ORTHOPAEDIC TRAUMA CARE™

Bret L. Mason, D.O.

Board Certified Orthopaedic Surgery
Orthopaedic Traumatologist

Complex Fractures
Pelvis & Acetabulum
Sports Injuries
Hand Surgery

2751 DeBarr Road, Suite 300
Anchorage, Alaska 99508

(907) 279-5589
(907) 279-2970 fax

Patient's Last Name	First Name & Middle Initial	Male / Female
Mailing Address	City & State	Zip Code
Home Number	Work Number	Cell Number
Date of Birth	Social Security Number	Driver's License
Employer's Name	Address, City & State	Zip Code

If patient is a minor:

Parent or Guardian's Last Name	First Name	Home Number
Parent or Guardian's Date of Birth	Social Security Number	Driver's License
Parent or Guardian's Employer's Name		Work Number

Spouse / Significant Other's Full Name	Contact Number

Referring Doctor's Name	Office Number

Primary Insurance	Policy / SSN	Group Number
Secondary Insurance	Policy / SSN	Group Number

I realize that payment is expected at the time of service, unless prior arrangements have been made. I give authorization to Dr. Mason and staff to release to the above-mentioned Insurance Company(s), any information required to expedite the processing of claims. I hereby authorize assignment of benefits to Dr. Bret L. Mason, D.O. I understand that Dr. Mason will submit claims as a courtesy and the account balance is always the patient's responsibility. Please circle method of payment: Cash Check Credit Card

I allow the staff to act on my behalf for any appeal regarding a decision made to disallowed amount for out of network, above the usual and customary fee or other reasons not noted. Dr. Mason has permission to keep my signature on file for any future appeals necessary until written notice is received. Please accept any facsimile or Photocopy with my full approval as states with my signature below.

Also Dr. Mason's staff has permission to release protected health information pertinent to patient care to other healthcare providers to ensure quality care. This permission also extends to billing questions the above-mentioned spouse or significant other may have.

Patient Signature (Parent of Authorized Guardian) Date