

**ALASKA FAMILY ENT - DAVID S. KILLEBREW, M.D. FACS**  
Reconstructive Surgery, Head & Neck Surgery, Facial, Plastic, Trauma & Maxillofacial Surgery, Otolologic

**Patient Information (Please Print)**

Name: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Home Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Work Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Married \_\_\_/ Single \_\_\_/ Divorced \_\_\_/ Widow \_\_\_  
Cell Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**Emergency Contact**

Name	Relationship	Phone
_____ Last First	_____	_____-_____-_____

**Primary Physician:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

Were you seen at an Emergency Room or Urgent Care? (Providence \_\_\_) (Alaska Regional \_\_\_) Other \_\_\_  
When were you seen? \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Patient Employment Information**

Employed \_\_\_/Retired \_\_\_/Unemployed \_\_\_/Self \_\_\_/Minor \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Name of Work/School: \_\_\_\_\_

**Responsible Party/Guardian (For patients under 18 years)**

Name: _____	Home Phone: _____-_____-_____
Address: _____	Work Phone: _____-_____-_____
City, State, Zip: _____	Social Security Number: _____-_____-_____ Date of Birth: ____/____/_____
Employer: _____	Relationship: _____

**INSURANCE**

**Primary Insurance/Worker's Compensation**

Insurance Name: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  
Subscriber SS#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Subscriber Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Subscriber Employer: \_\_\_\_\_

**Secondary Insurance**

Insurance Name: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  
Subscriber SS#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Subscriber Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Subscriber Employer: \_\_\_\_\_

**I hereby certify the above information is true and correct to the best of my knowledge. I give consent for medical examination and treatment. I further authorize Dr. Killebrew to release to any insurance company, which has issued medical or hospitalization insurance, all information regarding any treatment by said doctor. I assign direct payment to Dr. Killebrew: all medical and surgical benefits payable due for services provided and cause for action for the collection of said benefits. Payment is required at the time of service unless other arrangements have been made.**

**Signature patient/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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This notice is effective as of \_\_\_\_\_  
Date

I have read/or been offered the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Alaska Family ENT with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Authorized Facility Signature

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TO ALL PATIENTS WITH COMMERICAL INSURANCE  
Cigna, Aetna, ODS, Blue Cross Blue Shield, EBMS ECT

**A new policy has become effective on January 1<sup>st</sup> 2010 for most commercial insurance companies**

Patients must now call their insurance to get **pre-authorization** for **Office Visits**. You should also address the fact that **There are no In-network ENT providers in the entire state of Alaska**. Most insurances use words such as: benefits exception, network deficiency, in for out, enhancement, or other types of phrases that indicate there is no in-network provider available within a 50 mile radius from the patient. This new policy varies from insurance company to insurance company and may be plan specific. Some insurance companies and plans account for the out-of-network/pre-authorization issue here in Alaska. Please call your insurance to address the pre-authorization/out-of-network issues.

Please help us so we can help you by understanding your benefits, plan, and how the out-of-network issue affects all of us.

Thanks,

Alaska Family ENT

By way of my signature, I have read the above message. I have called my insurance company for pre-authorization for office visits. I do understand that the insurance company will deny benefits if I have not been pre-authorized by my insurance company. I will be financially responsible for my bill.

Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

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**OUR FINANCIAL POLICY INCLUDES THE FOLLOWING:**

You as the patient are responsible for payment of the account regardless of insurance coverage. Insurance is a contract between you and your insurance company. Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. This office can not accept responsibility for collecting a settlement on a disputed claim. You are responsible for payment on deductibles, co-payments, disputed or denied claims, as well as the portion not covered under the terms of your individual policy. In order to bill your insurance(s) we do require a copy of the issued card(s). If no card is provided then the patient or guardian is responsible for filing any claims.

For patients requiring surgery, we will contact the insurance carrier for medical benefits and pre-authorizations. This does not guarantee payment of benefits. It is the insured's responsibility to know his/her policy for any pre-existing exclusions, waiting periods, and/or waivers placed on his/her policy. If a claim is denied we will assist you in furnishing any information that pertains to this office.

