

Marital Status: S M Partnered W Div Sep Presently Living With: _____

Spouse's Name: _____ Date of Marriage: _____

Spouse's Occupation: _____ Dates of Previous Marriages (You): _____ (Spouse): _____

Is Your Father ___ Living ___ Deceased Age (or year he died): _____

Is Your Mother ___ Living ___ Deceased Age (or year she died): _____

Number of Brothers & Sisters: _____ Ages & Gender of Your Children: _____

Names of Emergency Contact: _____ Phone: _____

Please Briefly Describe Why You Are Seeking Services At This Time:

Current Medications: _____

Describe Current Health Status: _____ Approximate Date of Last Physical Exam: _____

Major Illnesses, Accidents, or Surgeries (include year): _____

Current & Previous Mental Health and or Substance Abuse Treatment, Including Medication: _____

Family History of Problems with Mental Health, Substance Abuse, Trauma, Etc. (including parents, spouse, children)

Personal Symptoms History

Check any that apply to you now. Place a "P" by those that have been problems in the past but are not problems now.

- | | | | |
|--|--|---|--------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> School Problems | Other: |
| <input type="checkbox"/> Insomnia/Sleep Problems | <input type="checkbox"/> Feel Tense | <input type="checkbox"/> Work Problems | |
| <input type="checkbox"/> No Appetite | <input type="checkbox"/> Constant Worrying | <input type="checkbox"/> Financial Problems | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Legal Problems | |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Excessive Fears | <input type="checkbox"/> Marital / Partner Problems | |
| <input type="checkbox"/> Can't Make Decisions | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Relationship Problems | |
| <input type="checkbox"/> Low Self Esteem | <input type="checkbox"/> Excessive Guilt | <input type="checkbox"/> Physical Abuse | |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Over Ambitious | <input type="checkbox"/> Emotional Abuse | |
| <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Overly Suspicious | <input type="checkbox"/> Dislike Weekend/Holidays | |
| <input type="checkbox"/> Anger Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Family Conflict | |
| <input type="checkbox"/> Attention & Focus | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Loneliness | |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Recent Loss | |
| <input type="checkbox"/> Violent Behavior | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Childhood Trauma | |
| <input type="checkbox"/> Obsessive Compulsive | <input type="checkbox"/> Seizures | <input type="checkbox"/> History of Sexual Abuse | |
| <input type="checkbox"/> Overeating | <input type="checkbox"/> Disorientation | <input type="checkbox"/> History of Sexual Assault | |
| <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Flashbacks | |
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Excessive Alcohol Use | |
| <input type="checkbox"/> Sexual Preoccupation | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Drug Abuse | |
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Medical Problems | <input type="checkbox"/> Hallucinations | |
| <input type="checkbox"/> Past Suicidal Attempts | <input type="checkbox"/> Significant Childhood Illness | | |

Patient-Clinician Agreement

Thank you very much for choosing the Meridian Group for mental health services. We understand that the decision to seek treatment is not always an easy one. Please be assured that we will provide individualized, quality services that will actively involve you in your treatment. Should you have any questions or concerns about any aspect of your treatment or office procedures, please do not hesitate to talk to your clinician.

Your clinician is associated with the Meridian Group of Chesterfield, which was formed to more fully serve the community by offering a full range of mental health and substance abuse services. However, each individual clinician maintains their own independent practice. Record keeping and confidential clinical information is maintained separately by each clinician, and therefore your individual clinician is solely responsible for your treatment. Your clinician may occasionally find it helpful to consult other health and mental health professionals about you. During a consultation, HIPAA regulations are always observed to ensure that all information remains confidential. The other professionals are also legally bound to keep the information confidential. If your clinician is out of town or otherwise not available, another clinician of the Meridian Group of Chesterfield may be asked to cover for emergencies. Any information given to them about you will be kept confidential.

In Case of Emergency: If you believe there is an emergency that could result in injury to yourself or another, call 911. For other emergencies, during office hours, call our main number, 751-8644 and press “0” and the office manager will contact your clinician. Outside of office hours, call our main number and follow the prompts for emergency contact after hours. You will be given instructions on how to contact the answering service, who will contact the on-call clinician, who will return your call promptly. In the unlikely event that you cannot reach the clinician on call, contact your local Community Mental Health Crisis Line. For any medical emergencies, including problems with medication, your prescribing physician should be contacted.

Psychotherapy: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and patient, and the particular problems you are experiencing. It is a collaborative process between you and your clinician. There are many different methods to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor’s visit, in that it requires an active effort on your part. In order for the therapy to be most successful, you will have to work toward treatment goals both during your sessions and at home. Please inform your clinician of any problems you anticipate in following recommendations.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience. If you have questions about procedures, please feel free to discuss them whenever they arise.

Psychological Testing: Psychological testing involves standardized measures that may include measures of attention, intelligence, achievement, emotions, personality, or other psychological factors. You will be provided with an explanation of the purpose of testing and testing procedures and will have access to the results. If the testing referral was made by an outside referral source, please be sure you understand how the results will be used and how they will affect you.

HIPAA and Patient Rights and Responsibilities: Clinicians of the Meridian Group believe that intervention is most effective when you are aware of your rights and responsibilities. We are also committed to protecting your confidentiality and privacy. The HIPAA Notice of Privacy Practices and Policies given to you (blue form) tells you about the ways your clinician may use and disclose the protected health information about you. It explains the limits of confidentiality and describes the clinician’s obligations and your rights regarding the use and disclosure of information.

