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: _____

TO BE COMPLETED ONLY BY STAFF Provider:_____ Appt: _

_____ Acct. #:_____

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
□ ρ 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 Coordinator			
Fine Motor Coordinator			
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 ρ 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 ρ Don't Know

Have there been any pregnancies or abortions? □ Yes □ No ρ 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 Tourette's	
Depression		Bipolar Disorder (manic depression)	
Anxiety Disorder		Birth Defects	
Alcohol or drug abuse		Diabetes	
Arrests		Suicide Attempts/Suicide	

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

Adolescent Questionnaire

NOTE: THIS FORM IS OPTIONAL! Any information you give me would help me to know more about you (rather than just what your parents say about you). If you would rather not, please feel free to answer only part or none of the questions.

Name: _____ Age: _____

How do you feel about being here?

( ) It's fine with me

( ) I don't care either way

( ) I'm against it

Have you ever seen a counselor before? ( ) Yes ( ) No

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

_____

_____

_____

Health

Check all that apply to you:

( ) I have difficulty falling asleep.

( ) I wake up frequently during the night.

( ) I wake up very early and can't get back to sleep.

( ) I feel tired much of the time.

( ) I have gained or lost 10 lbs. or more within the past 2 months.

( ) I sometimes eat way too much or feel my eating is out of control.

( ) I sometimes vomit after eating too much to get rid of the food.

( ) I have a hard time concentrating.

( ) My memory is not as good as it used to be.

( ) I have stomach aches or headaches a lot.

( ) I have thoughts that trouble me sometimes.

( ) I worry a lot.

( ) Sometimes I wish I didn't have to go on living.

Check below the three (3) feelings you most often have:

( ) happy	( ) sad	( ) angry
( ) irritable/"touchy"	( ) anxious/nervous	( ) bored
( ) confused	( ) confident	( ) shy
( ) "hyped up"/energetic	( ) guilty	( ) depressed
( ) worried	( ) lonely	( ) worthless

List any medications you are currently taking: _____

School

What school do you go to? _____

What grade are you in? _____

What activities (if any) are you in at school (such as sports, music etc.)?

_____

What do you like the most about school? _____

What do you like the least about school?_____

Activities and Interests

What do you do for fun?

_____

What activity would you like to do that you haven't done yet in your life?_____

_____

Friendships & Relationships

How much time do you spend with others your age? ( ) a lot of time ( ) some time ( ) not much time

Do you have a "best" friend? ( ) Yes ( ) No

If so, how long have you known him/her? _____

Do you have a boyfriend/girlfriend? ( ) Yes ( ) No

If so, how long have you been dating? _____

Do people at school tend to label your group of friends (e.g. skaters, metalheads, preps, etc.)?

( ) Yes ( ) No

If so, what label would you usually be given?

_____

Do you have someone you can talk to about personal issues in your life? ( ) Yes ( ) No

If so, who? _____

How do you generally think of adults? (Please check all that apply)

( ) helpful
( ) friendly
( ) overly strict
( ) smart or wise most of the time
( ) can be trusted and counted on
( ) usually mean
( ) out of touch with you
( ) caring
( ) jerks
( ) stupid or dumb most of the time
( ) can't be trusted or counted on

Drug and Alcohol Use

	Never	Tried	Rarely	Monthly	Weekly	Daily
How often do you drink?	( )	( )	( )	( )	( )	( )
Smoke cigarettes?	( )	( )	( )	( )	( )	( )
Smoke marijuana?	( )	( )	( )	( )	( )	( )
Use cocaine/crack?	( )	( )	( )	( )	( )	( )
Use acid/LSD?	( )	( )	( )	( )	( )	( )

Tried other drugs? (Please list) _____

Family

Describe your family in a few words: _____

_____

Who do you get along with the best in your family? _____

_____

What would you change about your family if you were given the power to do so? _____

_____

Faith

Do you currently attend church, synagogue, or mosque? ( ) Yes ( ) No

Are you involved in a religious youth group? ( ) Yes ( ) No

Have you had any positive or negative experiences related to your faith? ( ) Yes ( ) No

Please List: _____

General

What is your earliest memory from childhood? _____

_____

Please list any major changes in your life over the past five (5) years (e.g., moving, parents divorced, etc.):

_____

Is there anything else you want me to know about you?

