your account. If your insurance company denies your claim, you are responsible for the unpaid balance on your account and payment is expected in full. It is your responsibility to know which procedures or diagnostic testing may require pre-authorization or a second opinion for coverage. Please advise us of any changes in your insurance coverage. Don't hesitate to speak with our staff in financial services if you need information or codes requested by your insurance company to secure coverage.

When signing this agreement you consent and authorize the payment of insurance benefits to ACENT and acknowledge understanding that you are financially responsible for any and all charges for services given regardless of insurance coverage. In addition, you authorize the release of any information acquired in the course of your examination or treatment, to and from any medical providers, facilities, and or your insurance company.



**Financial Obligation/Payment Terms/Options**

It is the patients or guardians responsibility to notify ACENT of any changes to your contact phone numbers, address, employment, or insurance coverage.

All patients or guardians are required to pay any co-payments, co-insurance, or deductibles at the time of your visit per the requirement of your healthcare insurance plan policy. If proof of insurance is not provided, you will be expected to make a payment in full at the time of service.

Payment is due upon receipt of a statement from our Financial Services billing office. Account balances must be paid in full or an individual payment plan must be set up with the billing department. All accounts for which payment arrangements have not been made are subject to collections procedures. There will be a \$35.00 charge for any checks returned to us for non-payment.

If your account is not current or paid as outlined in this policy we reserve the right to refuse future appointments to be scheduled.

**FMLA Forms/Disability Forms/Medical Records**

A patient's first request for the copying, faxing, or mailing of medical records will be free of charge. Subsequent requests will be subject to \$1.00 per page charge. These are not billable charges to your insurance company. Please allow 5-7 working days for the completion of any forms, prior authorizations, or letters.

Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restrict us from releasing any information without your written consent. You may choose to fill out an Authorization to Release Medical Records at one of your visits to keep on file in case an urgent need arises for such records.

This is an agreement between ACENT and the patient named below. By signing this agreement you are acknowledging your understanding and that you are agreeing to all of our policies discussed above.

I have read, understand, and agree to comply with these policies. A photocopy of this agreement shall be as valid as the original. I acknowledge that I have been offered a copy of the Notice of Privacy Practices for ACENT, and have been given a copy if requested.

**Photo Consent**

•Do you authorize use of my photographs for teaching purposes or to illustrate scientific papers, books, or lectures? **(Please Circle One) Yes or No**

•Do you authorize the use of your photos for advertisement or release to media, i.e. website, newspaper, television or trade shows? **(Please Circle One) Yes or No**

**I further consent to examination and the performance of treatments that may be medically necessary or advisable.**

**Signature and Date:**

**Patient/Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_