Your signature below indicates that you have read this Client-Clinician Agreement and agree to its terms. It also serves to acknowledge that you have received the HIPAA Notice described above. Concerning all of these forms and notices, please feel free to bring up any questions or points of clarification with your clinician at any time.

Payment Policies

1. Insurance companies will generally reimburse for services at the same level as other medical visits. We will file your insurance claims as a courtesy to you. Please be aware, however, that you, not the insurance company, are ultimately responsible for payment of all charges. By agreeing to these Payment Policies, you agree to be responsible for paying for all services provided. Please have your insurance card available on your first visit to verify coverage. You should also determine if there is an annual deductible before your first visit. Deductibles usually apply at the beginning of your benefit year. **Your co-pays and deductible payments must be made at the time of each visit.**
2. If your account is unpaid for more than 45 days and arrangements for payment have not been agreed upon, then the option of using legal means may be used to secure payment. This may involve hiring a collection agency, attorney, or going through small claims court which will require the disclosure of otherwise confidential information. The cost of that service, up to 33.33% of the amount owed, will be added to your balance. In most collection situations the only information released regarding a patient's treatment is his/her name (and parents' names for children), address, phone numbers, the nature of services provided, payment history, and the amount due.
3. In some cases another party may be legally responsible for payment of medical bills. However, responsibility for payment of fees falls to the individual, parent or guardian who arranged for services.
4. Insurance companies do not reimburse for missed appointments. Therefore, there will be a \$50.00 charge for missed appointments unless the clinician or the receptionist is notified at least 24 hours prior to the appointment. This charge may be waived in the event of emergency or illness. There is also a \$50.00 returned check fee for checks written with insufficient funds. If records are requested, there is a copying fee of \$.50 per page plus mailing costs.
5. If consultation with the legal system is requested or required as a result of services provided to you or your child, you will be expected to assume the expenses associated with the time involved. Court appearance cost includes travel, preparation, and total time spent at the courthouse. It also includes time lost at the office if the court hearing is canceled on short notice. Court related activities are charged at a minimum of \$750 which includes the first 3 hours of time. There is an additional charge of \$250 per hour when more than three hours is required. Court appearance for one-half day, four hours or less, is \$750. A full day court appearance, more than four hours, is \$1500. An initial fee of \$750 is due fourteen (14) days in advance of the court date. Payment is due by you regardless of who initiates a court appearance. For contact with others involved in legal proceedings (e.g.: attorneys, CASA workers, guardians ad litem, social services, court evaluators, judges) the cost is \$250 per hour, billed by the quarter hour. Payments for letters, reports, treatment summaries, or other information provided to third parties will also be assessed at \$250 that will be due prior to the release of the information. Brief contact with those involved in legal proceedings will not result in a charge. If records are requested, there is a copying fee of \$.50 per page plus mailing costs.
6. If you wish to seek third-party reimbursement for services, your contract with them gives them the right to request information for determination of medical necessity and payment. Typical information supplied includes dates of treatment, type of treatment, and nature of your problem or illness (diagnosis). Some insurance companies may also require more detailed information such as treatment plans and periodic chart reviews. Information provided to them will become part of the insurance company file and your clinician will not have control over their use of the information. They are, however, bound by HIPAA, state and federal law to handle the information with your confidentiality in mind. Your signature below provides authorization for me to disclose this information. Please refer to your insurance contract for their specific information requirements.
7. If you are self-pay and/or uninsured, you will be informed of a Good Faith Estimate of the cost of services. Your clinician will inform you of the estimated cost of services prior to receiving treatment and if those costs change. You will receive a confirmation of costs both orally and in writing. The estimate does not include additional charges due to complications or changes in circumstances. The Good Faith Estimate only pertains to those who are self-pay and/or uninsured. If you are using insurance, payments are determined by your insurance coverage.

I have read the patient-clinician agreement and office policies and agree to abide by conditions specified.

SIGNATURE: _____ DATE: _____



Authorization for the release of confidential information Primary Care Physician

It is often helpful to inform your primary care physician (PCP) that you are involved in psychological treatment. Your PCP is typically your family physician or pediatrician. While most insurance does not require an authorization from the PCP for you or your child to receive counseling, you may want your PCP informed that you are receiving services. However, you are under no obligation to have any information released. You or your child's treatment will not be affected in any way if you decide not to authorize the release of information.

If you authorize information released to your PCP, a brief letter or phone call may be made to your PCP informing him or her that you or your child have started receiving services and the reasons you have come for treatment. Ongoing contact may occur as needed.

Patient's Name: _____

Primary Care Physician (PCP): _____

Please sign A or B below, but not both:

A: I hereby **give** my authorization to inform my primary care physician that I or my child is receiving treatment and the reasons for treatment. This release is valid for one year unless noted otherwise.

I have the right to revoke this authorization at any time by informing the above-named therapist in writing. However my revocation will not be effective to the extent that my clinician has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Please understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Representative*: _____ Date: _____

B: I hereby **decline** authorization to inform my primary care physician that I or my child is receiving services (no information will be released to your primary care physician):

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Representative*: _____ Date: _____

* If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided. This information is confidential and is protected by Federal law. A photocopy of this completed form is considered as valid as the original.