mercy's place counseling services

507-226-7963
2480 Superior Drive NW, Rochester, MN 55901
www.mercysplace.com

Initial Contact/Insurance Form

Date: _____

Name & Date of Birth of the adult requesting services OR requesting services on their child's behalf:

_____

Child/Youth's Name & Date of Birth:

_____

Home/cell phone number:

_____

Address:

_____

Stated problem/reason for requesting services:

_____

_____

Specific services requested:

_____

_____

Who is available for treatment:

_____

_____

Previous mental health treatment/service providers:

_____

_____

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Current medications/dosage:

_____

_____

Referred by:

_____

_____

Insurance Information

** Please provide a copy of your insurance card (front and back)*

Primary Insured Name: _____

Primary Insured Date of Birth: _____

Place of Employment: _____

Primary Insurance Carrier:_____

Policy Number:_____

Group Number:_____

Deductible Amount: _____

Copay Amount: _____

**Please note- We can only submit secondary insurance if we have received the policy information by your first appointment.*

Secondary Insurance Carrier: _____

Policy Number:_____

Group Number:_____

Deductible Amount: _____

Copay Amount: _____