Ina Lasmane, LLC
Phone: (612) 559-8704, Fax: (612) 279-8205

# CLIENT PROFILE

**CLIENT INFORMATION:**

Client Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____ City: _____ Sate: _____ ZIP_____

Phone (home): _____ OK to leave a message? YES [ ] No [ ]

Phone (cell): _____ OK to leave a message? YES [ ] No [ ]

Phone (work): _____ OK to leave a message? YES [ ] No [ ]

Occupation: _____ Employer: _____

Appointment reminder (check one): **No** [ ] **Text** [ ] **E-mail** [ ] e-mail:_____

**EMERGENCY CONTACT:**

Name of Emergency Contact: _____ Relationship: _____

Phone: _____ (h), (w) or (c)

**PAYMENT OPTIONS:** [ ] Self-Pay: $_____(per intake), $_____ (per session) [ ] Insur. Deduct: $_____(per year)
[ ] Insurance Co-pay: $_____(per visit) [ ] Co-Insurance: $_____(per visit) [ ] EAP: _____(# of sessions) at 100%
[ ] Sliding Fee $_____(per session)

**PRIMARY INSURANCE:**

Insurance: _____ Insured Party: _____

Insurance ID: _____ DOB of Insured Party: _____

Group Number: _____ Insured's Address: _____

_____ Phone: _____

**SECONDARY INSURANCE:**

Insurance Company: _____ Insured Party: _____

Insurance ID: _____ DOB of Insured Party: _____

Group Number: _____

**PAYEE/RESPONSIBLE PARTY FOR PAYMENT** (if different than self)*:*

Full Name: _____

Address: (City/State,/Zip): _____Phone: _____

(Initial)_____ **Self-Pay.** I agree to the financial agreement as stated above.
(Initial)_____ **Insurance.** I authorize Ina Lasmane, MA, LMFT to release all information necessary to secure the payment for my mental health care to my insurance company. I authorize insurance carrier to pay for rendered mental health services directly to Ina Lasmane, MA, LMFT. I authorize use of this signature on all insurance submissions. Also, I understand that if I am covered under my parents' policy and want this therapist to bill to my insurance company, my parents may receive a copy of the explanation of benefits from my insurance.

(Initial)_____ **Insurance.** I certify that I have mental health insurance coverage. I agree that it is my responsibility to verify my insurance benefits prior to each session. I agree to pay my co-pay, co-insurance, and deductible to Ina Lasmane, MA, LMFT in accordance with my insurance policy. I understand that if my insurance denies payment or my insurance terminates, I am fully responsible for my bill and I agree to pay my bill in full. I understand and agree that if a payee is different than myself, the payee will be contacted to secure payment.

(Initial)_____ **Payee/Responsible Party for Payment** (if different than self)*:* I, _____, agree to serve as a payee for the above client. I agree to the financial agreement as stated above. I understand that Ina Lasmane, MA, LMFT no longer provides paper billing, therefore, a credit card on file is required. I agree that all bills pertaining to the above client will be billed to my credit card. **Note:** Please sign below. Please, also complete an **Authorization for Credit Form**. A receipt will be provided upon your request.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Payee/Responsible Party Signature (if different than self): _____ Date: _____