ALPINE
counseling services, llc

510 Main Ave Suite 1
Brookings, SD 57006

Phone: 605.620.1706
Email: info@alpinecounselingsd.com
Website: alpinecounselingsd.com

Client Information

Name: _____ ___ _____ Birthdate: _____ Age: ___
First MI Last

Physical Address

_____ _____ ___ _____
Street Address City State Zip Code

Mailing Address (if different than physical address)

_____ _____ ___ _____
Street Address City State Zip Code

Phone: _____ Email: _____ I consent to receive emails at this email: ☐ Y ☐ N

School / Employer: _____ _____
School/Employer Name School / Work Phone

☐ Spouse / Partner OR ☐ Legal Guardian (if client is a minor)

Name: _____ ___ _____ Birthdate: _____
First MI Last

Physical Address

_____ _____ ___ _____
Street Address City State Zip Code

Phone: _____ Email: _____ I consent to receive emails at this email: ☐ Y ☐ N

Relationship to Client: _____

Employer: _____ _____
Employer Name Work Phone

Family Members / Others Living in the Household

Name	Relationship to Client	Age	Birthdate	School / Employer

Medical Information

Primary Care Provider: _____
Current Medications: _____
Presenting Concern(s): _____
_____

Primary Insurance

In order to process your insurance, you must provide *complete* information

Name of Insurance Company: _____

Subscriber's Name: _____ Relationship to Client: _____

Subscriber's SSN: _____

Insurance Address:

_____ _____ ____ _____
Street Address City State Zip Code

Identification #: _____ | Group #: _____ | Phone #: _____

Have you obtained a pre-authorization if required? ☐ Yes ☐ No ☐ Not applicable

Pre-authorization will be your responsibility. Alpine Counseling Services, LLC will provide necessary treatment information when requested by the insurance company.

Third Party Responsibility

Please complete the following information if your account is to be billed to a third party. Please understand that we will not bill a third party unless they have provided us with written verification or a signed financial policy. Any services not reimbursed by a third party will be your responsibility to pay.

Name of Individual and / or Agency: _____

Address:

_____ _____ ____ _____
Street Address City State Zip Code

Phone: _____ | Has written authorization been provided? | ☐ Yes | ☐ No

Assignment and Release

The undersigned hereby authorizes the release of any information related to claims for benefits submitted on behalf of myself and / or dependent. I further expressly agree and acknowledge that my signature on this document authorizes Alpine Counseling Services, LLC to submit claims for services rendered. I further authorize insurance companies and other third party payers to make payment directly to Alpine Counseling Services, LLC.

_____ _____
Client or Legal Guardian Signature Date