Chime Mental Health Services
Therapy & ARMHS
(507) 461-0874 (call or text)
126 South Broadway Wells, MN 56097
www.chimementalhealth.com

Client Contact and Billing Information Form

Client Information

Full Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Information

Phone (W-H-C): _____ May We Leave Messages? Yes or No If Yes, Voice or Text?

Phone (W-H-C): _____ May We Leave Messages? Yes or No If Yes, Voice or Text?

Email address: _____

Insurance Info:

Primary Insurance: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Identification Number: _____ Group Number: _____

I hereby authorize Chime Mental Health Services to release to my insurance company or its intermediaries any medical information or other information needed related to an insurance claim. I authorize and request payment of insurance benefits to Chime Mental Health Services.

I also agree to pay the deductible and/or copayment at each office visit based on the contractual agreement between Chime Mental Health 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: _____

Consent for Treatment Signature Page

I affirm that I have read the "Chime Mental Health Services Informed Consent Information" (revised 07.10.2021) and give my consent to receive mental health treatment, including counseling.

I, _____, am requesting mental health services from Chime and agree to the practices outlined in the document. I understand that my participation is voluntary and that I can withdraw my consent at any time.

Client Signature Date

Parent/Guardian (if appropriate) Date

Good Faith Estimate Signature Page

By signing this form, I acknowledge that I was provided with the form labeled 'Good Faith Estimate.' If I have any questions related to this form, I am encouraged to ask my provider at any time during the therapeutic relationship.

Client Signature Date

Parent/Guardian (if appropriate) Date

Telehealth Consent Signature Page

I, _____, consent to participating in telehealth services provided by Chime Mental Health Services for my therapy and treatment goals. I understand that these sessions will include mental health evaluation, assessment, consultation, treatment planning, and therapy via a HIPAA-compliant platform. By signing this form, I confirm that I have read and understood the consent information and agree to participate voluntarily.

Client Signature Date

Parent/Guardian (if appropriate) Date

Patient Bill of Rights and Grievance Procedure

I, _____, have been given a copy of the Patient Bill of Rights, which outlines the grievance procedure as a client of Chime Mental Health Services. I have and will read these rights and procedures and understand that staff will respect my right to seek clarification and will answer questions clearly and respectfully.

Client Signature Date

Parent/Guardian (if appropriate) Date