CLIENT INFORMATION FORM

Legal Name: ____

Preferred Name: ___________________________________ DOB: _________________________

Gender Identity: ____________________________ Pronouns: _____________________________

Social Security Number: ______________________ Relationship Status: ________________________

Street Address: ____

City: ___________________________ State:__________ Zip Code: ______________________

Home Phone: ____________________________ Cell Phone: ______________________________

Email Address: ____

Employer: ______________________________ Referral Source: ___________________________

May we contact you with appointment reminders (may include call/voicemail, text, & email)? Yes ____ No ____

Insurance Information

Policy Holder Name: ___________________________________ SSN: ______________________

Relationship to Client: _____________________ Insurance Carrier: ___________________________

Member ID #: _______________________________ Group #: _____________________________

Policy Holder Address: ____

City: ____________________________ State: ________ Zip Code: _______________________

Policy Holder Phone #: _______________________ Policy Holder DOB: _______/________/_______

For Minors:

Parent/Legal Guardian Name: ____

Address (if different than client): ____

City: ____________________________ State: ________ Zip Code: _______________________

PRACTICE INFORMATION AND CONSENT FORM

Professional Services

Meridian Behavioral Health Inc. provides behavioral healthcare services for people through their lifespan. We have a variety of clinicians, including: clinical psychologists; clinical social workers; professional counselors; psychiatrists; and psychiatric nurse practitioners. We are a client-centered practice that follows a problem-solving approach to treatment. Treatment may include comprehensive evaluation, collaborative development of goals for treatment, psychiatric assessment, and medications when appropriate. Meridian Behavioral Health is a preferred provider for most insurance companies.

Meridian Behavioral Health offers multiple services to create the most effective approaches to patient care. Clients may see a psychotherapist, which includes building a relationship with a clinician to explore how thoughts, feelings and behaviors are impacting the client's daily life. This process is a partnership between the therapist and the client. Both parties hold responsibility in setting treatment goals and making progress in therapy. It is important for patients to be open, honest, and to keep regular appointments.

Clients may also be evaluated by a healthcare professional to determine whether medication is appropriate. Medication is prescribed after a thorough assessment. It is critical that if a patient is prescribed medication, all appointments with the provider are kept. In order to provide safe and proper medical care, prescriptions will be issued at initial and follow-up visits with the medical provider. **Urgent requests for medication refills without an office visit will be filled at the discretion of the provider and will incur a $25 administrative fee.** This fee will not be reimbursed by insurance and is the patient's responsibility. Please allow 48 hours to process such requests. To check on status of prescriptions, please contact your pharmacy.

In addition to therapy and medication, clients might be referred for psychological testing. Psychological testing involves the use of standardized, specialized tools to gain information about specific aspects of patient functioning. Most tests are administered in a one-on-one setting with a psychologist; however, some may be self-administered. In all cases, the results of the tests will be individually analyzed and interpreted with the patient by a psychologist. Please note that insurance companies often do not pay for psychological testing.

Appointments and Cancellations

Appointments and cancellations can be made by calling (502) 409-6993. The office is open Monday - Thursday, 8:30 am - 7:00 pm and Friday 8:00 am - 2:00 pm, excluding holidays. If a situation is an emergency and the client cannot safely wait for a provider at Meridian Behavioral Health, dial 911 for emergency services or go to the nearest hospital emergency room. Please note Meridian Behavioral Health **does not offer on-call, crisis, or after-hours care.**

If client needs to cancel or change an appointment, Meridian Behavioral Health requires **at least 24 hours notice. If client does not provide at least 24 hours notice, Meridian will charge a broken appointment fee of $60 for a psychotherapist or $75 for nurse practitioner/psychiatrist.** Please be aware that insurance companies do not pay for missed appointments. Patients will not be charged for true emergencies or weather-related cancellations. If the patient has multiple missed appointments or a standing appointment and does not call to cancel, all future appointments may be cancelled.

