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

CLIENT PROFILE/COUPLES

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

SPOUSE/PARTNER 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 [ ]
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 clients. 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: ____________________
Client Signature: ____ Date: ____________________
Payee/Responsible Party Signature (if different than self): ______________________________ Date: ____________________