# The Calli Institute
*a balanced approach to mental health*

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Maple Grove, MN. 55369
PH - 763-255-2125 Fax - 763-255-2126
Email – info@calliinstitute.com

## REGISTRATION - Client Information

| | | |
|---|---|---|
| Client Full Name | | Date of Birth |
| Gender/Preferred pronoun:<br>Male(he/him) Female (she/her) Other | Address City/State/Zip | |
| Primary Phone – Hm or Cell? (circle one)<br>*Permission to leave a voice message? Y / N* | Secondary Phone – Hm or Cell? (circle one)<br>*Permission to leave a voice message? Y / N* | Email address |
| Emergency Contact Name Relationship to Client | | Emergency Contact phone |
| I want to sign up for the portal: Yes / No<br>If yes, please ensure your email is listed above | Appointment reminders via: Text Email Voice Message<br>(Appointment reminders will go to the primary number listed above) | |

## Billing Information

| | | |
|---|---|---|
| Responsible billing party full name | Date of Birth | Relationship to client<br>Self Spouse Parent Other _____ |
| Billing Address City/State/Zip | | |
| Billing Phone | | Permission to leave a voice message? Y / N |

I understand that I am ultimately responsible for payment to Calli Counseling, PLLC for any and all services rendered due at the time of visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. The parent or guardian who brings a minor in for services will be considered the responsible party and will receive all billing statements and notifications. Any court ordered financial arrangements must be worked out between the parents.

**Signature** _____ **Date** _____

## Primary Insurance Information

| | | | |
|---|---|---|---|
| Policy Holders Name | DOB | Insurance Company | |
| Policy Holder address | Phone number | Member ID # | Group ID # |
| Relationship to Client: Self Spouse Parent Other _____ | | Do you have secondary insurance? Yes No | |

Will this be through an Employee Assistance Program? EAP? Yes No
If so, please provide authorization number_____

I authorize The Calli Institute, LLC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Calli Counseling, PLLC. I understand that I am responsible for payment for services rendered by Calli Counseling, PLLC, regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in non-payment by my insurance company. I agree to notify The Calli Institute, LLC of any changes to my insurance coverage. If I do not have adequate insurance coverage, or am otherwise eligible for self-pay, I agree to pay in full for services rendered pursuant to the attached Financial Agreement.

**Signature** _____ **Date** _____