_____

_____

_____

_____

Signature Date

MEIER CLINICS
One of the most trusted names in Christian Counseling

Grant Davis, APRN, MSN, PMHNP-BC

Telephone 972/437-4698 Voice Mail Extension 108

CLIENT – PATIENT AGREEMENT & TREATMENT CONSENT

GENERAL: I ask all new patients to carefully read this Agreement. Mark one copy with any questions you have and we will discuss them during your appointment. It will then become a part of your clinic record; keep the other copy for your records.

All medical staff and therapists within Meier Clinics® document your care in the same chart and communicate with each other as appropriate to coordinate your care. If you are seeing a therapist outside of Meier Clinics, I would appreciate a signed release of information so that I may speak with him/her as needed. Please direct any necessary questions between appointments to him/her unless your questions relate to medication issues.

In accordance with Meier Clinics' policy, I am not involved in worker's compensation cases, disability evaluations, child custody, or other legal matters. Therefore, you will need to be referred to another psychiatrist if the need for testimony and/or reports arises.

APPOINTMENTS AND FEES: After your first visit, I will need to see you within 1 to 4 weeks to review your progress. Thereafter, follow-up appointment frequency will be individualized as appropriate. Office visits are required for my ongoing assessment of your clinical status and treatment needs. I ask that you make every effort to arrange for childcare during appointments.

The length for follow-up appointments may vary. Normally, the time is 15 minutes. Payment is due at time of service.

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

Multiple missed appointments may result in termination of our clinician-patient relationship.

Late Arrival: I will not be able to see patients who are 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. If it is possible to exchange your appointment with another patient, we will make every *effort* to do so.

PHONE CALLS & EMERGENCIES: If needs arise that cannot wait until your next appointment, leave a message on my voice mail (ext.125) complete with details of your question or concern. Messages are retrieved Monday through Friday 9:00 a.m. to 3:00 p.m. I will respond to your call no later than the next business day. If you have an urgent need and CANNOT wait for a return phone call, or you are in danger of harming yourself, harming someone else, or being harmed by someone, go to the nearest hospital emergency room or call 911! Please do not leave any messages for me with the front office staff. All messages are to be left on my voice mail. Every effort is made to return your call the same day; however, please allow 24 hours for any non-urgent call. Emergency calls are to be restricted to needs that cannot wait until the next business day. The afterhours phone number is 972-216-6102. Refills are not considered an emergency and will be handled only during regular business hours.

Fees for Phone Calls: The fees for clinician phone calls are as follows:

After Hours Emergency
1. 5-15 minutes = $62
2. 15-30 minutes = $93
3. 30+ minutes = $165

Successful treatment requires that you attend all scheduled sessions and express your ideas and emotions honestly and openly using verbal communication. Threats or acts of physical harm to me, others, or clinic property will result in immediate termination of treatment and notification of the proper authorities.

It is important that I always have your current address, home and work phone numbers. I also need you to designate an emergency contact person:

Name: _____
Phone: _____
Relationship to you: _____

LAB WORK: I check laboratory values on all of my patients at least yearly, as there are many physiological factors that play a large role in mood and sleep. You can use the laboratory of your choice (patients with insurance need to find out which laboratories accept their insurance). The lab will bill you or your insurance company directly. Refusal to follow through with requested lab work is considered medical non-compliance. If I suspect illicit drug use, I may request you complete a drug screen.

CONFIDENTIALITY: Clinician-patient confidentiality is limited under the following circumstances:

- If a third-party payer (employer, insurance or managed care company, etc.) who is directly or indirectly paying for your care requests information or records.
- If a legal action is filed in which your mental health is at issue, and I am asked or ordered to testify.
- If malpractice is alleged.
- If I become aware of abuse or neglect of a child, elder, or disabled person, I am obligated to report it to the appropriate authorities.
- If I determine you are an imminent danger to yourself or others, I must contact a family member and/or the police in an effort to provide for your/others' safety.
- We cannot respond to any phone calls or correspondence from family members or friends unless we have a signed consent from you.

