751 OLD RICHARDSON HWY #200 FAIRBANKS, AK 99701

Please Circle: Insurance Medicare Medicaid VA Work Comp MVA Self Pay Other

PATIENT DEMOGRAPHIC INFORMATION

(Please Print Legibly – if a field does not apply to you, write "N/A" for "not applicable" in that field)

TODAY'S DATE_____

PATIENT NAME _____

IF MINOR, RESPONSIBLE PARTY _____RELATIONSHIP_____

MAILING ADDRESS LINE ONE _____

LINE TWO_____

ZIP CODE_____ CITY _____ STATE_____

PHYSICAL ADDRESS (if different than mailing address) _____

HOME PHONE _____ CELL PHONE _____ ALT. PHONE_____

E-MAIL ADDRESS_____

SOCIAL SECURITY # _____PATIENT BIRTH DATE (MM/DD/YYYY) _____

SEX ◯ MALE ◯ FEMALE MARITAL STATUS _____ RACE _____

LANGUAGES _____

EMERGENCY CONTACT_____ RELATIONSHIP_____

EMERGENCY PHONE _____ MESSAGE/CELL PHONE_____

PRIMARY CARE DOCTOR _____REFERRAL SOURCE _____

EMPLOYER NAME _____

ADDRESS LINE ONE_____

LINE TWO_____

ZIP CODE_____ CITY _____STATE _____

EMPLOYER CONTACT NAME _____TITLE_____

EMPLOYEE PHONE _____ EMPLOYEE FAX _____

OCCUPATION _____ HIRE DATE _____

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INSURANCE INFORMATION

GUARANTOR'S LAST NAME _____ FIRST NAME _____INITIAL_____

ADDRESS LINE ONE_____

LINE TWO_____

ZIP CODE_____ CITY _____ STATE _____

TELEPHONE NUMBERS _____

SOCIAL SECURITY # _____ E-MAIL ADDRESS _____

ALTERNANTE ADDRESS ONE_____

LINE TWO _____

ZIP CODE_____ CITY _____ STATE _____

PRIMARY INSURANCE COMPANY NAME_____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S EMPLOYER _____

GROUP NUMBER_____ POLICY (ID) NUMBER_____

PATIENT RELATION TO POLICY HOLDER_____

POLICY HOLDER'S SEX_____ POLICY HOLDER'S BIRTHDATE_____

SECONDARY INSURANCE COMPANY NAME_____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S EMPLOYER _____

GROUP NUMBER_____ POLICY (ID) NUMBER_____

PATIENT RELATION TO POLICY HOLDER_____

POLICY HOLDER'S SEX_____ POLICY HOLDER'S BIRTHDATE_____

TERTIARY INSURANCE COMPANY NAME_____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S EMPLOYER _____

GROUP NUMBER_____ POLICY (ID) NUMBER_____

PATIENT RELATION TO POLICY HOLDER_____

POLICY HOLDER'S SEX_____ POLICY HOLDER'S BIRTHDATE_____

I CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT. I UNDERSTAND THAT THE INFORMATION PROVIDED WILL BE USED TO MANAGE ANY ACCOUNT AND PROCESS INSURANCE CLAIMS.

PATIENT/PARENT-GUARDIAN SIGNATURE_____ DATE_____

Sportsmedicine
FAIRBANKS
751 OLD RICHARDSON HWY #200 FAIRBANKS, AK 99701

PAYMENT OF BENEFITS

I understand that Sportsmedicine Fairbanks will bill my insurance company as a courtesy, **if I have signed all claims and I have provided adequate information** (full insurance information - ID #'s, group #'s, insurance cards; accident questionnaire, completed claim forms) I authorize payment of benefits by my insurance company directly to Sportsmedicine Fairbanks. I understand that I am to pay all deductibles, insurance co-payment requirements, and supply items **at the time of service**. I agree that after 60 days all balances due to Sportsmedicine Fairbanks become my responsibility. I acknowledge I am responsible for all charges incurred. Sportsmedicine Fairbanks will accept partial payments whether or not marked 'Paid in full' without losing our rights under this agreement. I understand that Sportsmedicine Fairbanks policy is payment for the first visit to the clinic is due at the time of service and agree to pay this at this time.

Signed: _____Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Insured party or dependent patient, if not a minor, must sign all claims. I authorize my insurance company, organization, employer, hospital, or health care provider to release any information requested with regards to processing of my claim. I certify that the information which I furnish on this registration form is true and correct, know that it is a crime to fill out the form with facts I know are false or leave out facts that I know are important.

Signed: _____Date: _____

TERMS

ON THE INITIAL VISIT, PAYMENT FOR SERVICES IS DUE IN FULL AT THE TIME OF THE VISIT.

There will be a service charge of .875% (10.5% annual) (or as allowed by Alaska State Law) on any balance over 60 days. This is the patient's responsibility. There is a $35.00 fee per returned check from your bank. If no insurance coverage, full payment is require at the time of service.

In the event surgery is deemed necessary, Sportsmedicine Fairbanks will require a **deposit** of the estimated patient responsibility for surgical fees based on insurance coverage and deductible prior to the surgery being performed. This policy does not apply to confirmed Workers Compensation, Medicare, Native Health Benefits, Medicaid, or Denali Kid Care patients. In the event that there is no insurance coverage, prior arrangements must be made with the business office before surgery is performed.

Deductibles and insurance co-payments are due from patients at time of service. We must have an assignment of insurance benefits to establish a line of credit for your patient-account for all services not paid in full at the-time of service. A patient services representative will gladly assist you in financial arrangements or review of your insurance coverage. Workers' compensation claims must be verified with both the employer and the insurance carrier. **Sportsmedicine Fairbanks does not accept out of state workers' compensation claims.** Claims not verified are the financial responsibility of the patient and are payable at the time of service. Refunds will be available when the insurance carrier has settled the account. Automobile accident claims must be pre-authorized for payment by your insurance carrier. **Sportsmedicine Fairbanks does not accept third party liability claims**. Veterans Administration patients must pre-authorize their treatment with the VA, prior to any medical visit. Any treatment or supplies provided prior to this authorization is the responsibility of the patient at the time of service. If your account is turned to a collection agency, an additional prevailing fee will be added to your account for collection agency fees. I understand and agree to the above financial policies of Sportsmedicine Fairbanks/Cary S. Keller MD, P.C.

Signed: _____Date:_____