

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

INTERNAL USE ONLY

ID: _____
MS: _____
CS: _____
MB: _____
Date: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____ Gender: _____

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

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

Email: _____ Preferred contact method: Text Email Phone Call

Drivers Lic. #: _____ Primary Care Provider (Doctor): _____

Occupation: _____ Employer: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

PAYMENT POLICY:

Self-paying patients must pay in full at the time of the visit to be eligible for immediate pay discount. **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.*

Are you enrolled in Medicare: Yes or No

PRIMARY INSURANCE:

Insurance Co.: _____ Member ID/SSN: _____ Group Name/No.: _____

Subscriber Name: _____ Subscriber Birthdate: _____ Relationship to Subscriber: _____

APH Policy for Secondary Insurance: APH will make **one** attempt to file your secondary insurance if the balance expected from your secondary exceeds \$50. Otherwise, you are responsible for filing to your secondary and for any unpaid balances.

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. Fees charged follow national coding standards and are primarily determined by the duration of your office visit with your provider and secondarily by the complexity of your visit. Any appointment exceeding 25 minutes will be billed at a higher rate (complexity) than the standard 15 minute appointment.
5. Our "No Limits" diagnostic test special includes no-charge routine annual lab panels for weight loss patients only. This special requires the patient complete 4 follow-up appointments. Patients who do not complete 4 follow-up appointments are responsible for all lab fees at regular cost.
6. Quest Diagnostics will independently bill insurance for lab panels performed for primary care appointments and for non-routine lab panels for weight loss patients.
7. Past due accounts will be sent to collections after 90 days overdue. \$35 fees apply to NSF checks.

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 and agree to the APH Privacy Policy.

Signature _____ Date _____