COUNSELING
Solutions
OF ALASKA, LLC

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Patient Information

Name: (Last, First, M.I.)		DOB		Soc. Sec. Number
Mailing Address		City	State	Zip Code
Home Phone #	Work Phone #	Message Phone #	OK to leave message? Yes No	Cell Phone #
Marital Status (Circle one): Single / Married / Divorced / Widowed	Sex Male / Female	Occupation/ Place of work		
Name of Spouse		Name of Parent / Guardian		
Emergency Contact Information (other than home)		Phone Number:		
Name:		Relationship:		

Primary Insurance Information

Insurance Company Name:	Billing Address:		Phone Number:
Sponsor's Name (Last, First, M.I.)		Male/Female	Sponsor's DOB
Sponsor's Address	City	State	Zip Code
Sponsor's ID #/ Medicaid #	Policy Group #		Relationship to Sponsor Self / Spouse / Dependant
Sponsor's Employer	Address		Phone Number

Secondary Ins. Information

Insurance Company Name:	Billing Address:		Phone Number:
Sponsor's Name (Last, First, M.I.)		Male/Female	Sponsor's DOB
Sponsor's Address	City	State	Zip Code
Sponsor's ID #/ Medicaid #	Policy Group #		Relationship to Sponsor Self / Spouse / Dependant
Sponsor's Employer	Address		Phone Number

Welcome to CSA! Please take a few moments to read the following information. Your decision to visit us is a serious one and it is our desire that our work will be beneficial to you. We comply with strict confidentiality measures. For assurance to quality care, all providers in this office may share charts when treating you and will review cases with a supervisor and/or peers on a regular basis. It is also mandatory by law to report sexual and physical abuse of a minor or senior citizen, or threats of harm to self or others. Your medical records may be subpoenaed by a court of law.

I consent to be treated and/or have my child treated by Counseling Solutions of Alaska. I authorize the release of any medical or other information to process my insurance claims. Counseling Solutions of Alaska is not a Medicare Provider. I also acknowledge responsibility for payment of my account(s) regardless of my insurance coverage (i.e. all deductibles, co-pays, and unpaid balances). All payments are due at the time of appointment. I Authorize Assignment of benefits to this provider for services rendered. I agree to pay any collection costs, including interest or attorney fees in attempting to collect on any delinquent balances.

______________________________ Signature

____________________ Date