Bridges Counseling Connection

8717 Dimond D Cir ~ Anchorage, Alaska 99515
Office: (907) 771-0536 ~ Fax: (907) 771-0537

OFFICE REGISTRATION FORM ***DATE***_____

PLEASE FILL OUT COMPLETELY

Clients Legal Name: _____ DOB:_____
(LAST) (FIRST) (M)

☐ Male ☐ Female

Mailing Address: _____
(City) (State) (Zip Code)

Physical home address:_____
(City) (State) (Zip Code)

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:_____ DOB:_____
(LAST) (FIRST) (M)

Employer:_____Relationship to Client:_____ SSN#:____

Personal Mailing Address:_____
(City) (State) (Zip Code)

Home Phone #:_____ Work Phone #:_____

Cellular Phone #:_____ Which # is best?_____

2ND Guardian's Name:_____DOB:____
(LAST) (FIRST) (M)

Employer:_____Relationship to Client:_____SSN#:_____

Personal Mailing Address:_____
(City) (State) (Zip Code)

Home Phone #:_____ Work Phone #:_____

Cellular Phone #:_____ Which # is best?_____

Who Referred You To Our Clinic?_____

Relationship To Client _____

Bridges Counseling Connection

8717 Dimond D Cir ~ Anchorage, Alaska 99515
Office: (907) 771-0536 ~ Fax: (907) 771-0537

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:_____Relation to Client:_____

Policy I.D. Number:_____Group:_____

Policy Holders SSN: _____ DOB:_____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____

Claims Address:_____

Policy Holder's Name:_____Relation to Client:_____

Policy I.D. Number:_____Group:_____

Policy Holders SSN: _____ DOB:_____

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL CHARGES FOR SERVICES RENDERED TO ME OR MY CHILD BY BRIDGES COUNSELING CONNECTION (BBC). MY INSURANCE WILL BE BILLED AS A COURTESY TO ME ONLY IF I PROVIDE ACCURATE INSURANCE INFORMAION TO BCC. I AM RESPONSI BLE FOR ANY POR- TIONS OF MY BILL AT THE TIME THAT SERVICES ARE RENDERED, UNLESS INSURANCE IS PREDETERMINED TO COVER IT BY BCC. I HEREBY AUTHOR IZE PAYMENT BY MY INSURANCE DIRECTLY TO BCC. I FURTHER AUTHORIZE RELEASE BY BCC OF ANY INFORMATION NECESSARY TO MY INSURACE COMPANY FOR PAYMEN T OF CLAIMS.

(GUARDIAN OR PATIENT SIGNATURE—PLEASE SPECIFY)	**(DATE)**	**1ST YR**
(GUARDIAN OR PATIENT SIGNATURE—PLEASE SPECIFY)	**(DATE)**	**2ND YR**
(GUARDIAN OR PATIENT SIGNATURE—PLEASE SPECIFY)	**(DATE)**	**3RD YR**