Alliant Therapy Group, LLC
200 1st Ave W #400 Seattle, WA 98119 alliantthерapy@gmail.com
110 Main Street Suite 104 Edmonds, WA 98020 425-361-7987

**Patient Name**:_____ **SSN**:_____

**Address:**_____**Apt #**:_____

**City:**_____**State:**_____**Zip**:_____

**Patient's Date of Birth**: _____Age :_____Gender: Male ☐ Female ☐

**Home Phone**: _(_____)_____**Cell Phone**:_(_____)_____

**Email address**:_____

***Primary Insurance Co. Name:***_____

Insurance Co. (800) Number:_____

Name of Insured (Subscriber):_____Date of Birth:_____

**Insurance ID#**:_____**Group #**:_____

Subscriber's Employer:_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Partner

***Secondary Insurance Co.Name:***_____

Insurance Co. (800) Number:_____

Name of Insured (Subscriber):_____Date of Birth:_____

**Insurance ID#**:_____**Group #**:_____

Subscriber's Employer:_____SS#_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

*I authorize provider to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies, including co-pays, deductibles, failed and late cancelled appointments.*

*If it becomes necessary to effect collections of any amount owned, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.*

**Signature:**_____**Date:**_____

Please be sure to include all of the information that is in **BOLD.**