M.D., Inc dba ALASKA PREMIER HEALTH
3300 ARCTIC BLVD, SUITE 101
ANCHORAGE, AK 99503
PHONE (907) 561-3488 FAX (907) 562-3488

PATIENT INFORMATION

Date: _____

Patient Name: _____ **Sex:** ☐ Male ☐ Female

Patient Address: _____**City:** _____ **State:** _____ **Zip:**_____

Date of Birth: _____ **Age:** _____ **Primary Care Provider (Doctor):**_____

Do we have your permission to share your medical data with your Primary Care Provider? Yes No

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Which number is the best to reach you at? _____ **OK to leave Message and/or send text?** (circle one or both)

Occupation: _____ **Employer:** _____

Email: _____ **Drivers Lic. #:** _____

IN CASE OF EMERGENCY, CONTACT **Are you enrolled in Medicare** Yes or No

Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

INSURANCE INFORMATION

PAYMENT POLICY: Self Pay: Yes or No **Insurance Pay:** Yes or No

Self paying patients must pay in full at the time of the visit. **Insurance** will be verified and accepted, however, the co-pay, deductible, and/or charges not covered must be paid in full at time of visit.
Without a copy of your insurance card, we will be unable to bill your insurance.

PRIMARY INSURANCE: Insurance Co._____ **Group Name or #** _____

Subscriber Name: _____**Subscriber Birthdate:** _____ **ID/SS#**_____

Patient's relationship to the Subscriber: _____

APH Policy for Secondary Insurance: Secondary Insurance is to be processed by the patient. When you receive your Explanation of Benefits (EOB) from your primary insurance, attach the EOB to your secondary insurance form and send it in, along with a copy of your original office visit bill.

Financial Policy Regarding Insurance:
1. Patients are responsible for all charges regardless of insurance coverage.
2. Patients are responsible for any pre-authorizations and referrals required for payment.
3. We will not be involved in disputes between you and your insurance company regarding deductibles, covered charges and usual and customary fees, other than to provide factual information.
4. Past due accounts will be sent to collections after 90 days overdue. $35 fees apply to NSF checks.
5. A $50 fee applies to a no show appointment

I, the patient/guardian, have accurately and truthfully completed the patient information listed above. I agree that all fees incurred are my responsibility regardless of insurance coverage.

Signature_____ **Date**_____

PATIENT PRIVACY POLICY

By signing here, I certify that I have read the APH Privacy Policy.

Signature_____ **Date**_____