TWIN CITIES
MENTAL HEALTH
& COUPLES CENTER

Client Name: _____

Name of Parent(s) or Legal Guardian(s) if Minor: _____
Date of Birth: ____/____/____ Gender: _____ Age: _____
Address: _____ City:
_____ State: _____ZIP: _____

Home Phone: _____May I leave a message? ▫Yes ▫No

Cell Phone: _____ May I leave a message? ▫Yes ▫No

E-mail: _____May I e-mail you? ▫Yes ▫No

Emergency Contact: _____Phone: _____
INSURANCE INFORMATION:

Primary Insurance Carrier: _____ID# _____ Group #_____ Co-Pay $:_____ Deductible $:_____ Co-Insurance $:_____

Secondary Insurance Carrier: _____ _____ ID#_____ Group #_____ Co-Pay $:_____ Deductible $:_____ Co-Insurance $:_____

If I am unsure what the deductible amount will be, a payment of $150.00/session will be taken, until the deductible amount is determined. I understand that I will be billed for any remaining balance following submission of the insurance claim.

Policy Holder's Name (if differs from client): _____DOB: _____

Policy Holder's Address: _____ City: _____State: _____Zip Code: _____

Policies with a co-pay, deductibles or co-insurance REQUIRE a non-HSA credit card to be kept in your client file.

Card Number: _____Exp. Date: _____ CVV Code: _____

I hereby give consent below, to charge my credit card for any outstanding balance such as deductibles, co- payments, fees or other amounts my carrier determines as my responsibility to pay. Additionally, I understand that all PRIVATE PAY or SLIDING FEE session payments are due at the time of service:
Card Holders Signature: _____ Date: _____