Anchorage Neurosurgical Associates, Inc.

3831 Piper Street, Suite S450, Anchorage, AK 99508 **Phone (907) 258-6999 Fax (907) 258-6247**

Welcome and Thank You for choosing ANAI! Please complete this form. All information will be strictly confidential.

Patient Name: _____ **Date of Birth:** _____ **Social Security Number:**_____

Mailing Address: _____ **Marital Status:** **Primary Phone #** _____
S M W D Sep **OK to leave message? YES NO**

City, State: _____ **Alternate Phone #** _____
OK to leave message? YES NO

Zip Code: _____

Patient's Employer:_____ **Occupation:**_____

Spouse or Parent's Name: _____ **Social Security #** _____ **Date of Birth:** _____

If patient is a minor, who may authorize treatment?

Name: _____ **Relationship:** _____ **Phone #**_____

Do you have Medical Insurance?

☐ **Yes (Please complete the Insurance Section)** ☐ **No, I intend to be Self Pay.** ☐ **Workers Compensation**

Is this related to a motor vehicle accident or any other third party liability claim? YES NO

Primary Insurance:	**Secondary Insurance:**	**Tertiary Insurance:**
_____	_____	_____
I.D. # or Social Security #	**I.D. or Social Security #**	**I.D. or Social Security #**
_____	_____	_____
Group Number:	**Group Number:**	**Group Number:**
_____	_____	_____
Insured Person and Date of Birth:	**Insured Person and Date of Birth:**	**Insured Person and Date of Birth:**
_____	_____	_____

Insurance Authorization and Assignment

_____ I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to ANCHORAGE NEUROSURGICAL ASSOCIATES, INC. for services furnished to me by that facility and the affiliated physician(s).

_____ I authorize this office to release and disclosure to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

_____ I have received a copy of Anchorage Neurosurgical Associates, Inc.'s Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Signature of Patient, Guardian, Person or Legal Representative ***Date***