Rhonda “Roni” Lanier, M.S., LPC, CDCI

4400 Business Park Blvd.

Building B, Suite #11

Anchorage, AK 99503

(907) 223-4374

**Insurance Information**

|  |  |  |
| --- | --- | --- |
| Client’s Name Last: First: MI: | Client’s DOB: | Client ID: |
| **Primary Insurance Company:**  | Insurance Phone:( ) - Ext: |
| Claims Address: |
| Insurance ID Number:  | Insurance Group Number: | Effective Date: |
| Client’s relationship to Policyholder:  |
| Policyholder’s Name Last: First: MI: | Policyholder’s DOB: | Policyholder’s Gender: Female Male |
| Policyholder’s SSN: | Policyholder’s Phone Number:( ) -  |
| Policyholder’s Employer:  |
|  |
| **Secondary Insurance Company:**  | Insurance Phone:( ) - Ext: |
| Claims Address: |
| Insurance ID Number:  | Insurance Group Number: | Effective Date: |
| Client’s relationship to Policyholder:  |
| Policyholder’s Name Last: First: MI: | Policyholder’s DOB: | Policyholder’s Gender: Female Male |
| Policyholder’s SSN: | Policyholder’s Phone Number:( ) -  |
| Policyholder’s Employer:  |

The above information is true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to Arctic Owl Counseling, LLC/Rhonda Lanier M.S., LPC, CDC I. I understand that I am responsible for any balance not covered by insurance. I also authorize Arctic Owl Counseling, LLC/ Rhonda Lanier M.S., LPC, CDC I, or the above-identified companies to release any information required to process my claims.

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_