DIAGNOSTIC HEALTH ANCHORAGE™

***Office Use Only ***

Patient Name

Birth Date

Demographic Information

Name _____Birth Date _____ Sex _____

Address _____ City _____ State_____ Zip _____

Home Phone (_____) _____ Cellular Phone (_____) _____

Social Security Number _____

Employer _____ Work Phone (_____) _____

Married _____ Separated _____ Divorced _____ Widow _____ Single _____ Other _____

Emergency Contact _____ Phone (_____) _____ Relation: _____

Referring Physician / Provider _____

Insurance Information

Insurance Company Name: _____

Policy/ID Number: _____ Group Number: _____

Billing Address: _____

Phone Number: _____

Contact person/ case manager _____ Claim Number: _____

Was the injury a result of an accident? _____

If yes (Check One): Work Comp_____ Auto _____ Other_____

Date of Injury or onset (Required): _____

Subscriber/Guarantor Information □ Check if self (If other than self complete the section below)

Name of Insured: _____ Birth Date _____

Address _____ City _____ Zip _____

Phone (_____) _____ Employer: _____

Assignment of Benefits

- I understand if I have provided complete and accurate insurance information, Diagnostic Health Center of Anchorage (DHA) will file both my primary and secondary insurance. I understand based on the agreement DHA has with my insurance network and information they have received at the time of verification my co-pay/co-insurance amount due today is $_____. I also agree to be responsible for any additional co-share and or non paid amounts identified by my insurance after my claim has been processed.
- In the event legal action should become necessary, I agree to be financially responsible for all collection, attorney and court fees incurred. I understand if the services provided today are being represented by an attorney, auto insurance and or third party payor, I am financially responsible for all charges incurred.
- I authorize DHA to release to my insurance company any medical information which may be necessary for processing my insurance claim. I also assign "benefits payable to" for my services today to Diagnostic Health Anchorage.
- I further authorize the release of any medical information in regard to the services which are provided by DHA to any physician or health care provider by whom I have been or will be treated who request such information.

I have reviewed the above information and verify it is accurate.

Procedure(s): _____ Estimated Cost: $_____

Patient/Guardian Signature: _____ Date: _____

DHA Representative Signature: _____ Date: _____