Brent H. Taylor, M.D., F.A.C.S.

2490 S. Woodworth Loop, Suite 400
Palmer, AK 99645
(907) 745-9400 (907) 745-9444 fax

Last Name ____First ____________________M.I.________

SSN _________________________________ Male ( ) Female ( ) Date of Birth _________________

Mailing Address ____

City ____ State ________________ Zip ______________

Main Phone ____________________ Cell/Msg __________________ Work______________________

May we call you at work: **Y N** Employer: ____________________Occupation: ________________

Marital Status: (Circle One) **M S W D** Spouse/Partner Name______________________________

Emergency Contact _________________________________Phone #___________________________

Responsible party if other than patient:

Name: ______________________________________DOB____________ Phone #________________

SSN _________________________________Relationship to patient: ___________________________

Primary Physician: ____

Referring Physician: _________________________ Friend/Family _____________Other___________

Primary Insurance ______________________________ **ID Number** _________________________

Insured' Name ____________________ **Date of Birth** ___________ **Employer** _________________

Relationship to Insured Self ( ) Spouse ( ) Child ( ) Other ( )

Secondary Insurance ____________________________**ID Number**___________________________

Insured' Name ____________________ **Date of Birth** ___________ **Employer** __________________

Relationship to Insured Self ( ) Spouse ( ) Child ( ) Other ( )

FINANCIAL POLICY & PATIENT AGREEMENT/CONSENT

I certify that the above information is true and correct to the best of my knowledge.
I authorize payment of medical benefits to Brent Taylor MD for my dependents or myself. I understand I am responsible for all fees regardless of insurance coverage. I authorize my medical records to be provided to my insurance if required to secure payment.

I am responsible for any preauthorization requested by the insurance company for clinic visits and/or surgical procedures and to contact my insurance company for benefit verification. Our billing office will try to check benefits but this is not a guarantee of payment. It is also my responsibility to respond to all requests for additional information by my insurance company. I authorize my doctor and billing personnel to act as my agent in helping obtain payment from my insurance. Delinquent accounts will be turned over to a collection agency and will incur an additional $25.00 collection fee.

Brent H Taylor, MD is required to inform patients he has a minor ownership interest in Mat-Su Regional Hospital.

In signing this consent form, I show my understanding and agreement to the above stated policies. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as the original.

____ ________________________

Patient / Responsible Party Date