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)
				❒	❒	❒	
				❒	❒	❒	
				❒	❒	❒	
	Pastor			❒	❒	❒	

CONSENT FOR CONTACT

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: _____

Appointment Reminders: ❑ text me at _____ **OR** ❑ call me at _____

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: _____

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

Staff Witness: _____Comments:_____

PARENT/LEGAL GUARDIAN QUESTIONNAIRE/PSYCHOSOCIAL

Child and Adolescent Assessment for Ages 15 and Younger

Name of Child/Adolescent: _____ Age: _____ Sex: ❒ M ❒ F

Grade: _____ School: _____ Ethnicity/Race: _____

What event(s) or problems have caused you to come for treatment? _____

_____

_____

_____

PAST TREATMENT

Has your child ever had any previous mental health treatment? ❒ Yes ❒ No

If so, check which type(s) and the date/age at time of treatment:

- ❒ Psychological Testing: _____
- ❒ Individual/Group/Family Therapy: _____
- ❒ Psychiatric Hospitalization: _____
- ❒ Residential Treatment: _____

What was the diagnosis? _____

Is your child currently on any medications? ❒ Yes ❒ No

List: _____

_____

What medications has your child taken in the past for anxiety, depression, ADHD, etc?

List: _____

_____

_____

Do you think any of these medications, past or present, have been effective? ❒ Yes ❒ No

Please explain: _____

_____

_____

_____

SYMPTOMS Please check any that apply presently or in the past.

❒ Sleep Problems	❒ Anger Problems	❒ Behavior Problems at School
❒ Nightmares	❒ Mood Swings	❒ Academic Problems
❒ Low Energy	❒ Temper Tantrums	❒ Talk/Thoughts of Death
❒ Concentration Problems	❒ Depressed Mood	❒ Hurt Self or Others
❒ Appetite Problems	❒ Anxiety/Worry/Panic	❒ Harm to Animals
❒ Bingeing/Purging	❒ Obsession/Compulsions	❒ Alcohol/Drug/Tobacco Use
❒ Health Complaints (e.g., headaches, stomach aches)	❒ Fears	❒ Sexual Acting Out
	❒ Oppositional/Defiant	❒ Runaway

MEDICAL HISTORY

Please rate your child/adolescent in each of the following areas:

	Good	Fair	Poor
Health			
Hearing			
Vision			
Gross Motor Coordination			
Fine Motor Coordination			
Speech Articulation			

Did your child/adolescent experience prenatal exposure to alcohol, tobacco or drugs? ❒ Yes ❒ No

Has your child/adolescent's physical development been normal? ❒ Yes ❒ No

If no, please explain: _____

Has your child/adolescent had any chronic health problems (e.g. asthma, diabetes, heart condition)? ❒ Yes ❒ No

If yes, please explain: _____

Are immunizations current and up to date? ❒ Yes ❒ No

Check which of the following illnesses your child/adolescent has had:

❒ Mumps ❒ Chicken Pox ❒ Measles ❒ Whooping Cough ❒ Scarlet Fever ❒ Pneumonia ❒ Seizures
❒ Encephalitis ❒ Otitis Media ❒ Lead Poisoning ❒ Other _____

How many accidents has your child/adolescent had? ❒ One ❒ 2-3 ❒ 4-7 ❒ 8-12 ❒ over 12

Check if your child/adolescent has had any accidents resulting in the following:

❒ Broken Bones ❒ Head Injury ❒ Stomach Pumped ❒ Lost Teeth ❒ Eye Injury ❒ Severe Lacerations
❒ Stitches ❒ Severe Bruises ❒ Other _____

Check if your child/adolescent has had surgery for any of the following conditions:

❒ Tonsillitis ❒ Appendicitis ❒ Leg Or Arm ❒ Burns ❒ Adenoids ❒ Digestive Disorder ❒ Hernia
❒ Eye, Ear, Nose or Throat ❒ Urinary Tract ❒ Other _____

Does your child/adolescent have bladder control problems?

At night? ❒ Yes ❒ No If yes, how often? _____

During the day? ❒ Yes ❒ No If yes, how often? _____

Does your child/adolescent have bowel control problems?

At night? ❒ Yes ❒ No If yes, how often? _____

During the day? ❒ Yes ❒ No If yes, how often? _____

Has your child/adolescent ever been diagnosed with a medical problem? ❒ Yes ❒ No

If yes, what and how treated? _____

_____

_____

_____

_____

What are your child/adolescent's current medical needs? _____

_____

_____

_____

_____

_____

_____

SEXUAL MATURATION HISTORY

At what age did your child/adolescent show adult body development? _____

At what age did your daughter begin menstruating? _____

Were there any special problems with the onset of menstruation/body development? ❒ Yes ❒ No

Does your child/adolescent appear appropriately comfortable with the opposite sex? ❒ Yes ❒ No

Is your child/adolescent sexually active? ❒ Yes ❒ No ❒ Don't Know

Have there been any pregnancies or abortions? ❒ Yes ❒ No ❒ Don't Know

Has your child/adolescent ever been the recipient of or perpetrator of neglect, violence, or sexual abuse? ❒ Yes ❒ No

If yes, please explain: _____

_____

_____

Additional Comments: _____

_____

_____

SCHOOL HISTORY

Indicate any of the following school problems that apply.

