Alaska Hand-Elbow-Shoulder
Alaska's Premier Upper Extremity Surgical Specialists
4015 Lake Otis Parkway, Suite 201 Anchorage, AK 99508 | (907) 771-3500 | www.akhanddoc.com

PATIENT REGISTRATION

Name: DOB: Sex: Marital Status:
Last First MI

Mailing Address:
Street City State Zip Code

Cell phone (text message confirmations): Email (portal and forms):

Home Phone: Voicemail Preferences: May we leave detailed messages? ☐ Yes ☐ No Social Security #:

Work Phone: Employer:

Employer's Address: Occupation:

Spouse/Parent/Responsible Party: DOB: SSN:

Mailing Address:
Street City State Zip Code

Home Phone: Cell Phone: Work Phone:

Employer: Employer's Address:

INSURANCE INFORMATION

Primary Insurance (or Workman's Comp carrier):

Subscriber Name: DOB: SSN:

Subscriber ID#: Group#:

Secondary Insurance (if applicable):

Subscriber Name: DOB: SSN:

Subscriber ID#: Group#:

Emergency Contact: Relationship: Phone #:

Right to Privacy: May we share your health information with your spouse or a designated party? If yes, complete below:

Name: Relationship: Phone #:

Referred by: Hospital: Doctor: Other:

Accident/Injury Information: Work/Auto? What State? Date of Injury Is there an attorney?

Attorney's Name: How did it happen?

I verify that the above information is true and correct and that I will keep AkHES informed of any changes in the above.

***Signature** (responsible party): Date:

**Signatures on this page expire one year from date signed. A new signature is required yearly. By typing your name in this area you are stating the above information is true and correct to the best of your knowledge and this electronic form of signature will be treated the same as your original signature.*

FINANCIAL POLICY & HIPAA RELEASE

Please review the following policies and acknowledge receipt by your signature.

Charges

- Payment according to insurance benefits is expected at the time of all visits.
- If your injury is related to an auto accident or third party injury we require payment in full at **each** visit.

Insurance Billing

- It is your responsibility to provide us with correct insurance information for billing purposes.
- We will bill your insurance as a courtesy. All balances not paid by your insurance are due upon receipt of bill from AkHES. If your account balance is less than $5.00 or has less than $5.00 credit we will adjust the balance to $0.00.
- We will bill your insurance for surgical procedures, but may require a deposit prior to your surgery. A patient account representative will discuss this in detail if surgery is required.
- It is your responsibility to contact your insurance company if a claim is denied, paid at a lower rate than you expected or if it has not been paid within 45 days. Charges not paid in a timely manner by your insurance company will become your responsibility.
- It is your responsibility to contact your insurance company for benefits verification. It is also your responsibility to respond to all request for information your receive from your insurance company.

Overdue Accounts

- If your account has an amount due now, it is your responsibility to pay your balance timely.
- Accounts with a patient balance that are not paid within 60 days will be charged a re-billing fee.
- Accounts with a patient balance that are not paid within 90 days may be turned over to an outside collection agency. This action may affect your credit rating.

Authorization and Release

I have read and understand the information above. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. I authorize this clinic to release to my insurance carrier any medical information needed to obtain payment for services rendered. I hereby assign to the physician payments for medical services rendered to myself or my dependents.

****Signature**:** _____ Date: _____

Patient/Responsible party

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- I hereby acknowledge that I have been offered, received or viewed a copy of Alaska Hand-Elbow-Shoulder (AkHES) Notice of Privacy Practices (NPP). (Ask receptionist for copy.)
- With my consent, AkHES may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as discussed in the NPP.
- With my consent, AkHES may call my home or other designated location and leave a message on voicemail or in person in reference to any items that may assist the practice in providing my healthcare.
- With my consent, AkHES may mail or email to my home or other designated location any items that assist the practice in providing my healthcare.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures relying upon my prior consent. If I do not sign this consent, AkHES may decline to provide treatment to me.

****Signature**:** _____ Date: _____

Patient/Responsible party

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For clinic use only

☐ Patient refused to sign Patient unable to sign because: _____

Employee Signature: _____ Date: _____