CLIENT / INSURED INFORMATION

THERAPIST NAME	OFFICE LOCATION	INTAKE DATE

CLIENT INFORMATION

CLIENT FULL NAME			DATE OF BIRTH
ADDRESS		EMAIL	SOCIAL SECURITY NUMBER
CITY/STATE/ZIP		GENDER MALE ☐ FEMALE ☐ If Other, Specify_____	MARITAL STATUS SINGLE ☐ MARRIED ☐ OTHER ☐
HOME PHONE	LEAVE MSG? YES ☐ NO ☐	IF A MINOR, NAMES OF PARENTS/GUARDIANS	
WORK PHONE	LEAVE MSG? YES ☐ NO ☐	EMPLOYER/SCHOOL	
CELL PHONE	LEAVE MSG? YES ☐ NO ☐	EMERGENCY CONTACT NAME/PHONE	

BILLING INFORMATION

PRIMARY INSURANCE INFORATION			**SECONDARY INSURANCE INFORMATION**		
A copy of both sides of the insurance card(s) is needed at intake.					
INSURANCE COMPANY			INSURANCE COMPANY		
CLIENT GROUP ID#	EFFECTIVE DATE		CLIENT GROUP ID#	EFFECTIVE DATE	
CLIENT MEMBER ID#			CLIENT MEMBER ID#		
SUBSCRIBER NAME			SUBSCRIBER NAME		
RELATION TO CLIENT			RELATION TO CLIENT		
SUBSCRIBER DOB	SOCIAL SECURITY NUMBER		SUBSCRIBER DOB	SOCIAL SECURITY NUMBER	
SUBSCRIBER ADDRESS			SUBSCRIBER ADDRESS		
CITY/STATE/ZIP			CITY/STATE/ZIP		
SUBSCRIBER PHONE	LEAVE MSG? YES ☐ NO ☐		SUBSCRIBER PHONE	LEAVE MSG? YES ☐ NO ☐	
CO-PAY:	CO-INSURANCE:	*DEDUCTIBLE:	COPAY:	CO-INSURANCE:	*DEDUCTIBLE:

I authorize/consent to the release or exchange of information from/to FBTA, my insurance company, and/or other third-party payer in order to facilitate payment, treatment or healthcare operations. I am aware that the contract with my health insurance company requires that FBTA provide information (i.e. clinical diagnoses) relevant to the services that are provided to me. Sometimes FBTA is required to provide additional clinical information (i.e. treatment plans or summaries, or copies of my entire clinical record. Any inaccuracy in the information on this form may result in non-payment by my insurance company. I agree to notify FBTA as soon as I am aware of any changes in my health condition or health plan coverage.

Fee for service payments and co-payments are due at the time of your appointment. Deductibles and co-insurance will be determined when your claim is processed by your insurance company. Co-insurance and Deductibles will be applied to your account. If your account becomes delinquent (30 days from date of invoice), mental health services will not continue until account is paid in full. A finance charge of 18% annually (1.5% per month) will accrue on all past due accounts. FBTA reserves the right to send past due accounts to a collection agency. Accepted methods of payment are cash, check and major credit cards.

Verification of benefit coverage is not a guarantee of claim payment. All benefits are subject to the terms and conditions (e.g. authorizations, network requirements) outlined in the member contract with your insurance company. **Ultimately it is your responsibility to know and understand your health insurance coverage.** For benefit and coverage questions, please call the customer/member service number on the back of your insurance card.

A 24-hour notice of appointment cancellation is required. Failure to do so will lead to a $60 cancellation fee.

SIGNATURE (LEGAL GUARDIAN) By signing this agreement, I agree to the above terms and conditions.	**DATE**

fbta Personal, Comprehensive Mental Health Care

Cambridge 763.689.9407 (T)
Clinic 763.552.0164 (F)

Coon Rapids 763.780.1520 (T)
Clinic/Administration 763.780.2114 (F)

Chisago City 651.257.2733 (T)
Clinic 651.257.2783 (F)