MEDICATION MANAGEMENT:

In order to provide the best quality care, treatment is not conducted over the phone.

THE FOLLOWING REQUIRE AN APPOINTMENT:

1. New prescriptions and medication refills.
2. Any adjustment that needs to be made to your current medications.
3. If you are having problems with your medication such as side effects or if you feel they are not effective in managing your symptoms.
4. If you notice a change in your mood or personality.

You will be prescribed enough medication to last until your follow-up appointment, at which time you will be given medication refills. The following prescription refill requests that are in-between appointments will incur a $15 *non-insurance reimbursable* charge:

1. Failing to make an appointment before medication runs out
2. A lost or stolen script
3. Letting a script expire

Patients who fail to make an appointment before medication runs out will only be given a 2 week refill, in which time a follow-up appointment must be made. The enforcement of these refill policies is at the discretion of each provider.

CONTROLLED AND SCHEDULED MEDICATIONS

Lost or stolen prescriptions for a controlled or scheduled medication will not be replaced or filled early. These medications include such medicine as Klonopin, Xanax, Ativan, Valium etc.; ADD medicine such as Adderall, Ritalin, Concerta, Vyvanse, Focalin etc.; and sleep aids like Ambien and Lunesta. **In order**

to provide appropriate treatment, I insist that I be the only physician prescribing your psychiatric medications, including sleep aids.

MEDICATION USE PRECAUTIONS: Any medication can impair thinking or reaction time until your body gets accustomed to it. Therefore, do not operate hazardous machinery, including automobiles or do anything potentially dangerous until you are certain any newly prescribed medication(s) do not affect your abilities. It is necessary to notify me and all your other doctors of any and all changes in prescribed and over-the-counter medicines including "herbal/natural" remedies. Contact me if you experience any unanticipated medication effects including a skin rash, as that indicates a medication allergy. I advise you not to consume alcohol, including beer or illicit drugs, while taking medication, as this will prevent your medications from working optimally and the combination can be physically dangerous. Mixing alcohol and illicit drugs with your medication or taking more than what is prescribed is considered medical non-compliance, which may result in discontinuation of treatment.

If you or someone else takes more than the recommended dose of a medicine, contact poison control, call 911 or go to an emergency room. Do not allow others to take your medicine and do not take medications prescribed for someone else. Keep all medications out of the reach of children and impaired adults.

WOMEN: Please **notify me** of any pregnancy or intent to become pregnant, as most medications should be discontinued prior to conception. Waiting to stop medication until you miss a menstrual cycle and discover you are pregnant exposes your baby to medication during the critical periods of organ development and can lead to birth defects. Whenever possible, psychiatric medications should not be used at any time during pregnancy or while breastfeeding.

REFERRALS: The only hospital setting in which I see a patient is the Meier Clinics' Catalyst Program. If the need arises for you to be admitted to an inpatient hospital for care, you will be under the authority of that facility's attending psychiatrist. Most of the time the attending physician will contact me, but I cannot guarantee what he or she will do. Resuming your care upon discharge will be worked out according to your specific needs. As your treating clinician, it is my duty to seek your best interest, therefore, I cannot also serve as a consultant or witness in any legal matters and will refer you to another psychiatrist for an objective evaluation if at any time legal reports or testimony is needed. If there is some aspect of your care that we are unable to agree upon, I will need to refer you to another clinician to continue your care.

AGREEMENT: Your signature below indicates that you have carefully read, understand and accept all the terms of this Agreement and that you are hereby giving your consent for appropriate medical treatment by Grant Davis, APRN, MSN, PMHNP-BC. It also indicates, that the risks and benefits of medications have been explained to your satisfaction. Keep your copy of this agreement for future reference. This agreement is in addition to the general Meier Clinics Patient Information and Consent to Treatment which is signed by all new clients.

