12110 Business Blvd Ste 34 Eagle River, AK 99577 P: (907)726.3535 F: (907)726.0627

Client Information:

Name (Last, First M.): _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address(if different):_____

Telephone: Main: _____ Work: _____Other: _____

E-mail: _____

Primary Insurance Information:

Policy Holders Name: _____ Date of Birth: _____

Policy Holders Social Security Number: _____

Policy Number: _____ Group Number: _____

Plan Name: _____ Clients Relationship to Policy Holder: _____

Policy Holders Address:_____

Secondary Insurance Information:

Policy Holders Name: _____ Date of Birth: _____

Policy Holders Social Security Number: _____

Policy Number: _____ Group Number: _____

Plan Name: _____ Clients Relationship to Policy Holder: _____

Policy Holders Address:_____

Authorized to Discuss Scheduling and Participate in Sessions **Other than parent/legal guardian**

Name(Last, First M.): _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Main: _____ Work: _____Cell: _____

E-mail: _____

I consent to myself or my dependent being treated by the staff at Our Meadows, LLC

This office does not bill or receive payment from Medicaid or Medicare.

RELEASE OF INFORMATION: I authorize **Our Meadows LLC** to disclose and release to my insurance carrier(s) and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize the use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize Our Meadows and its authorized agents to act as my agent in helping obtain payment from my insurance companies. **ASSIGNMENT OF BENEFITS:** I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to **Our Meadows LLC,** and its providers, for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation. **AGREEMENT OF RESPONSIBILITY:** I understand that copayments, coinsurance and deductibles may be collected at time of service. I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to Our Meadows LLC if this matter is referred to collection. I acknowledge that I have discussed, been informed of how to obtain, and/or received a copy of Our Meadows, LLC **Informed Consent** as well as the **Client Financial & Privacy Agreement**. I acknowledge that I have or will review the information contained therein. I understand I shall agree to the terms and conditions specified and am able to discuss any questions or concerns I may have with a staff member at any time.

_____ _____ _____

Signature Relation to Client Date.