Alaska Medical Laboratory Services, LLC

REGISTRATION FORM

Today's Date:	Physician Name & **Phone no**.:				
PATIENT INFORMATION					
Patient's last name: First:			Middle:		
Former name:	Social Security no. (last four):	Marital status:	Date of Birth:	Age:	Sex: ○ M ○ F
Address:		City, State, Zip code:			
Email address:	Home phone no.:		Cell phone no.:		
Is patient a minor?	Parent or Legal Guardian's name:		State Relationship:		
Referred to lab By:					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:		

INSURANCE INFORMATION

The above information is true to the best of my knowledge. I authorize Alaska Medical Laboratory Services to furnish information to my insurance carriers concerning my illness and payment and I understand that Alaska Medical Lab Services is not a preferred provider for any insurance company and are not subscriber to Medicare/Medicaid. We cannot guarantee that your insurance will pay. I hereby assign Alaska Medical Laboratory Services all benefits be paid directly to their office. I understand that I am financially responsible for any balance.

In order to be submitted to Insurance, tests must be ordered by a provider, not by the patient.

Patient Initial and date_____ Insurance Pricing differs from our Cash discount pricing, which is discounted for payment at time of service. Once Insurance is billed, it may not be "unbilled". You are responsible for any remaining balance.

Patient Initial and date_____ Alaska Medical Lab Services is not a preferred provider for any insurance company.

Patient/Guardian signature _____ Date _____

AMLS Employee signature _____ Date _____

CONTINUED ON OTHER SIDE

Consent

I give this clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews.

I have been informed that I may review the clinics Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the clinic is not required to agree to the request. If the clinic agrees to my restriction request, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I understand a normal result does not necessarily mean the absence of disease. If I am experiencing symptoms or have abnormal results, It is my responsibility to seek a healthcare provider.

Signature: _____ **Date:** _____

Patient, Parent or Legal Guardian

If signed by patient representative, state relationship to patient _____