MEIER CLINICS PATIENT REGISTRATION

PATIENT INFORMATION

Name:____
(Last) (First) (Middle Initial) (Nickname)

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

Home Phone:____________________ Work Phone:____________________Ext. #:________ Cell:____________________

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 if different from patient above.)

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.

Name	Relationship	Daytime Phone #	Evening Phone #	OK to leave message	Financial Info.	Medical Info.	Other (Specify)
				❑	❑	❑	
				❑	❑	❑	
				❑	❑	❑	

CONSENT FOR CONTACT VIA E-MAIL

By providing an e-mail below, I hereby consent to the following: Contact by Meier Clinics (MC) via e-mail communication at the personal address below. I am 18 years old or older, or the e-mail is that of a parent/legal guardian. E-mails may be viewed by unintended persons as e-mails are not sent by way of encryption. E-mail communication may be seen, received and/or responded to by any MC staff. E-mail is not intended for clinical purposes or as a replacement to therapy but may be used as a simple adjunct to therapy or for administrative purposes (i.e., billing, appointments, satisfaction surveys, donor opportunities, events, etc.). I release and hold harmless MC and MC staff for any claim(s) I may have, past, present and future, arising from the use of e-mail. This consent will remain in force until I provide written revocation to MC.

E-mail Address:

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 understand Meier Clinics serves as a training ground for mental health professionals and that I may be seen by an intern who will provide care to me under the supervision of a licensed professional. 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 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 attest that I am coming strictly for counseling needs, not for any type of litigation purposes. If in the course of my care, I become involved in litigation and need Meier Clinics to provide any type of report, testimony or other litigation required services, I understand I am fully responsible for any fees for these services and that these fees are payable in full and in advance of services.
- 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 if applicable): ______________________________

PLEASE COMPLETE THIS 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: ______________

MEIER CLINICS

PSYCHOSOCIAL ASSESSMENT

Age 16 and Above

Name: ____ Acct. # ________________

Age: _____ DOB: ___________ Sex: _____ Clinician: ___________________________________

DIRECTIONS: Please answer the following questions as fully as possible.

Problem Assessment

Present Problem/Stressors —*Please check all that apply:*

❑ Marital issues ❑ Health issues ❑ Job issues ❑ Financial issues
❑ Parent/child issues ❑ Issues of past (guilt, abuse, neglect, family of origin issues, etc.)
❑ Other ____

Symptoms —*Please check all that apply:*

❑ Change in sleep pattern ❑ Depressed mood ❑ Mood swings
❑ Decreased energy ❑ Decreased interest or pleasure ❑ Anger problems
❑ Decreased concentration ❑ Change in appetite ❑ Thoughts of death
❑ Decreased motivation ❑ Anxiety/Worry/Panic
❑ Other ____

Suicidal/Homicidal Ideation —*Please check all that apply:*

Have you attempted to commit suicide or homicide in the past? ❑ yes ❑ no
If yes, how? ____
Is there a history of suicide in your nuclear and/or extended family? ❑ yes ❑ no
Have you ever inflicted burns or wounds on yourself? ❑ yes ❑ no
Are you presently suicidal or homicidal? ❑ yes ❑ no
Are there any other risk-taking behaviors that you engage in? ❑ yes ❑ no
If yes, please explain ____

What event(s) in the recent past has prompted you to seek counseling? ______________________
____
____

Describe additional problems you are experiencing. ______________________________
____
____
____

When did these problems develop? ____
____
____

Check any recent losses you have experienced.
❑ Family ❑ Health ❑ Disruption of lifestyle ❑ Job ❑ Significant other
❑ Other ____

List your strengths and weaknesses.

Strengths	Weaknesses

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If applicable, please list abilities/interests and preferences that you have.

Abilities/Interests	Preferences

Psychiatric History

Have you ever had any previous outpatient counseling? ❑ yes ❑ no If yes, please complete information below.

Place	Length of Time	Date(s)

Have you ever been admitted to the hospital for mental health or addiction issues? ❑ yes ❑ no

Place: ______________________________ Dates: ______________________________

Name of current doctor and/or therapist: ______________________________

Have you ever received a psychiatric diagnosis? ❑ yes ❑ no If yes, please explain. ____________

____

Do you feel medications you have been on, past or present, have been effective? ❑ yes ❑ no

Please explain: ______________________________

List all medications you have taken *in the past* for anxiety, depression, and/or sleep. ____________

____

Medical Information

How would you describe your current condition of health? ______________________________

Do you have any disabilities and/or disorders? ❑ yes ❑ no If yes, explain. ____________

____

Explain any special adjustments needed for the disability or disorder: ______________________________

____

Are you currently on any medication? ❑ yes ❑ no If yes, please complete the information below.

