

Greatland Clinical Associates

1400 W. Benson, Suite 525 ~ Anchorage, Alaska 99503

Office: (907) 929-4009 ~ Fax: (907) 929-4902

OFFICE REGISTRATION FORM <small>PLEASE FILL OUT COMPLETELY</small>		DATE _____
Client's Name: _____ <small>(LAST) (FIRST) (M)</small>	DOB: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Physical home address: _____ <small>(City) (State) (ZipCode)</small>		
Home Phone #: _____	Client's SSN#: _____	
If you are filling out data on yourself, please proceed to next box and fill in additional lines.		

1ST Guardian's Name: _____ <small>(LAST) (FIRST) (M)</small>		DOB: _____
Employer: _____	Relationship to Client: _____	SSN#: _____
Personal Mailing address: _____ <small>(City) (State) (ZipCode)</small>		
Home Phone #: _____	Work Phone #: _____	
Cellular Phone #: _____	Which # is best? _____	

2ND Guardian's Name: _____ <small>(LAST) (FIRST) (M)</small>		DOB: _____
Employer: _____	Relationship to Client: _____	SSN#: _____
Personal Mailing address: _____ <small>(City) (State) (ZipCode)</small>		
Home Phone #: _____	Work Phone #: _____	
Cellular Phone #: _____	Which # is best? _____	

Who Is the Client's Primary Care Provider? _____	Last Seen : _____
Who Referred You To Our Clinic? _____	

FORM OF PAYMENT FOR SERVICES

If you have insurance cards please give them to the receptionist for copying.

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____

Claims Address: _____

Policy Holder's Name: _____ Relationship to Client: _____

Policy I.D. Number: _____ Group I.D.: _____

Policy Holder's SSN#: _____ DOB: _____

FORM OF PAYMENT FOR SERVICES

If you have insurance cards please give them to the receptionist for copying.

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____

Claims Address: _____

Policy Holder's Name: _____ Relationship to Client: _____

Policy I.D. Number: _____ Group I.D.: _____

Policy Holder's SSN#: _____ DOB: _____

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL CHARGES FOR SERVICES RENDERED TO ME OR MY CHILD BY GREATLAND MENTAL HEALTH,LLC (GMH,LLC). MY INSURANCE WILL BE BILLED AS A COURTESY TO ME ONLY IF I PROVIDE ACCURATE INSURANCE INFORMAION TO GMH,LLC. I AM RESPONSIBLE FOR ANY PORTIONS OF MY BILL AT THE TIME THAT SERVICES ARE RENDERED, UNLESS INSURANCE IS PREDETERMINED TO COVER IT BY GMH,LLC. I HERBY AUTHORIZE PAYMENT BY MY INSURANCE DIRECTLY TO GMH,LLC. I FURTHER AUTHORIZE RELEASE BY GMH,LLC OR DR. GARBY OF ANY INFORMATION NECESSARY TO MY INSURANCE COMPANY FOR PAYMENT OF CLAIMS.

(GUARDIAN OR PATIENT SIGNATURE—PLEASE SPECIFY)

(DATE)