Client Contact Information and Consent for Third Party Billing

Mankato Mental Health Associates
Union Square Building
201 North Broad Street, Suite 308
Mankato, MN 56001-3569

Therapy Providers:
Main Phone: (507) 345-4448
Main Fax (507) 625-6829
www.mankatomentalhealth.com

Medication Management Provider:
Rebecca Moore (507) 508-9278
Fax (507) 345-6761

Client Information

Name_____
Date of birth_____
Address_____
City_____ State_____ Zip_____

Home phone_____
Cell phone_____
Work phone_____

Email address (optional – by providing you are authorizing use of your email address for appointment reminders, treatment and/or billing related communications)
_____

May we leave messages, ***including text messages? *** Circle:

Home phone: YES NO
Cell phone: YES NO
Work phone: YES NO

Emergency Contact: _____
Phone: _____

Insurance Policy Holder Information (if different than client)

Name_____ Date of birth_____
Employer_____ Phone_____

Insurance Information (please complete all information)

Primary Insurance_____ Employer_____
Address_____
City_____ State_____ Zip_____
Phone_____ Fax_____
Identification Number_____ Group number_____

Secondary Insurance_____ Employer_____
Address_____
City_____ State_____ Zip_____
Phone_____ Fax_____
Identification Number_____ Group number_____

I hereby authorize Mankato Mental Health Associates, P.A., to release to my insurance company or its intermediaries any Protected Health Information or other information necessary for payment of an insurance claim, treatment facilitation, or required operations (such as chart audits) as required by my insurance plan. I authorize and request payment of insurance benefits to Mankato Mental Health Associates, P.A. when assignment is accepted.

Authorized Signature_____ **Date**_____

I agree to pay the deductible and/or any copayment or coinsurance at each office visit based on the contractual agreement between Mankato Mental Health Associates, P.A., and my insurance company. **I agree to pay any applicable failed appointment fees according to the policy listed in the Informed Consent Document which I have been given.**

Authorized Signature_____ **Date**_____