Name of Medication	Dosage/Frequency	Prescribing Physician

Are you allergic to any medications or have you ever had an adverse reaction to medication? ❑ yes ❑ no

If yes, please list: ______________________________

Has it been more than a year since your last physical exam, including blood tests? ❑ yes ❑ no

Have you ever had an abortion? ❑ yes ❑ no Males: Has a child of yours ever been aborted? ❑ yes ❑ no

Do you have allergies? ❑ yes ❑ no If yes, explain. ______________________________

____

Are you pregnant? ❑ yes ❑ no

Could you become pregnant? ❑ yes ❑ no

List any prenatal care you are receiving:______________________________

List any previous health problems, operative procedures, and medical hospitalizations.

Problem	Dates	Treatment

Use History

Describe your current usage, or usage within the past year of the following items.

Substance	Amount	Frequency	Age of 1st Use	Age regular use started	Last use
Caffeine					
Nicotine					
Marijuana					
Alcohol					
Other (please list)					

Have you experienced a recent increase in the use of alcohol and/or other substances? ❑ yes ❑ no

Do you, your family, or your friends see your current usage as a problem? ❑ yes ❑ no If yes, when did it become problematic? ______

Please describe any previous experience with drugs or alcohol. ______

Describe any significant family history of substance abuse. ______

______

______

Nutrition

Do you feel you have balanced, healthy eating patterns? ❑ yes ❑ no

Do you have a lot of concerns about your weight and shape? ❑ yes ❑ no

Do you often eat out of depression, boredom, anger? ❑ yes ❑ no

Do you ever binge eat or fear losing control of your eating? ❑ yes ❑ no

Do you ever self-induce vomiting? ❑ yes ❑ no

How do you feel about eating with others in a group? ______

Do you use laxatives, diuretics (water pills), or diet medications to control your weight? ❑ yes ❑ no

Do you or others believe you exercise excessively? ❑ yes ❑ no

Legal History — Please explain all that apply.

Charges as a minor: ______

Charges presently: ______

Arrests (How many): ______

Incarcerations (How many): ______

Parole: ______

Convictions (How many): ______

Probation: ______

Bankruptcy: ______

Civil Suits: ______

Child Custody Problems: ______

Developmental History

List members of your family of origin and comment on how you got along with each one.

Name	Relationship	Comment

What was your birth order? I was the _____ of _____ children. Who primarily raised you? _________________

How would you describe your childhood? ❑ Traumatic ❑ Painful ❑ Uneventful ❑ Good ❑ Happy

What were you like as a child (include friends, school, hobbies, and personality)? __________________________

____

____

____

Did you have any unusual or traumatic experiences as a child, either experienced or witnessed?

Date	Age	Event

Have you ever been the recipient of unwanted sexual acts? ❑ yes ❑ no

If yes, please explain: ____

Have you ever been the victim of abuse, neglect, or violence? ❑ yes ❑ no

If yes, please explain: ____

Have you ever been the perpetrator of abuse, neglect, or violence towards another person? ❑ yes ❑ no

If yes, please explain: ____

____

____

What is your sexual orientation? ❑ Heterosexual ❑ Homosexual ❑ Bisexual

What is your gender expression? ❑ Male ❑ Female ❑ Other ___________________________

Living Arrangements

❑ Satisfactory? ❑ Unsatisfactory?

Where do you currently live? ____ How long there? ____________

With whom are you living? ____

Describe your current relationships with family members. ____________________________________

____

____

____

____

____

____

Social Relationships/Support System

Who can you count on for support? *Check as many as apply.*

❑Parents ❑Spouse ❑Siblings ❑Extended Family ❑Employer ❑Church ❑Pastor ❑Co-worker
❑Neighbor(s) ❑Close Friend ❑Self-help Group ❑Community Services ❑Therapist ❑Medical Doctor

List close friends, outside of family, if any. ______________________________

____

What are your hobbies or leisure activities? ______________________________

____

Marital History (if applicable)

When were you married? ____________ Name and age of spouse. ______________________________

Previous marriage(s)? ❑ yes ❑ no If yes, date of divorce(s). ______________________________

How many children from above marriage(s)? ______________________________

What is your perception of your current marriage (include communication patterns, problems, sexual relations).

____

____

____

List names and ages of children. How do you get along with each one?

Name	Age	Comment

Financial Situation

Describe briefly your financial situation. ______________________________

____

____

____

Religious/Cultural Factors

What is your religious background? ______________________________

Describe the religious atmosphere in your home (past or present). ______________________________

____

____

____

____

Do you currently attend church, synagogue, mosque, or other religious services? ❑ yes ❑ no

What does God seem like to you? ______________________________

____

____

____

____

Describe your relationship with God. ______________________________

____

____

____

____

What do you consider to be the role of God in your recovery? ____

Please list any issues (positive or negative) which are important or may have affected you in regard to religion or ethnic/cultural background. ____

Educational History

What was school like for you? ____

Highest grade level achieved. ____________ What type of grades did you make? ____________________

Are you currently in school? ❑ yes ❑ no If yes, what grade level? ____________________

How would you describe your current literacy level? ______________________________

Work Adjustment History

Describe your current job/career. ____

Would you enjoy doing this job on a long-term basis? ______________________________

How do you deal with authority figures? ____

Describe your relationship with co-workers. ____

Describe your job performance. ____

Have you ever been fired or laid-off? ❑ yes ❑ no If yes, explain. ____________________

How many jobs have you held within the previous five years? ______________________________

Military History

List branch, dates, and duties. ____

____

____

Family

Would it be beneficial for any member(s) of your family/legal guardian to be involved in your treatment? explain who and why. ____

____

____

____

May we contact any of the persons you have mentioned above for their input and involvement in your care?

