# Client Contact and Billing Information

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

Phone: (507) 345-4448
Fax: (507) 625-6829
Medication Management:
(507) 508-9278

www.mankatomentalhealth.com
Federal ID: 41-1685882
NPI: 1083863245

## Client Information

Name_____ Home phone_____
Date of Birth_____ Cell phone _____
Work phone _____
May we leave messages? Circle:
Home phone: YES NO
Cell phone: YES NO
Work phone: YES NO

**Parent/Legal Guardian of Client**
Name_____
Address_____
City_____ State _____ Zip _____
Email address (optional – only provide if we can use for appointment reminders)_____

**Parent/Legal Guardian of Client**
Name_____ Home phone_____
Address_____ Cell phone _____
City_____ State _____ Zip _____ Work phone _____
Email address (optional – only provide if we can use for appointment reminders)_____
May we leave messages? Circle:
Home phone: YES NO
Cell phone: YES NO
Work phone: YES NO

**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 medical or other information needed for a related insurance claim. 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_____