	During what grade(s)?
Oppositional	
Disrupt class	
Inattentive	
Refuse to go to school	
Fail to turn in work	
Disorganized	
In-school suspension	
Out-of-school suspension	
Expelled from School	

Has your child/adolescent ever had problems with his or her learning ability? ❒ Yes ❒ No

If yes, please explain: _____

_____

Summarize your child/adolescent's progress (e.g. grades, academic, social, behavioral) within each of the following grade levels. Also list whether your child/adolescent attended public, private or home school.

Preschool: _____

Kindergarten: _____

Grades 1-3: _____

Grades 4-6: _____

Middle School/Junior High: _____

High School: _____

Have instructional modifications been attempted? ❒ Yes ❒ No

If yes, please list: _____

_____

Has your child/adolescent had any educational testing? ❒ Yes ❒ No

If yes, please list: _____

_____

What is your child's learning style? _____

SOCIAL HISTORY

How does your child/adolescent get along with his/her brothers/sisters?

❒ Better than average ❒ Average ❒ Worse than average ❒ Doesn't have any siblings

How easily does your child/adolescent make friends?

❒ Easier than average ❒ Average ❒ Worse than average

About how many close friends does your child/adolescent have?

❒ None ❒ 1 ❒ 2 or 3 ❒ 4 or more

On the average, how long does your child/adolescent keep friendships?

❒ Less than 6 months ❒ 6 months – 1 year ❒ 2 years or more

Describe your child socially:

❒ Withdrawn ❒ Insecure ❒ Outgoing ❒ Passive ❒ Aggressive ❒ Other _____

What extracurricular activities is your child/adolescent involved in? _____

_____

What jobs or chores does your child/adolescent have? _____

_____

Has your child/adolescent ever had any legal problems? ❒ Yes ❒ No

If yes, please explain: _____

_____

Are you aware of any alcohol, tobacco, and/or other drug use by your child/adolescent? ❒ Yes ❒ No

If yes, please explain: _____

_____

RELIGIOUS/FAITH HISTORY

What is your family's religious background? _____

Does your child/adolescent currently attend religious services? ❒ Yes ❒ No

If yes, where? _____

Please list any issues (positive or negative) that are important or may have affected your child in regard to faith:

_____

_____

_____

_____

FAMILY HISTORY

Check if there is any history of the following in the family. If yes, write in who (e.g., mother, grandfather, aunt, etc.)

	Who		Who
Learning Disabilities		Physical or Sexual Abuse	
ADD/ADHD		Psychosis or Schizophrenia	
Mental Retardation		Tics or Tourettes	
Depression		Bipolar Disorder (Manic Depression)	
Anxiety Disorder		Birth Defects	
Alcohol or Drug Abuse		Diabetes	
Arrests		Suicide Attempts/Suicide	

Who has legal custody of your child/adolescent? _____

Current living situation of child/adolescent:

❒ Both parents' home ❒ Relative's Home

❒ One parent's home ❒ Friend's Home

❒ Legal guardian's home ❒ Other _____

Primary living situation for past year:

❒ Both parent's home ❒ Relative's Home

❒ One parent's home ❒ Friend's Home

❒ Legal guardian's home ❒ Other _____

Please describe the family home: ❒ House ❒ Apartment ❒ Condo Other _____

Number of rooms _____ Number of bathrooms _____ Number of bedrooms _____

Please indicate who sleeps in each bedroom: _____

_____

Please describe your neighborhood: _____

_____

Who has taken care of your child/adolescent most of their life? _____

_____

Who is the primary disciplinarian in the family? _____

Are they: ❒ Strict ❒ Lenient

Do parents agree on the issues of parenting, rules and discipline? ❒ Always ❒ Usually ❒ Sometimes ❒ Rarely

What strategies have been used to address problems? (Check those that apply and circle those that have been successful):

❒ Verbal Reprimands ❒ Time Out ❒ Removal of Privileges ❒ Rewards

❒ Physical Punishment ❒ Giving In To your child ❒ Avoiding your child

On the average, what percentage of time does your child/adolescent comply with initial commands?

❒ 0-20% ❒ 21-40% ❒ 41-60% ❒ 61-80% ❒ 81-100%

On the average, what percentage of the time does your child/adolescent eventually comply with commands?

