MIDWEST CENTER FOR TRAUMA AND EMOTIONAL HEALING
16204 Highway 7 Minnetonka, MN 55345
Phone: 952-934-2555, Fax: 952-934-3010

CONFIDENTIAL CLIENT INFORMATION

PERSONAL INFORMATION

Name:______________________________ Date:______________
Phone (Home):______________ (Work):______________ (Cell):______________
Address:______________________________
City:______________ State:______________ Zip Code:______________
Date of Birth:______________ Social Security Number:______________ Sex:______________
Marital Status: Single Married Partnered Separated Divorced Widowed
Student: Yes No Full-time Part-time
Referred by:______________________________
Email:______________________________

WORK INFORMATION

Occupation:______________________________
Business/Employer Name:______________________________
Business/Employer Address:______________________________
City:______________ State:______________ Zip Code:______________
Employment Status: Full-time Part-time Retired Not Employed

PRIMARY INSURANCE INFORMATION (THIS INFORMATION CAN BE FOUND ON YOUR INSURANCE PROVIDER CARD)

Name of Insurance Company & Policy:______________________________
Insurance Information Phone Number:______________________________
ID Number:______________ Group Number:______________
Claims Address:______________________________
Relationship to Insured: Self Spouse/Partner Family Member Other

SECONDARY INSURANCE INFORMATION OR SPOUSES INSURANCE INFORMATION

Name of the Primary Insured Person:______________________________
Name of Insurance Company & Policy:______________________________
Information Phone Number:______________________________
Date of Birth:______________ Social Security Number:______________
ID Number:______________ Group Number:______________
Claims Address:______________________________
Relationship to Insured: Spouse/Partner Family Member Other

INSURANCE AUTHORIZATION

I hereby certify that the above statements are correct. I authorize the release of any medical information necessary to process this claim. I also authorize benefits under this claim to be paid directly to my health care provider for the services rendered to me and/or my dependants.

Client Signature (or parent/guardian): ______________________________Date: ______________

PAYMENT RESPONSIBILITY

I understand that if I am using my insurance I am responsible for all deductible and co-insurance/co-payment amounts and that these will be paid at the beginning of each appointment unless a prior payment arrangement has been made with my psychologist. I also understand that I am financially responsible for full payment of all charges not covered by my insurance company or third party payer and that my doctor my use an outside agency to receive collection if my account becomes delinquent.

I agree to be responsible for paying in full all charges for appointments missed or cancelled less than 24 hours in advance and that my insurance company does not cover these charges.

Client Signature (or parent/guardian): ______________________________Date: ______________