INTERNAL USE ONLY
ID: _____
MS: _____
PP: _____
CS: _____
MB: _____
Date: _____

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

Patient Name: _____ **Date of Birth:** _____ **Sex:** _____

APH collects ethnicity demographics to accurately compute body composition in accordance w/device recommendations -please circle the group you identify as: **African American Caucasian Asian South/Central American Japanese Other**

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

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

Email: _____ **Preferred contact method: Text Email Phone Call**

Drivers Lic. #/State: _____ **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 an 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, 2024 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 labs for weight loss patients only. Any abnormal results may lead to additional testing and fees not covered under the "No Limits" promotion. This special requires the patient complete 4 follow-up appointments. **Patients who do not complete 4 follow-up appointments within 3 months are responsible for all "No Limits" routine lab fees at regular cost ($297). These tests are not billable to insurance after agreeing to the "No Limits" special.**
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**_____