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: _____ **Gender:** **Alternate Phone #** _____

M ○ F ○ **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- Initial Below for Each

_____ 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).

_____ I have received a copy of Anchorage Neurosurgical Associates, Inc.'s Notice of Electronic Communications and authorize this office to communicate with me by email or text message.

Email:_____

Phone Text:_____

_____ _____

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

*****PLEASE TURN OVER THIS FORM AND COMPLETE THE OTHER SIDE!*****

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Patient Name:_________________________________

Primary Medical Health Care Provider (First and Last Name):___________________________________

Would you like a copy of your chart notes from today to be sent to them for their records? **Yes** ☐ **No** ☐

Other Health Care Providers: Would you like them to receive your chart notes? (Yes/No)

____ ____________

____ ____________

Do you have any forms with you today that will need to be completed? **Yes** ☐ **No** ☐
Do you have a Nurse Case Manager to assist with your care? **Yes** ☐ **No** ☐

Person(s) to Contact in Case of an Emergency

Name: ___________________________________ **Relationship**: _________________________________

Phone 1: __________________________________ **Phone 2**: _________________________________

ANAI may discuss my Medical Info with this person ☐ **ANAI may discuss my Billing Info with this person** ☐ **This person may pick up my prescriptions from ANAI** ☐ **This person may pick up my records, forms or information** ☐

Name: ___________________________________ **Relationship**: _________________________________

Phone 1: __________________________________ **Phone 2**: _________________________________

ANAI may discuss my Medical Info with this person ☐ **ANAI may discuss my Billing Info with this person** ☐ **This person may pick up my prescriptions from ANAI** ☐ **This person may pick up my records, forms or information** ☐

Name: ___________________________________ **Relationship**: _________________________________

Phone 1: __________________________________ **Phone 2**: _________________________________

ANAI may discuss my Medical Info with this person ☐ **ANAI may discuss my Billing Info with this person** ☐ **This person may pick up my prescriptions from ANAI** ☐ **This person may pick up my records, forms or information** ☐

I acknowledge that Anchorage Neurosurgical Associates, Inc may provide my medical information as noted to the person(s) I have designated above.

____ ________________________

Signature of Patient, Parent, Guardian, Personal or Legal Representative **Date**