

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: \_\_\_\_\_  
PP: \_\_\_\_\_  
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 are in compliance with January 1, 2021 revised National Insurance Coding regulations. Office visits fees are based on set levels of Medical Decision Making criteria and length of visit.
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 within 4 months are responsible for all "No Limits" routine lab fees at regular cost.**
6. \_\_\_\_\_ Quest Diagnostics or LabCorp will independently bill insurance for lab panels performed for primary care appointments and 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 \_\_\_\_\_