_____
Print your name

Signature _____ Date _____

MISSED APPOINTMENT AGREEMENT

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 a no-show, no call appointment is $50

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

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

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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Name _____ Date _____ ID # _____

P S Y C H I A T R I C M E D I C I N E S

ANTI-DEPRESSANTS	MOOD STABILIZERS	ANTI-ANXIETY	Major Tranquilizers	ADHD	SLEEP	PAIN
Anafranil	Carbatrol	Ativan (Lorazepam)	Abilify	Adderall	Ambien	Amerge
Aplenzin	Celontin	Buspar	Clozaril	Clonidine	Ambien CR	Anaprox
Brintellix	Depakote	Klonopin (Clonazepam)	Fanapt	Concerta	Dalmane	Axert
Celexa	Dilantin	Librium	Geodon	Cylert	Doxepin	Butalbital
Cymbalta	Felbatol	Moban	Haldol	Daytrana	Lunesta	Codeine
Desyrel	Gabitril	Neurontin	Invega	Dexadrine	Restoril	Darvocet
Effexor	Keppra	Restoril	Latuda	Focalin	Rozerem	Esgic
Elavil	Lamictal	Serax	Loxitane	Intuniv	Silenor	Fiorcet
Emsam	Lithium	Tranxene	Mellaril	Metadate	Sonata	Frova
Fetzima	Lyrica	Valium (Diazepam)	Navane	Methylin	Trazadone	Hydrocodone
Lexapro	Myosline	Vistaril	Prolixin	Nuvigil		Imitrex
Luvox	Phenobarbital	Xanax	Risperdal	Provigil		Lorcet
Nardil	Tegretol		Saphris	Ritalin		Lortab
Norpramin	Topamax		Seroquel	Strattera		Midrin
Pamelor	Trileptal		Stelazine	Tenex		Norco
Parnate	Zarontin		Thorazine	Vyvanse		Percocet
Paxil	Zonegran		Trilafon			Phrenilin
Pristiq			Zyprexa			Stadol
Prozac						Ultracet
Remeron				**ALCOHOL/DRUG**		Ultram
~~Serzone~~				**~~CRAVINGS~~**		~~Vicodin~~
~~Sinequan~~				Campral		~~Zomig~~
~~Viibyrd~~				Naltrexone		~~Zydone~~
~~Vivacti~~		**PSUEDOBULBAR AFFECT(PBA)**		Neurontin		
Wellbutrin		Nuedexta		Suboxone		
Zoloft						

Place a check mark next to any medications you think you may have taken in the past even if it was for a very short time. Then, off to the side please write a one to two word description or phrase describing your experience with the medicine (e.g. “good” “bad” “great” “made me dizzy” “made me sleepy” etc.). Knowing how you responded on certain medication in the past will help us in your treatment.

MEDICATIONS: *Please list medications you are currently taking (psychiatric or other)*

_____

_____

List any Medications you are allergic to:

_____

Name: _____ Date: _____

Age: _____ Marital Status: _____ Employment Status: _____

Date Symptoms Began: _____ Date Symptoms Worsened: _____

What is your goal for seeking Counseling at this time in your life? _____

_____

_____

SYMPTOM CHECKLIST

☐ Depressed or Sad Mood
☐ Irritability/Short tempered
☐ Lack of Motivation/Drive
☐ Poor Concentration
☐ Can't sleep well
☐ Appetite/weight changes
☐ Loss of pleasure in activities
☐ Diminished self-esteem
☐ Hopeless/Helpless
☐ Decreased Energy/fatigue
☐ Excessive guilt or worry
☐ Crying Spells
☐ Decreased sex drive
☐ Intense fear of being fat

☐ Spending sprees
☐ Special Abilities
☐ Increased self-esteem
☐ Decreased need for sleep
☐ Lots of great ideas to get out
☐ Racing thoughts/can't keep up
☐ Increased energy/hyperactive
☐ Increased Sex Drive
☐ Making lots of plans/schemes
☐ Rapid speech
☐ Nonstop talking/can't interrupt
☐ Day-to-Day mood swings

