Lake Country Associates
1426 Bemidji Ave NW, Suite 1
Bemidji, MN 56601
Phone: 218-444-2233 Fax: 218-237-2520

# CHILD INTAKE FORM

Date:______________________

Child's Name:______________________Age:_________Date of Birth:_______________Sex: ☐ Male ☐ Female

Your name and relationship to child ______________________________________________________________

Who has current legal guardianship of child?________________________________________________________

Race: ☐ White ☐ Black/African American ☐ Native American/Alaskan
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino

Home #:__________________________ Work #:_________________________ Cell#____________________________

Physical Address:________________________________________Mailing Address: _______________________________

City:______________________ State:_________ Zip:_______________County of Residence:______________________

Who referred this child to Lake Country Associates?____________________________________________________

Does a copy of your assessment need to be forwarded to someone outside of this office? ☐ Yes ☐ No If yes, please tell us

Who ______________________________ Office __________________________________________________

Child Currently Lives:

☐ at home with family
☐ at a relative's home (name and relationship of custodial adults in this home): _____________________
☐ in a foster home (name of foster parents)___________________________________________________
☐ at a group home or residential facility (name of facility)________________________________________
☐ other (please explain)________________________________________________________________
length of time child has been at current placement?________________________________________

People residing in the same household with child:

| Name | Age | Occupation | Relationship to child |
|---|---|---|---|
| | | | |
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| | | | |

HEALTH Current physician: ________________________________ Location: __________________________

When was your child's last physical examination? __________________________ Results: ___________________

Is your child allergic to any drugs? ☐ Yes ☐ No

If Yes, please list _________________________________________________________________________

SCHOOL

Current school/Childcare: _________________________________ Grade: _______

School Contact: ____________________________________________________________________________

Emergency contact: __________________________________ Phone Number: _________________________________

*I authorize Lake Country Associates, Inc. to release necessary information to my emergency contact in the event of an emergency*. Initial: _________

Client name:______________________________________________ DOB:________________ Today's Date:_________________

# Lake Country Associates

**Acceptance of Financial Responsibility**

**Charges for services are to be billed to the following sources:**

☐ Insurance (primary) Company________________ Subscriber Name________________
Group #________________ Subscriber dob ________________
Policy # ________________ Subscriber Relationship________________
Co-Pay Amount ________________ Subscriber Address ________________

☐ Insurance (secondary) Company________________ Subscriber Name________________
Group #________________ Subscriber dob ________________
Policy # ________________ Subscriber Relationship________________
Co-Pay Amount ________________ Subscriber Address ________________

☐ Medical_Assistance MA#________________

☐ EAP Provider Name ________________ Number of Sessions Approved ________________

I understand if coverage has lapsed, if services requested are not covered by the plan, if plan caps have been exceeded, or if the services are denied by the carrier but I wish to have them anyway, **that I will be responsible for the payment.** I also agree to any self-pay amounts indicated by the carrier contract. I authorize LCA to furnish information to the payment sources concerning my illness and treatments and hereby assign to Lake Country Associates all payments for services rendered to my dependents or myself. This authorization shall remain in effect until otherwise cancelled by Policy Holder or Representative. I understand my insurance carrier or other third party payer may inform the "subscriber" of any services billed to the payer.

________________________________ ________________________________
**Parent or Legal Guardian Signature** **Date**

**Private Pay Clients:**

☐ Name________________ Relationship________________
Address ________________ Phone # ________________
________________

By signing below I agree that payment for services requested is the responsibility of the patient or guardian. I agree to accept the terms and conditions as indicated on the FEE SCHEDULE and PAYMENT CONTRACT. Any financial assistance that applies to these services is listed in the payment contract.

________________________________ ________________________________
**Parent or Legal Guardian Signature** **Date**

As a client of Lake Country Associates, I agree to the following statements with regard to payment for services:

1. Clients are required to pay for services received. A client may choose to bill third party insurance including Medical Assistance and Medicare. In the event that the third party insurance is billed, clients will be required to pay for all services which are not covered by insurance. Exceptions will include those items which are not appropriate to bill the client under the terms of the provider contract.
2. If clients choose to use insurance, they agree to provide insurance information to Lake Country Associates and agree to assist in billing for insurance reimbursement.
3. Self-pay clients are expected to pay for services at that time they are received. A 10% discount is offered for full cash payment at the time of service. Billing arrangements accepted by LCA other than full payment at the time of service are listed below under SPECIAL CONDITIONS.
4. If a billing arrangement is made, a minimum payment of $75 per month or 10% of the total bill, whichever is higher, will be expected.
5. Any services provided by LCA not covered by client's insurance which are 60 days in arrears will be charged monthly interest at a rate of 1.5% of the balance.
6. In the event of non-payment, the bill will be sent to collections.
7. LCA reserves the right to decline service or to require cash payment if a previous billing arrangement has not been honored.

The client agrees that if circumstances such as income, number of dependents, insurance or eligibility for various programs change, the client will notify LCA.

SPECIAL CONDITIONS:________________________________________________
________________________________________________

________________________________ ________________ ________________
**Parent or Legal Guardian Signature** **Date** **LCA representative**

Client name:________________ DOB:________________ Today's Date:________________