

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: _____

Payment Authorization

Payment in the amount of \$_____ for 50 minute sessions are due the day of the appointment. Payments can be made with credit card, Venmo or check (case by case basis). I agree to make those payments on the day of the appointment. I understand that no further appointments will be scheduled until previous sessions are paid in full.

Authorized Signature: _____ Date: _____