☐ Suspiciousness/Paranoia
☐ Hallucinations (see/hear things)
☐ Unusual facial expressions
☐ Strange posture/gestures
☐ Disorganized thoughts
☐ Confusion
☐ Bizarre Behaviors
☐ Unusual or unwanted thoughts
☐ Constantly washes hands

☐ Anxiety about everything
☐ Intense episodes of fear
☐ Fear of Going crazy/losing control
☐ Chills/Hot flashes
☐ Abdominal distress/nausea
☐ Chest discomfort/choking
☐ Dizziness
☐ Numbness/tingling
☐ Feeling jumpy/on edge/easily startled
☐ Constantly Alert/Vigilant
☐ Nightmares/reliving trauma
☐ Avoiding of stressors/stimulus
☐ Heart racing/palpitations
☐ Sweating
☐ Trembling
☐ Shortness of Breath
☐ "Lump in Throat"/can't swallow
☐ Intense anxiety, fear, or panic
☐ Unable to leave home

☐ Counts things constantly
☐ Impaired intellect/thinking
☐ Language/speech difficulties
☐ Impulsive/poor judgment
☐ Unusual sleep pattern
☐ Disorganized/Confused
☐ Poor Memory

SUBSTANCE ABUSE
☐ Amphetamines/Stimulants
☐ Cocaine/Crack
☐ Marijuana/Cannabis
☐ Alcohol
☐ Sedative/Hypnotics
☐ Opiates/Narcotic pain pills/Heroin

Suicidal thoughts? ☐ Yes ☐ No
☐ passing thoughts/no intent
☐ persistent thoughts
☐ current plans/definite intent
☐ recent attempt
☐ past attempts

☐ Pulling hair out
☐ Anger/Emotional outburst
☐ Binge Eating/Purging
☐ Uncontrolled Gambling
☐ Stealing or Lying
☐ Ritualized behaviors/obsessions

☐ Attention/concentration issues
☐ Impulsive/can't wait turn
☐ Hyperactive/restless
☐ Can't perform at work/school
☐ Aggressive/Assaultive
☐ Self-mutilation/Self-harm
☐ Sleeping all the time
☐ Staring spells
☐ Chronic Pain
☐ Self induced vomiting
☐ Constant agitation
☐ Intense fear of rejection
☐ Legal Troubles
☐ Unexplained body complaints

Personal Past Psychiatric History: ☐ Counseling ☐ Psychiatrist ☐ Hospitalization ☐ Suicidal Attempts

Past or Current Medical Issues (thyroid/high blood pressure/etc): _____

_____

Please List your top 3 symptoms: _____ _____ _____

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and…	Yes	No
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
…you were so irritable that you shouted at people or started fights or arguments?	☐	☐
…you felt much more self-confident than usual?	☐	☐
…you got much less sleep than usual and found you didn't really miss it?	☐	☐
…you were much more talkative or spoke much faster than usual?	☐	☐
…thoughts raced through your head or you couldn't slow your mind down?	☐	☐
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
…you had much more energy than usual?	☐	☐
…you were much more active or did many more things than usual?	☐	☐
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
…you were much more interested in sex than usual?	☐	☐
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
…spending money which got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐
3. How much of a problem did any of these cause you- like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only*. No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

Patient Name		Today's Date					
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.			Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?							
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?							
3. How often do you have problems remembering appointments or obligations?							
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?							
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?							
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?							
							Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?							
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?							
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?							
10. How often do you misplace or have difficulty finding things at home or at work?							
11. How often are you distracted by activity or noise around you?							
12. How often do you leave your seat in meeting or other situations in which you are expected to remain seated?							
13. How often do you feel restless or fidgety?							
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?							
15. How often do you find yourself talking too much when you are in social situations?							
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?							
17. How often do you have difficulty waiting your turn in situations when turn taking is required?							
18. How often do you interrupt others when they are busy?							
							Part B