

**Marie McQueen, ANP / Alaska Pacific Rim Counseling / John McQueen, LCSW**  
**Patient Billing Information**

Patient Name \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last, first, middle)

Male Female Marital Status: **M S D W** Patient's Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_

HM Phone: \_\_\_\_\_ WK Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

ST: \_\_\_\_ Zip: \_\_\_\_\_ email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you learn about our clinic? \_\_\_\_\_

Employer: \_\_\_\_\_ Employee Type: **R FT PT Not Employed**

Address: \_\_\_\_\_ Student Type: **FT PT NON Student**

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Insurance #1: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Address: \_\_\_\_\_ Sex: \_\_\_\_ Marital Status: **S M D W**

City, State, Zip: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Number: \_\_\_\_\_ Deductible: \_\_\_\_\_

Group #: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance #2: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Address: \_\_\_\_\_ Sex: \_\_\_\_ Marital Status: **S M D W**

City, State, Zip: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Number: \_\_\_\_\_ Deductible: \_\_\_\_\_

Group #: \_\_\_\_\_ Employer: \_\_\_\_\_

I understand that I am fully responsible for any and all charges for services rendered to me by Alaska Pacific Rim Counseling (APRC). My insurance company will be billed as a courtesy to me, only if I provide insurance information. **I am responsible for my portion of the bill at the time services are rendered.** I hereby authorize payment directly to APRC or Dr. or Ms. McQueen. I further authorize release by Dr. or Ms. McQueen of any information necessary to my insurance Company for payment of claims.

**Date:** \_\_\_\_\_ **Patient or Guardian signature** \_\_\_\_\_