❑ yes ❑ no If yes, Contact Information: ____

What is your family/legal guardian's perception of your difficulties? ______________________________

____

____

____

____

Miscellaneous

Are there any other things that would be helpful for us to know about you? ______________________

____

____

____

____

With your permission, is there anyone else that would be appropriate to contact in regard to your care?

❑ yes ❑ no Name and phone number. ____

How were you referred to Meier Clinics®? ____

Is there anyone that we are legally required to notify in regard to your care? ❑ yes ❑ no

If yes, please give us the necessary information to contact them. ______________________________

____

Is there a need for assistive technology in your treatment? ❑ yes ❑ no If yes, what is that need? __________

____

____

What would you like to accomplish during your treatment with Meier Clinics®? ____________________

____

____

____

____

____

____

Client Signature: ______________________________ Date: ____________________

Read and Reviewed by ______________________________ Date: ____________________

(Clinician)

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MISSED APPOINTMENT AGREEMENT

After your first visit, follow-up appointment frequency will be individualized as appropriate for your individual treatment needs. Office visits are required for ongoing assessment of your clinical status and appropriate care. Sessions are 45-50 minutes in length.

Payment is due at time of service. If you have an outstanding balance, either the balance needs to be paid in full or a payment plan needs to be set up with our billing department before a follow-up appointment can be scheduled.

Please be careful to keep track of all of your appointments. We make every effort to call and remind you of your appointment but this is a *courtesy* call.

If you need to change an appointment, please provide as much notice as possible as this time is reserved solely for you. In accordance with clinic policy, you will be charged for appointments cancelled with less than 24 hours notice and for missed appointments. Insurance companies do not cover missed appointments, therefore, Meier Clinics will not bill your insurance plan(s). The credit card you placed on file will automatically be processed for any missed appointment charges.

The fee for the first late cancellation appointment is half of the full fee for the session. The fee for subsequent late cancellations and missed appointments is the full fee for the session.

Session Length	Fee			
	PhD	LPC	LPC Intern	Practicum
45-50 mins.	$154.00	$134.00	$51.00	$26.00

Multiple missed appointments, late cancellations, or consistently rescheduled appointments may result in termination of service.

Please make arrangements for childcare, as infants and children who are not here for treatment are not allowed in sessions or to be left unattended. If you are the parent of a child in treatment and want updates on their progress, you can schedule a separate appointment with me or we can meet individually for 10-15 minutes during your child's appointment. Please note the latter option will reduce the appointment time for your child.

If you are significantly late for an appointment, please be aware that you will most likely need to reschedule your appointment so that other clients' scheduled times are not adversely affected. If you think you may be late, please call ahead to inform the office staff so they can determine if there is any flexibility in the appointment schedule for the day to accommodate your late arrival.

____________________________________ ____________________________________

Client Signature Provider Signature

____________________________________ ____________________________________

Printed Client Name Printed Provider Name

MEIER CLINICS
One of the most trusted names in Christian Counseling

CREDIT CARD AUTHORIZATION WORKSHEET

(PRINT ALL INFORMATION LEGIBLY AND COMPLETE FORM IN ITS ENTIRETY)

DATE:____________________ LOCATION/FACILITY: ________________________________

PROVIDER: ____

CLIENT NAME: ____

CLIENT ACCOUNT NUMBER: ____

DATE(S) OF SERVICE BEING PAID: ____

CARD HOLDER NAME: ____
(EXACTLY AS IT APPEARS ON CREDIT CARD)

MAILING ADDRESS: ____

CITY, STATE, ZIP ____

CARD NUMBER: ____ CVV Code: ___________
(Amts. over $50)

EXPIRATION DATE: ________/____________ AMOUNT: $__________________(dollars & cents)

CIRCLE ONE: MasterCard Visa American Express Discover

I authorize Meier Clinics® to keep my signature on file and to charge my credit card for all late cancellations or missed appointments during my treatment at Meier Clinics.

This agreement for payment shall not exceed $________________ (dollars & cents) per service.

CARD HOLDER SIGNATURE: ____________________________________ DATE: ___________

PROCESSED BY: ____ DATE: ________________

COMMENTS: ____

____

MC Staff: *Send or fax completed form with your record of services (fee ticket/summary) to your collector.*

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