Alaska Pediatric Specialties

3841 Piper Street, Suite T4-020 Anchorage, AK 99508
PH: 907-929-7337 FX: 907-929-7330

ALASKA PEDIATRIC SPECIALTIES PHYSICIAN CONSENT

Patient Name: _____

Patient Date of Birth: _____

Patient Financial Responsibilities

I authorize my insurance company to pay any benefits to Alaska Pediatric Specialties, LLC at 3841 Piper Street, Suite T4-020, Anchorage, AK 99508. I also authorize to release any medical information filed on my behalf. I authorize the release of other medical records to Alaska Pediatric Specialties, LLC to facilitate payment of this account. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account and for any collection fees. I have reviewed all the information and completed the answers. I certify that this information is true and correct to the best of my knowledge, and I will notify you of any changes in the information.

Signature: _____

Date: _____