Alaska Colorectal Surgery, PC

PATIENT INFORMATION:

Patient Last Name: _____ First Name: _____ M.I.: ____
Physical Address: _____ City: _____ State: _____ Zip: _____
Mailing Address: _____ City _____ State: _____ Zip: _____

Social Security #: ____/_____/_____ Date of Birth: ____/____/_____ Sex: M / F

Employer: _____ Occupation: _____
Marital Status: M S D O Spouse's Name: _____

Preferred Pharmacy & Location: _____ Preferred Hospital: _____
Referring Physician: _____ Primary Care Provider (If Different): _____
How did you hear about our office?: _____

EMERGENCY CONTACT:
Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION: **** Please fill out completely even if cards have been scanned in****

Primary Insurance: _____
ID Number: _____ Group: _____
Subscriber Name (If Different): _____
Subscriber Employer: _____
D.O.B.: _____ Patient Relationship to Insured: _____
Subscriber's SSN: _____

Secondary Insurance: _____
ID Number: _____ Group: _____
Subscriber Name (If Different): _____
Subscriber Employer: _____
D.O.B.:_____ Patient Relationship to Insured: _____
Subscriber's SSN: _____

Confidential Communication

I wish to be contacted in the following manner (Check All That Apply):

Home Telephone: _____ □ Leave detailed message □ Leave call back number **only**

Work Telephone: _____ □ Leave detailed message □ Leave call back number **only**

Cell Telephone: _____ □ Leave detailed message □ Leave call back number **only**

Please initial the following items and sign at the bottom:

_____**All Patients**: 18 years and older must present with valid photo identification. Children under the age of 18 must have a parent or legal guardian present during their appointment. By signing below, I give my consent for examination, and the performance of any necessary tests and/or procedures. If patient is a minor: As the above patient's legal guardian, I give consent for examination and treatment, to include necessary tests and/or procedures.

_____ **Financial Policy**: Payment is expected when services are rendered. We offer payment plans through Care Credit. Our colorectal providers are not preferred with any private insurance carrier. As a result, you may have a higher out-of-pocket responsibility. Patients with Federal Blue Cross insurance plans will be expected to pay in full, at the time of service.

_____ **Non-Covered Services /Low-Claim Payments:** Our role is to provide you with medical specialty care. If your insurance does not pay as you expect, you will need to handle this matter directly with your insurance carrier. Please be advised, payment is expected in full at the time of service.

_____ **Personal Injury Cases:** This office does not bill for auto accidents, liability, or lawsuit-related cases. You are responsible for cash or credit card payment at the time of service. We do not accept liens.

Missed Appointments: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. If you miss three appointments, you may be dismissed from the practice. There may be a charge of $100.00 for no-show appointments.

Release, Assignment and Statement of Responsibility

I authorize release of any information necessary to process my insurance claims, and assign/request payment to be made directly to the provider(s). I understand that I may revoke this consent at anytime in writing to this office. I further understand that I am responsible for payment for all services rendered to me, or any patient for which I am listed as the responsible billing party.

Signature: _____ Date: _____