

### 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: \_\_\_\_\_

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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)
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meier Clinics®				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**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, Nightmares, Low Energy, Concentration Problems, Appetite Problems, Bingeing/Purging, Health Complaints (e.g., headaches, stomach aches), Anger Problems, Mood Swings, Temper Tantrums, Depressed Mood, Anxiety/Worry/Panic, Obsession/Compulsions, Fears, Oppositional/Defiant, Behavior Problems at School, Academic Problems, Talk/Thoughts of Death, Hurt Self or Others, Harm to Animals, Alcohol/Drug/Tobacco Use, Sexual Acting Out, 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: 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
- One parent's home
- Legal guardian's home
- Relative's Home
- Friend's Home
- Other \_\_\_\_\_ Primary

living situation for past year:

- Both parent's home
- One parent's home
- Legal guardian's home
- Relative's Home
- Friend'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?

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

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

If yes, what is that need? \_\_\_\_\_

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

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***Note: 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

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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.

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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? \_\_\_\_\_

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### 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:

- |   |  |                                    |
|---|--|------------------------------------|
| <input type="checkbox"/> happy                | <input type="checkbox"/> sad             | <input type="checkbox"/> angry     |
| <input type="checkbox"/> irritable/"touchy"   | <input type="checkbox"/> anxious/nervous | <input type="checkbox"/> bored     |
| <input type="checkbox"/> confused             | <input type="checkbox"/> confident       | <input type="checkbox"/> shy       |
| <input type="checkbox"/> "hyped up"/energetic | <input type="checkbox"/> guilty          | <input type="checkbox"/> depressed |
| <input type="checkbox"/> worried              | <input type="checkbox"/> lonely          | <input type="checkbox"/> 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 you life? ( ) Yes ( ) No

If so, who? \_\_\_\_\_

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

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

**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



## 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

\_\_\_\_\_  
Signature  
Printed Client Name

\_\_\_\_\_  
Date  
Printed Provider Name



**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.

Signature

Date