17101 Snowmobile Lane Suite 109
Eagle River, AK 99577
Office: (907) 726-0426 Fax: (907) 726-2926
thetalkingplace@gci.net
www.thetalkingplace.org

Patient Information:

Name (Last, First M.): _____

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

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Guardian Information if minor child: This person will receive all correspondence from this office

Name(Last, First M.): _____

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

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

E-mail: _____

Primary Insurance Information:

Policy Holders Name: _____ Date of Birth: _____

Policy Holders Social Security Number: _____

Policy Number: _____ Group Number: _____

Plan Name: _____ Patients Relationship to Policy Holder: _____

Policy Holders Address if different from patients _____

Secondary Insurance Information:

Policy Holders Name: _____ Date of Birth: _____

Policy Holders Social Security Number: _____

Policy Number: _____ Group Number: _____

Plan Name: _____ Patients Relationship to Policy Holder: _____

Policy Holders Address (if different from patients) _____

Welcome to our office! Please take a few minutes to read the following information.

I consent to myself or my dependent being treated by the staff at The Talking Place, Child & Adolescent Counseling, LLC.

Providers at The Talking Place Child & Adolescent Counseling, LLC are not Medicaid or Medicare Providers.

I hereby assign my insurance benefits to be paid directly to the provider. I am financially responsible for payment on this account regardless of my insurance company (i.e. all deductibles, co pays, and unpaid balances.) I also authorize the provider to release any information acquired in the course of examination or treatment to assist with payment by the insurance companie(s).
The Talking Place, Child & Adolescent Counseling, LLC will NOT provide litigation related services and may permanently discontinue providing therapeutic services, if at any time, any party to any litigation, requests that litigation services be provided.
All payments are due no later than 30 days after initially billed to me. I agree to pay any collection costs, including interest or attorney fees in attempting to collect on delinquent balances.

_____ _____ _____

Signature of Responsible Adult Relation to Patient Date

Copies of front and back of all insurance cards and Responsible Parties ID must be obtained