



Alaska Compass LLC
 2600 Denali Street, Suite 300
 Anchorage, AK 99503
 Phone: (907) 318-9050
 Fax: (907) 202-5565

Patient Name:		
Date of Birth:	SSN:	
Street Address:		
City:	State:	Zip code:
Cell phone:	Home phone:	
Email address:		

Emergency contact name:	Relationship:
Phone number:	

Who referred you?

Primary insurance:	Date effective:
Insurance address:	Insurance phone:
Policy ID:	Group number:
Policy holder name:	Policy holder DOB:
Relationship to patient:	

Secondary insurance:	Date effective:
Insurance address:	Insurance phone:
Policy ID:	Group number:
Policy holder name:	Policy holder DOB:
Relationship to patient:	

I understand I am fully responsible for any and all charges for services provided by Alaska Compass LLC. Payment is due at the time of service for services not covered by insurance as well as copays, co-insurance, or deductibles. Insurance is billed as a courtesy only if I provide accurate and updated information to Alaska Compass LLC. I understand I am responsible for verifying and understanding what my insurance company covers. **I agree that it is my responsibility to inform the practice of any changes to insurance prior to each of my visits, or I may be responsible for the full fee.**

Signature: _____ Date: _____

Parent/Guardian Signature: _____