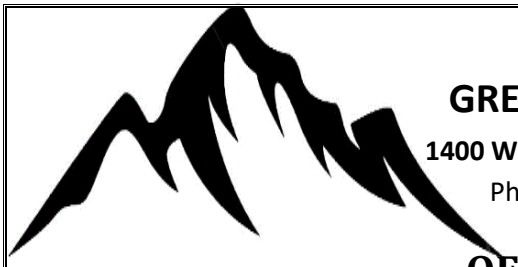

GREATLAND CLINICAL ASSOCIATES

1400 W. Benson Blvd., Suite 315, Anchorage, AK 99503
Phone: **(907) 929-4009** Fax: **(907) 929-4902**

OFFICE REGISTRATION FORM

PATIENT INFORMATION		
Legal Name:		**Preferred Name**:
Date of Birth:	**SSN**:	**Phone #:**
Pronouns: He/ She / They/ Other: _____	**Email**:	**Alt Phone #**:
Sex Assigned at Birth: Male Female Intersex	**Gender Identity**: Male Female Non-Binary Other: _____	
Physical Address:		
City:	**State**:	**ZIP Code**:
Mailing Address:		
City:	State:	ZIP Code:
Emergency Contact Name:		
Relationship to Patient:	**Phone #**:	**Alt Phone #**:
Primary Care Physician:		
Who referred you to see us?		

INSURANCE INFORMATION		
Primary Insurance:		
Insurance address:		**Effective Date**:
Phone:		
Policy ID:	**Group**:	
Policy Holder:	**Policy Holder DOB**:	**Policy Holder SSN**:
Relationship to Patient:		
Secondary Insurance:		
Insurance Address:		Effective Date:
Phone:		
Policy ID:	Group:	
Policy Holder:	Policy Holder DOB:	Policy Holder SSN:
Relationship to Patient:		

BILLING NOTIFICATION

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL COSTS OF SERVICES RENDERED TO ME BY GREATLAND MENTAL HEALTH, LLC "DBA" GREATLAND CLINICAL ASSOCIATES, LLC (GCA). **I AM RESPONSIBLE FOR MY PORTION OF ALL BILLS AT THE TIME THAT SERVICES ARE RENDERED.** MY INSURANCE COMPANY(S) WILL BE BILLED AS A COURTESY TO ME ONLY IF I PROVIDE ACCURATE INSURANCE INFORMATION TO GCA AT THE TIME IN WHICH THE INSURANCE EFFECTUATES. I HEREBY AUTHORIZE PAYMENT ON MY CLAIMS BY MY INSURANCE DIRECTLY TO GCA. FURTHERMORE, I AUTHORIZE GCA TO RELEASE ANY NECESSARY INFORMATION TO MY INSURANCE COMPANY TO OBTAIN PAYMENT OF CLAIMS.

SIGNATURE OF PATIENT:	**DATE**:
PRINTED PATIENT NAME:	