

### PATIENT INFORMATION

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial) (Nickname)

Mailing Address: \_\_\_\_\_  
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. #: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex:  M  F Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Other \_\_\_\_\_

Ethnicity:  American Indian/Alaskan Native  Asian  African/American  Hispanic  White  Hawaiian/Pacific Islander  Other \_\_\_\_\_

### GUARANTOR INFORMATION (Person who is financially responsible)

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Mailing Address: \_\_\_\_\_  
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Relationship to Patient:  Spouse  Mother  Father  Sibling  Other (relationship) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

### INSURANCE INFORMATION

**NOTE: Meier Clinics® ONLY files insurance if your provider is contracted with your insurance plan. Complete the following ONLY if we are filing claims for you.**

**Primary** Insurance Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Pt:  Self  Spouse  Parent  Other \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group ID #: \_\_\_\_\_

**Secondary** Insurance Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Pt:  Self  Spouse  Parent  Other \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group ID #: \_\_\_\_\_

### CONSENTS TO RELEASE INFORMATION

I hereby consent for Meier Clinics to contact my Primary Care Physician or other health care provider as noted below regarding my treatment, as deemed necessary. This consent shall remain in force during my treatment at Meier Clinics and for 90 days following my last visit unless expressly revoked by me in writing.

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

I hereby consent for Meier Clinics to contact the person(s) below as deemed necessary regarding the information indicated. This consent shall remain in force during my treatment at Meier Clinics and for 90 days following my last visit or after services have been paid in full unless expressly revoked by me in writing.

<u>Name</u>	<u>Relationship</u>	<u>Daytime Phone #</u>	<u>Evening Phone #</u>	<u>OK to leave message</u>	<u>Financial Info.</u>	<u>Medical Info.</u>	<u>Other (Specify)</u>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**CONSENT FOR CONTACT**

I agree to have my name placed on a mailing list to receive follow-up contact from Meier Clinics, including, but not limited to, seminars/events, educational information, Meier Clinics updates, etc. I understand that I can revoke this consent at any time. By initialing, I provide my consent. Initials: \_\_\_\_\_

**ACKNOWLEDGEMENTS**

By signing below, I acknowledge the following:

- I have been offered the "Notice of Privacy Policies and Clients Rights."
- I have consented to treatment provided by Meier Clinics and its employees or designees (caregivers). I authorize the services deemed necessary or advisable by my caregivers to address my needs.
- I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Meier Clinics. I authorize Meier Clinics to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Meier Clinics may release objective clinical information related to my diagnosis and treatment that may be requested by my insurance company (if applicable) or its designated agent.
- I authorize and request my insurance plan(if applicable) pay directly to Meier Clinics the amount due for services rendered to the patient, myself, or others covered by the above insurance plan(s). I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered. I understand that this consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this consent will be null and void six months after the final payment has been received on this account. This consent is subject to state and federal confidentiality regulations.
- I agree to take full responsibility for the entire amount due for any and all services rendered. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by the insurance plan. If I do not inform Meier Clinics in a timely manner of any changes to my insurance coverage, I understand that I may need to pay for services in full if payment is denied in part or in full by my insurance carrier. I further understand that I may not be able to schedule appointments if my account becomes delinquent and/or my account is turned over to collections.
- I understand that my patient records are the property of Meier Clinics and shall be treated as confidential; that Meier Clinics will conduct routine patient audits to insure quality record maintenance; that my records will not be released without my written consent or as provided by the laws of the State where I am receiving treatment. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing using Meier Clinics "Authorization for Use and Disclosure of Protected Health Information" form or another acceptable form, with the exception of information I have agreed to release per this Acknowledgement.
- I acknowledge that if I need to cancel or reschedule an appointment I will provide a minimum of one business day's notice. Otherwise, I understand that I am subject to the full charge for the missed appointment and am responsible for payment in full.
- I acknowledge that Meier Clinics is not a 24/7 care facility and that I am responsible for seeking care at my nearest emergency center or through another provider of choice when my Meier Clinics caregiver is not available.
- I certify that all the information I have provided above is true and correct.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor's Signature (if not patient): \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Name (please print): \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF APPLICABLE**

**CHILD AND ADOLESCENT CONSENT FOR TREATMENT**

I certify that I am the  father,  mother,  legal guardian and have legal custody of the above named patient. I, hereby, give my authorization and consent for the patient to receive outpatient assessment/treatment from \_\_\_\_\_ . I understand it is the policy of Meier Clinics that the parent/guardian bringing the patient for treatment is responsible for payment at the time services are rendered. I will be responsible for payment of the patient's treatment regardless of any financial arrangement for payment of the patient's medical care, either oral or written, with the patient's other parent or responsible party. I understand that Meier Clinics assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements for the patient's medical care.

Parent/Guardian Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TO BE COMPLETED ONLY BY STAFF Provider: \_\_\_\_\_ Appt: \_\_\_\_\_ Acct. #: \_\_\_\_\_

Staff Witness: \_\_\_\_\_ Comments: \_\_\_\_\_