Healing connections Therapy Center

PHONE: 952-892-7690
FAX: 952-898-4930
1751 Southcross Drive West
Burnsville, Minnesota 55306

Information Update Form

Client Information

Client Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Is it OK to leave a detailed message (Yes/No): _____
Social Security No. _____ Gender: _____ Email: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

Bill to: (select one) Self Parent/Guardian

Responsible Party

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____ Relationship to Client: _____

Insurance

Insurance Company: _____
ID #: _____ Group #: _____
Prescription Drug Coverage Info: **(may be found on primary insurance card or separate prescription insurance card)**
Rx #: _____ BIN: _____ PCN: _____

Secondary Insurance

Insurance Company: _____
ID #: _____ Group #: _____

Insurance Change Notification	You are responsible for notifying the billing office as soon as possible if your insurance changes. You may be responsible for additional charges if your appointments are billed with inaccurate insurance information.
Cancellation Policy	Cancellations or changes in appointments must be made at least 24 hours in advance to avoid charges. If you fail to notify us 24 hours in advance, you will be charged $60.00 for each missed or late cancelled appointment. Exceptions may be made for emergencies and other extenuating circumstances.
Payment Policy	Copayments are due at the time of service and are your responsibility. Statements are sent out monthly and require full payment. If you cannot pay the full amount, you may contact our Billing Specialist to make payment arrangements. Failure to make payment in full or to make a payment arrangement will result in termination of care, referral to collections or both.

By signing this form, I have read and understand the policies above and have provided accurate information. In addition, I assign all benefits from insurance or other third-party coverage to Healing Connections Therapy Center or its independent contractors. I understand that by signing this form I acknowledge that if my insurance carrier does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by Healing Connections Therapy Center or its independent contractors.

_____

Signature of Client or Guardian (if under 18) **Date**