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 #: _____

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, monthly e-newsletter, 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: _____

CONSENTS TO RELEASE INFORMATION (continued on page 2)

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: _____

CONSENTS TO RELEASE INFORMATION (continued)

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			❑	❑	❑	

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 that I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services. I agree that I am responsible for all deductibles, co-payments, co-insurance amounts, any other patient responsibility indicated by my insurance company and any amounts not paid by my insurance company for the services provided to me by Meier Clinics. I agree that it is my responsibility to provide the most recent, up to date, complete and accurate insurance information and to know my insurance benefits, including whether Meier Clinics is a contracted provider with my insurance company, my covered benefits and any exclusions in my insurance policy, and any pre-authorization requirements of my insurance company. I acknowledge and agree that (1) if I provide false, outdated or inaccurate information with regard to my insurance coverage, including failing to provide coordination of benefits information, (2) if the services provided are not a covered benefit of my insurance plan, (3) if I am no longer covered by this, or any other insurance plan, (4) if I present any insurance card with false, outdated or inaccurate information, or (5) if my insurance company denies payment for any reason, I acknowledge that I will be responsible for all payment obligations arising out of my treatment or care by Meier Clinics. In addition, I acknowledge and agree that I will be responsible for all payment obligations arising out of my treatment or care by Meier Clinics if any of the following apply: (i) my insurance requires prior authorization or a referral before receiving services and I have not obtained such an authorization or referral; (ii) I receive services in excess of such authorization or referral; or (iii) my insurance company determines that the services I received are not medically necessary and/or not covered by my insurance plan. I agree 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): _____