Youth Client Contact and Billing Information Form

Chime Mental Health Services
P.O. Box 121
Wells, MN 56097

Phone (507) 461-0874
www.chimementalhealth.com

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: _____

Parent/Legal Guardian of Client: _____

Address: _____

City: _____ State: _____ Zip: _____

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: _____