



## Alaska Pediatric Specialties

4100 Lake Otis Pkwy, Ste 312 Anchorage, AK 99508  
ph 907-929-7337 f 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 4100 Lake Otis Pkwy, Ste 312 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: \_\_\_\_\_