All accounts are expected to be paid in full within 60 days of receipt of your statement unless other arrangements have been made with our office. If you are unable to pay your account balance in full within this time, please call our office, 278-1016, as soon as possible to make payment arrangements.

**I understand that if my bill is past due it will be sent to collections, Cornerstone Credit Services, and I will not only be responsible for the original amount owed but also for the cost of collection due to the balance being forwarded to a collection agency.**

**I authorize the release of information in my medical history to Medicare/Medicaid and/or my insurance (s) and assign all benefits for unpaid services to Dr. Killebrew.**

**I understand that I am financially responsible for those charges not paid by my insurance. A photo copy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.**

\_\_\_\_\_ **Date** \_\_\_\_\_  
**Patient/Legal Guardian**

**NOTICE OF APPEAL - NON PARTICIPATING PROVIDER**

Commercial Insurance ONLY

\_\_\_\_\_  
NAME

DATE: \_\_\_\_\_

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY, STATE, and ZIP

RE: Date of Services: \_\_\_\_\_

\* Patient Name: \_\_\_\_\_ \*Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\* Insurance ID#: \_\_\_\_\_ \*Group #: \_\_\_\_\_

\* Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(IF DIFFERENT THAN PATIENT)

Dear Appeals Reviewer:

I \* \_\_\_\_\_ (the insured) formally appeal your determination of reduced and/or unpaid medical benefits for the patient named above, who is/was covered under medical benefits.

The reason provided for this reduction is because the patient was seen by an:

**OUT-OF-NETWORK OR NON PARTICIPATING PROVIDER (NPP)**

**PLEASE RE-PROCESS THE CLAIM FOR ADDITIONAL REIMBURSEMENT BECAUSE:**

**THERE IS NOT AN IN-NETWORK OR PARTICIPATING ENT DOCTOR IN ALASKA.**

**For this reason, your reduction of my medical benefits does not apply.**

For any further questions:

Please contact Alaska Family ENT 1200 Airport Heights Drive Suite 200 Anchorage, AK 99508.

Phone: 907-278-1016 Fax: 907-272-1475 or contact me directly at \* \_\_\_\_\_.

INSURED'S PHONE #

Your prompt handling of this appeal is appreciated,

\_\_\_\_\_  
\*SIGNATURE/NAME

\_\_\_\_\_  
\*ADDRESS

\_\_\_\_\_  
\*CITY, STATE, and ZIP



Name \_\_\_\_\_

Date \_\_\_\_\_

**PAST MEDICAL HISTORY**

*For the safety of Dr. Killebrew and his staff please inform us of any infectious diseases that you may have. Please keep in mind that all information is kept confidential and your standard of care will not be affected by the information that you have disclosed to our office.*

Medical Illnesses: Do you have any of the following diseases: (Circle)

High blood Pressure    Diabetes    Asthma    Cancer    Thyroid disease

Hepatitis \_\_\_\_\_    Cirrhosis    Seizures    HIV    Tuberculosis

Other: \_\_\_\_\_

(1) Bleeding Tendency?    Yes    No    If Yes, Please explain: \_\_\_\_\_

(2) Have you ever received a blood transfusion?    Yes    No    Year \_\_\_\_\_

(3) Trauma: Any head Injuries?    Yes    No    Year \_\_\_\_\_

(4) Loss of consciousness?    Yes    No

(5) Have you ever had your hearing tested?    Yes    No    Year \_\_\_\_\_    Location \_\_\_\_\_

**Family** Medical History (any medical conditions ONLY, no names please)

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brother/Sister: \_\_\_\_\_

Son/Daughter: \_\_\_\_\_

Is there anything else you wish Dr. Killebrew to know about your health or medical history?

\_\_\_\_\_

**On a regular basis**

Do you have difficulty breathing through your nose? (Circle one)

No/Rarely                      Occasionally                      Usually/Always

Does your nose get congested when you lie down or while you are sleeping? (Circle one)

No/Rarely                      Occasionally                      Usually/Always

Do you use nasal medications such as over-the-counter and/or prescription nasal sprays or decongestants? (Circle one)

No/Rarely                      Occasionally                      Usually/Always