

Ina Lasmane, LLC

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

CLIENT PROFILE/MINOR

MINOR CLIENT INFORMATION:

Client Name: _____ DOB: _____ Age: _____ Sex: _____
Address: _____ City: _____ State: _____ ZIP _____
Phone (cell): _____ OK to leave a message? YES [] No []
Student: YES [] No [] Part-Time [] Full-Time [] School: _____ Grade: _____
Appointment reminder (check one): No [] Text [] E-mail [] e-mail: _____
Parents' relationship/marital status: _____ Primary caregiver: _____

PARENT/GUARDIAN #1:

Name: _____ DOB: _____ Age: _____ Sex: _____ Relationship: _____
Address: _____ City: _____ State: _____ ZIP _____
Phone (cell): _____ OK to leave a message? YES [] No []
Phone (work): _____ OK to leave a message? YES [] No []
Appointment reminder (check one): No [] Text [] E-mail [] e-mail: _____

PARENT/GUARDIAN #2:

Name: _____ DOB: _____ Age: _____ Sex: _____ Relationship: _____
Address: _____ City: _____ State: _____ ZIP _____
Phone (cell): _____ OK to leave a message? YES [] No []
Phone (work): _____ OK to leave a message? YES [] No []

EMERGENCY CONTACT:

Name of Emergency Contact: _____ Relationship: _____
Phone: _____ (h), (w) or (c)

PAYMENT OPTIONS: [] Self-Pay: \$ _____ (per intake), \$ _____ (per session) [] Insurance 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 primary caregiver):

Full Name: _____ Relationship: _____
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 child's 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. **Note:** I understand that if I am covered under my parents' policy and want this therapist to bill to my insurance company, my parents will receive a copy of the explanation of benefits from my insurance.

(Initial) _____ **Insurance.** I certify that my child has a mental health insurance coverage. I agree that it is my responsibility to verify my child's insurance benefits prior to each session. I agree to pay my child's co-pay, co-insurance, and deductible to Ina Lasmane, MA, LMFT in accordance with my child's insurance policy. I understand that if my child's insurance denies payment or my child's insurance terminates, I am fully responsible for my child's bill and I agree to pay the 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 primary caregiver):** I, _____, agree to serve as a payee for the above child. 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 child 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 primary caregiver): _____ Date: _____