# MEIER CLINICS PATIENT REGISTRATION

## PATIENT INFORMATION

Name: _____
(Last, first, middle initial, nickname)

Full Address: _____

Home Phone: _____ Work Phone: _____ Ext. #: _____ Cell: _____

Social Security #: _____ Sex: ○ M ○ F Birth date: _____ Age: _____

Marital Status: Choose ○ Other: _____

Ethnicity: ○ AmericanIndian/Alaskan Native ○ Asian ○ African/American ○ Hispanic ○ White ○ Hawaiian/PacificIslander ○ Other _____

## GUARANTOR INFORMATION
## (Person who is financially responsible if different from patient above.)

Name: _____ Birth date: _____
(Last, first, middle initial, nickname)

Full Address: _____

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 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: _____