Mente Salus Psychological Services, LLC

4319 Jeffers Road, Suite 101, Eau Claire, WI 54703
www.mentesalus.com
715-839-7240
FAX: 715-598-6216

CLIENT CONTACT INFORMATION & HIPAA NOTICE

Office Use Only	Intake Date:	File No.	Client Type: ☐Indiv ☐Couple ☐Family ☐Minor

1-CLIENT (if Client is under age 18, a custodial parent or legal guardian must also be identified in Box 3 below)

Last name	First Name	Mid Initial	Identify as ☐Female ☐Male
Street 1	(Area)Cell Phone ( ) -		Message OK? ☐yes ☐no
Street 2	(Area)HomePhone ( ) -		Message OK? ☐yes ☐no
City / State	Zip	(Area)Work Phone ( ) -	Message OK? ☐yes ☐no
Birthdate / / (mm/dd/yyyy)	Email		Email OK? ☐yes ☐no

Current Marital Status ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Employment Status (check all that apply) ☐ Employed-Fulltime ☐ Employed-Part-time ☐ Stay home parent ☐ Unemployed ☐ Retired

If Student, Status ☐High School ☐College-Part-time ☐College-Full-time ☐Grad./Prof. School | Occupation or Major

Employer or School Name | City, State, Zip

Would you like to receive appointment reminders? ☐yes ☐no Reminders to: ☐Cell ☐Home ☐Work ☐Email (check all that apply)

Referral Source: | Phone: ( ) - | Coordinate Services? ☐yes ☐no

2-SPOUSE/PARTNER (for cross-referencing, *couples therapy only*)—both partners will ALSO register individually

Last name	First Name	Mid Initial	Identify as ☐Female ☐Male
Birthdate / / (mm/dd/yyyy)	(Area)Cell Phone ( ) -		Message OK? ☐yes ☐no
Email / Email OK? ☐yes ☐no	(Area)HomePhone ( ) -		Message OK? ☐yes ☐no
Who will be responsible for scheduling appointments?	(Area)Work Phone ( ) -		Message OK? ☐yes ☐no

3-PERSON RESPONSIBLE FOR PAYMENT (if not Client) OR Custodial Parent/Guardian (when Client is under age 18)

Last name	First Name	Mid Initial	Relationship to Client:
Street 1	(Area)Cell Phone ( ) -		Message OK? ☐yes ☐no
Street 2	(Area)HomePhone ( ) -		Message OK? ☐yes ☐no
City / State	Zip	(Area) Work Phone ( ) -	Message OK? ☐yes ☐no
Birthdate / / (mm/dd/yyyy)	Email		Email OK? ☐yes ☐no

Identify as ☐Female ☐Male | Current Marital Status ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Employment Status (check all that apply) ☐Employed-Fulltime ☐Employed-Part-time ☐Stay-at- home parent ☐ Unemployed ☐Retired

If Student, Status ☐High School ☐College-Part-time ☐College-Full-time ☐Grad./Prof. School | Occupation or Major

Employer or School Name | Address, City, State, Zip

If guardian, when did child enter guardianship? / / (mm/dd/yyyy) Reason:

4-EMERGENCY CONTACT (not at same address as Client)	Name		Relationship
	Phone	City, State	

5-PAYMENT INFORMATION

Please refer to Fee Schedule. Reduced fees are possible when discussed in advanced. Client or Person Responsible for Payment is responsible for all deductibles, co-insurance and co-pays. Balances in excess of $250 will be sent to collections after six months. Outstanding balances are due before rescheduling after a break in services. Payment by cash, check or credit card is possible. Major credit card (pay in office or online at www.mentesalus.com using Paypal); information is secure; use of this convenience is at your discretion and consent is implied; your receipt will show as payment to MSPS LLC.	If you will be using checks to make payments, please enter your driver's license number: _____-_____-_____-_____ State:_____

6-INSURANCE INFORMATION (Please bring insurance card to first appointment)

PRIMARY INSURANCE	Subscriber ID	Subscriber's relationship to Client: ☐Self ☐Spouse ☐Parent ☐Other		
Insurance Company		Type ☐Medicare ☐Medicaid ☐Tricare Champus ☐HMO ☐Champva ☐Group Plan ☐FECA Blk Lung ☐Other		
Insurance Address		Policy or Group Number		
Insurance Phone		Plan Name		
Subscriber Info (if different from Client)	Name	☐Female ☐Male	Birthdate (mm/dd/yyyy) / /	
	Street Address		(Area) Phone ( )- -	
	City	State	Zip	Employer
SECONDARY INSURANCE	Subscriber ID	Subscriber's relationship to Client: ☐Self ☐Spouse ☐Parent ☐Other		
Insurance Company		Type ☐Medicare ☐Medicaid ☐Tricare Champus ☐HMO ☐Champva ☐Group Plan ☐FECA Blk Lung ☐Other		
Insurance Address		Policy or Group Number		
Insurance Phone		Plan Name		
Subscriber Info (if different from Client)	Name	☐Female ☐Male	Birthdate (mm/dd/yyyy) / /	
	Street Address		(Area) Phone ( )- -	
	City	State	Zip	Employer

AUTHORIZATIONS:

☐ I verify the above information is complete and accurate;

☐ I verify that the person identified as "responsible for payment" assumes responsibility for payment of fees not covered by insurance;

☐ I have had the opportunity to review billing, late cancellation, insurance coverage, and other policies and procedures;

☐ I understand my protective health information will be used ONLY for treatment, billing and operating purposes;

☐ I understand my insurance benefits will be paid to Mente Salus Psychological Services LLC;

☐ I have reviewed the Informed Consent booklet and the content at www.mentesalus.com and have had the opportunity to ask questions about service and the limits on confidentiality;

☐ I understand the risks and benefits of treatment/counseling/psychotherapy;

☐ I will participate as fully as possible in treatment planning, coordination of services as requested, and follow through on recommended homework assignments and self-care; and

☐ I give permission to be contacted as specified above for scheduling or billing purposes.

Signature of Client (ages 14 and over)		Date
Signature, Parent or Guardian if Minor Client		Date
Signature of Provider		Date