



Northern Lights Surgical Associates, P.C.  
Sarah C. Troxel, M.D.  
3340 Providence Drive Suite #363  
Anchorage, AK 99508

## PATIENT INFORMATION FORM

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Name of Guardian (If Minor) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: Male / Female

Social Security #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Additional Message Phone # \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address (please print): \_\_\_\_\_

Is this a work related injury? YES/NO Referring Doctor: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**\*\*\*Is it okay to leave our doctor's name on your home answering machine or with a family member that answers the phone? YES/NO**

### INSURANCE INFORMATION

**\*\*\*Please include your insurance info even if you are being seen for cosmetic reasons\*\*\***

**PRIMARY INSURANCE:** \_\_\_\_\_

Employee ID #: \_\_\_\_\_ Group#/Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Insured Social Security # \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

Employer ID #: \_\_\_\_\_ Group#/Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Insured Social Security # \_\_\_\_\_

Worker's Compensation Carrier: \_\_\_\_\_

Claim #: \_\_\_\_\_ Contact: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

## **FINANCIAL POLICY**

Please take a moment to review our financial policy. A clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibilities. Changes to the financial policy may occur without advance notification.

- All Patients must complete the “Patient Information Form” located on the previous sheet and sign the bottom of this sheet before seeing the doctor.
- Payment is due at the time of service.
- We will accept cash, check, Visa, MasterCard or American Express for payment.

### **Regarding Cosmetic Payments:**

Any payment for consultation is due at the time of service. Payments for cosmetic surgeries will need to be paid in full at the time of scheduling surgery. Cancellation of a cosmetic surgery prior to two weeks will result in a refund with a deduction of \$500 of the total amount paid. Cancellation of a cosmetic surgery within less than 14 days of the scheduled surgery date will result in a 20% loss of payment.

### **Price Quotes:**

**Any price quotes that you are given by our office staff (cosmetic and/or medically necessary), are the surgeon’s fee only and expire 3 months from the date of your consultation. Our office does not give anesthesia and operating room price quotes.**

### **Regarding Insurance:**

Private insurance is a contract between you and your insurance company. WE are not a party to this contract in most cases. The patient is responsible for any pre-authorization required by the insurance companies regarding clinic visits and surgical procedures.

If there are disputes between you and your insurance company, we will assist you by supplying necessary medical information. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “Usual and Customary Charges”; other than to supply factual information as necessary. You are responsible for the timely payment of your account.

### **Medicare, Medicaid, Worker’s Compensation:**

If you are covered by Medicare, Medicaid, Worker’s Compensation or any other government sponsored program, please discuss your payment situation with the billing office on the day of your visit.

### **Assignment of Benefits:**

I hereby authorize payment to **Northern Lights Surgical Associates, P.C.** for benefits rendered to me or a member of my family for medical services. I understand that I remain financially responsible for any charge not covered by or paid in accordance to this authorization. A photocopy of this authorization shall be considered as effective and valid as the original. I authorize the release of any medical or other information necessary to insurance companies, government agencies, or third party payers to allow processing of claim.

### **Consent:**

I hereby authorize the taking of photographs for medical evaluation and/or treatment. All photographs are the property of **Northern Lights Surgical Association, P.C.**, and will remain with the patient’s medical chart.

**RESPONSIBLE PARTY SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_