Assistive Technology NW

Andrea Ekstam, LLC — 319-329-3007
Carrie Luse, LLC — 503-312-3348
Kim Elliott, LLC — 503-708-5720

Client Registration Form- information required to bill insurance

Client Name:	DOB:	Todayøs Date:	
Race: (Caucasian, Hispanic, Asian, etc.)			
Guardian Information(1) - Name:	Relationship:		
Home Phone:	Cell Phone:	Email:	
Guardian Information (2): - Name:	Relationship:		
Home Phone:	Cell Phone:	Email:	
Street Address: *Must be complete*:	Mailing Address *if different*:		
Primary Care Physician:	**ICD-9** *(if known)*:		
Phone:	Fax:	Referred By:	
Insurance Information			
Primary Insurance Name:	Address:	Phone:	
Name of Insured:	Relationship: DOB:	I.D. No.	Group No.

Terms/Conditions for Services

I hereby authorize Andrea Roehs, LLC, Carrie Luse, LLC, and/ or Kim Elliott, LLC, to release and/or obtain information concerning the patientøs present condition with the above named insurance company.
The undersigned authorizes the release of any information relating to all claims for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature on this document authorizes Andrea Roehs, LLC, Carrie Luse, LLC, and/or Kim Elliot, LLC, to submit claims for benefits and for services rendered without obtaining my signature on each and every claim.

_______________________________________ ____/____/____

Client or Guarantor **Date**

Please return by email or fax to **503.536.6733**