Insurance

Please note that it is the client's responsibility to contact their insurance company to obtain initial authorization for services, to ensure the clinician's panel membership, and to determine copayment obligation. In order to obtain insurance reimbursement, client must consent to release information about your care. Please familiarize yourself with your insurance policy, including any yearly session limitations.

Confidentiality and Communication

Although it is the goal and responsibility of Meridian Behavioral Health Inc. to protect the confidentiality of client records, there may be times when the disclosure of client records or testimony will be compelled by law. Discussions between a clinician and a client are confidential. No information will be released without a client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following stations: child abuse; abuse of the elderly or disabled; disclosure of being a victim of domestic violence; negligence suit brought by the client against the clinician; filing of a complaint with a licensing board; or imminent danger to the client or another person. A HIPAA Notice of Privacy Practice will be made available to the client on a separate form. If the client has any questions regarding confidentiality, it is the client's responsibility to bring them to Meridian Behavioral Health's attention to discuss this matter further.

Consent to Treat

I voluntarily agree to receive mental health assessment, care, treatment, or other services. I authorize the licensed professionals at Meridian Behavioral health to provide such care, treatment, or services as they are considered necessary and advisable.

By signing, I, the undersigned client, acknowledge that I have both read and understood all terms and information contained herein and have been offered a copy of Meridian Behavioral Health's HIPAA Notice of Privacy Practices for my records.

____ ____________________

Client / Parent or Legal Guardian Date

As witnessed by:

____ ____________________

Authorized agent of Meridian Behavioral Health Inc. Date

PROFESSIONAL SERVICES AGREEMENT

I understand that the effectiveness of mental health services depends on efforts of the patient as well as those of the practitioner (Clinician), and I promise to make my best effort to comply with these procedures. These best efforts will include open and honest discussion of my thoughts and feelings, as well as an effort to perform any exercises or homework assignments that may be recommended. I also agree to return, undamaged any materials that have been loaned to me as part of the procedures and understand that I am liable for the cost of these materials. I understand that the effectiveness of the procedures cannot be guaranteed, and that the Clinician has sole professional responsibility for all services provided.

I understand that regular attendance will produce the maximum benefits, but I am free to discontinue treatment at any time. If I decide to do so, I will notify the Clinician at least two weeks in advance so that effective planning for continued care can be implemented.

I also agree to notify the Clinician **at least 24 hours in advance** if I will be unable to attend any session. **I understand that if I fail to make such notification, I will be charged a broken appointment fee ($60 for psychotherapist or $75 for nurse practitioner/psychiatrist), which will not be reimbursable by my insurance company.** I agree to be responsible for these charges.

I understand that conversations with the Clinician will be of confidential nature. I authorize my Clinician to discuss my treatment with other treatment providers to coordinate my care. I further understand that the Clinician, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the Clinician has a legal responsibility to protect anyone that the patient may threaten with violence, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the Clinician will make reasonable efforts to resolve these situations before breaking confidentiality. I also understand that in order to ensure patient confidentiality and privacy, electronic recording is strictly prohibited within any Meridian Behavioral Health office.

I understand that prescribed medication can only be provided in coordination with regular office visits, in order to provide me with safe and appropriate medical care, and that any urgent requests by me for medication refills without an office visit will incur a $25 administrative fee, non-reimbursable by insurance.

My signature below indicates that I have agreed to these terms and have read and understand a “Notice of Privacy Practices” and a “Practice Information and Consent Form” describing my rights and responsibilities as a patient or guardian.