❒ 0-20% ❒ 21-40% ❒ 41-60% ❒ 61-80% ❒ 81-100%

Do parents get along with one another? ❒ Always ❒ Usually ❒ Sometimes ❒ Rarely

Have there been or are there currently any major changes or stresses in the family where your child was raised?

❒ Yes ❒ No If yes, please check all the following that apply:

	In past	Current (6 months or less)
Financial problems		
Frequent moves		
Job changes		
Drinking and/or drug problems		
Arguments between parents/partners		
Separation or divorce of parents		
Remarriage of parent(s)		
Separation from sibling(s)		
Frequent physical punishment		
Physical confrontations between parents/partners		
Mental illness in family		
Physical illness in family		
Psychiatric hospitalization of a parent/partner		
Death in the family		
Incestuous behavior in family		
Other: Explain		

What are the family's strengths? _____

_____

_____

What are the family's weaknesses? _____

_____

_____

What are your child/adolescent's strengths? _____

_____

_____

What are your child/adolescent's weaknesses? _____

_____

_____

What do you see as an issue(s) important to your child/adolescent? _____

_____

_____

Please mark any of the statements below that apply to your family:

	Yes	No
Our family is warm and loving.		
People are often arguing in our family.		
Everyone goes his or her own separate way.		
Family members say what is on their minds.		
Our family hides things.		

What would you like to change about your family? _____

_____

_____

_____

_____

How has the family been changed by your child/adolescent's problem(s)? _____

_____

_____

_____

_____

What is the family's expectation of treatment? _____

_____

_____

_____

_____

What does the family see as their role in treatment? Which family members are willing and able to participate?

_____

_____

_____

_____

_____

List any disabilities or disorders that your child/adolescent has that were not previously mentioned?

_____

_____

_____

_____

Describe your child/adolescent's adjustment to these disabilities and/or disorders. _____

_____

_____

_____

_____

Is there a need for assistive technology in the treatment of your child/adolescent? ❒ Yes ❒ No

If yes, what is that need? _____

_____

_____

_____

Is there anything else about your child/adolescent or family that we should know in order to be more helpful?

_____

_____

_____

_____

_____

_____

_____

<u>Note</u>: Bring this form, as well as psychological or educational test results, report cards, behavior modification charts and any other pertinent documents to your next appointment.

_____ _____

(Parent/Legal Guardian Signature) (Date)

Read and Reviewed by _____ _____

(Clinician) (Date)

MEIER CLINICS
One of the most trusted names in Christian Counseling
1-888-7CLINIC

MISSED APPOINTMENT AGREEMENT

After your first visit, follow-up appointment frequency will be individualized as appropriate. Office visits are required for my ongoing assessment of your clinical status and treatment needs.

Sessions are 45-50 minutes.

Payment is due at time of service. If you have an outstanding balance, to schedule follow-up appointments, either the balance needs to be paid, or a payment plan needs to be worked out with our billing department.

Please be careful to keep track of all your appointments. I appreciate as much notice of appointment changes as possible, as I do not schedule more than one person per appointment time.

We make every effort to call and remind you of your appointment but this is a *courtesy* call. In accordance with clinic policy, you will be charged for appointments cancelled without 24 hours' notice and for missed appointments as well. Insurance companies do not provide a benefit for missed appointments. Therefore, Meier Clinics will not bill your insurance plan and/or other secondary insurance plans today or at any time in the future for missed appointments. If 24-hour notice is not given, then your credit card that you have placed on file with me will be automatically charged.

The fee for the first late-cancel appointment is half of the full rate for the session.
The fee for a no-show, no-call appointment is the full rate for the session.

Session Length	Ph.D. Rate	LPC Rate	LPC Intern Rate	Practicum Rate
45-50 minutes	**$154.00**	**$134.00**	**$51.00**	**$26.00**

Multiple missed appointments, late cancellations, or consistently rescheduled appointments may result in termination of our clinician-patient relationship.

Please make arrangements for childcare, as infants and children who are not here for treatment are not allowed in sessions. If you are the parent of a minor in treatment and want updates on progress, you can make an appointment on my calendar, or we can meet individually for 10-15 minutes during your child's appointment. Please note the latter option cuts in the appointment time for your child.

Late Arrival:

I will not be able to see patients who are significantly late for their appointments. It disrupts the schedule for the entire day and is not fair to the patients who arrive on time. If you think you may be late, please call ahead.

_____ _____

Signature of Client Signature of Provider

_____ _____

Printed Name of Client Printed Name of Provider

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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: _____/_____

CIRCLE ONE: MasterCard Visa American Express Discover

I authorize Meier Clinics® to keep my signature on file and to charge my credit card as indicated below:

____ All late cancellation or missed appointments this year.

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.*