____ ____________________

Signature of Patient or Guardian Date

FINANCIAL AGREEMENT

PATIENT RESPONSIBILITY FOR PAYMENT You are responsible for any co-payment, co-insurance, and deductible or service not covered by your insurance. If necessary, you are also responsible for handling, collection, and attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of service. Patient due balances noted on your monthly statement are due within 30 days of receipt. Charges for minor children will be billed to the parent with whom the child resides. We will not bill or contact a non-custodial parent on behalf of the custodial parent. You also agree to notify the Clinician **at least 24 hours in advance** if you will be unable to attend any session. **By signing, you verify that you understand that if you fail to give such notification, you will be charged ($60 for psychotherapist or $75 for nurse practitioner or psychiatrist), which will not be reimbursed by your insurance company.**

INSURANCE Your insurance coverage is a contract between you and the insurance company. It is your responsibility to know your insurance benefits. By signing, you acknowledge that to obtain your insurance company's contracted rates with Meridian Behavioral Health, all copayments, coinsurance and/or deductibles must be paid at the time of service. You also acknowledge that specific services may be provided that your insurance carrier may have chosen or will choose not to contract for, at which point you will be wholly responsible for these charges. If your mental health care is provided under the terms and conditions of a managed mental health care program to which the Clinician is contracted, your financial responsibilities may be limited by the terms of the contract. You understand that your failure to pay these bills may result in collection procedures (including court proceedings) being taken against you by the Clinician or a collection agency contracted by the Clinician to collect these bills. You also understand that if your account is placed in collection procedures, neither you nor any other patient of Meridian Behavioral Health for whom you are the guarantor will be able to schedule appointments with any other Meridian Behavioral Health clinician.

MEDICARE We accept primary Medicare insurance. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered.

PAYMENT OPTIONS If you are unable to pay your due balance in full, call our front office to make payment arrangements. Accounts with patient due balance outstanding over 150 days are subject to outside collections.

NON-PAYMENT Failure to pay will result in your account being referred to a collection agency. You are responsible for any expenses incurred by Meridian if your account is sent to a collection agency or if you name Meridian in a bankruptcy filing. Checks returned for insufficient funds will result in a $25 processing fee.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses.

____ ____________________________

Patient Signature Printed Name Date

____ ____________________________

Parent/Guardian Signature Printed Name Date

CREDIT CARD PAYMENT AUTHORIZATION AGREEMENT

Patient is responsible for notifying the Clinician **at least 24 hours in advance** if Patient will be unable to attend any session. If Patient fails to make such notification, **Patient will be charged ($60 for psychotherapist or $75 for nurse practitioner/psychiatrist), which will not be reimbursable by insurance company.** In the case that Patient fails to give Clinician 24 hours advance notice of cancellation or rescheduling, Meridian Behavioral Health reserves the right to charge the card on file.

Patient Name:____ Today's Date:_____________________

End Date of Authorization: card expiration date Amount not to exceed $300

Cardholder Name:____

Cardholder Address:____

Billing Address ZIP Code: ______________

Credit/Debit Card Number:____

Expiration Date:______________________ CVV (three digit number back of card):__________________

I hereby authorize Meridian Behavioral Health to keep my debit or credit card or bank account information (as indicated above) on file for payment and to initiate appropriate payment entries against the above referenced debit or credit card or bank account, as applicable, as amounts are owned by me on the Patient Account listed above. I acknowledge that the initiation of all such entries to make payments on the Patient Account listed above must comply with the provisions of U.S. law and any applicable state laws. I understand and agree that these entries may be made to my debit or credit card or bank account, as applicable to pay amounts owed by me on the Patient Account listed above. I also agree to notify Meridian Behavioral Health if my debit or credit card or bank account information (as indicated above) changes for any reason. This authorization shall remain in effect until the "End Date of Authorization" listed or until I communicate to Meridian Behavioral Health my intentions to cancel this authorization by calling Meridian Behavioral Health at (502) 409-6993 or writing Meridian Behavioral Health at the address below. In the event of a returned electronic or declined charge, my account will be charged a $10 service fee for each occurrence. I acknowledge receipt of a copy of this authorization form.

Signature:____ Date:_______________________

FINANCIAL RESPONSIBILITY (if other than patient)

Name ____

DOB _____/_____/_____ Relationship to Patient ____

Address ____
(if Different from Patient)

Phone ____

Signature of Financially Responsible Party ______________________________ Date _______________