mpa

Registration Date:_____

MERIDIAN PSYCHOLOGICAL ASSOCIATES, P.C.

Therapist:_____

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____

Social Security #: _____ Date of Birth: _____ Sex: _____

Married ____ Single ____ Other ____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I may be reached at (circle to authorize): Home / Cell / Work

Street Address: _____ City: _____ State: _____ Zip: _____

Primary Care Provider: _____ Office Phone: _____

Emergency Contact Name and Telephone #:

EMPLOYER INFORMATION

Employer Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION

Primary Insured (check one): ❑ Self ❑ Spouse ❑ Parent ❑ Other

Insured's Name: _____ Home Phone: _____

Social Security #: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Insured's Employer: _____ Address: _____ Phone: _____

PATIENT AUTHORIZATION

Please initial next to the statements below to indicate your understanding that:

_____ I request payment be made directly to the provider.

_____ As the authorizing signature, I assume sole financial responsibility for services rendered.

_____ I am personally responsible for payment of all appointments not cancelled 24 hours in advance.

Please provide a credit card number to keep on file which would be billed for appointments not cancelled at least 24 hours in advance (This does not apply to Medicaid recipients.) Fill in your card number and expiration date (we accept Visa or Master Card only.) This information will be kept confidential. Thank you.

_____ _____ _____ _____ Exp Date____/____

_____ I understand I will be charged $20 if a check I write to MPA is returned for Insufficient Funds.

_____ If this account is forwarded to a collection agency due to lack of payment, I will be responsible for all fees associated with this transaction including any legal fees.

_____ Voicemail is available to leave messages when the office is closed. In the case of an emergency: please contact the local Crisis & Suicide Hotline at 251-7575 or 911 or go directly to the hospital emergency room.

I have read and understand all of the above:

Authorized Person or Patient's Signature: _____

Print authorized person or patient's name: _____

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MERIDIAN PSYCHOLOGICAL ASSOCIATES, P.C.

CONSENT FOR MENTAL HEALTH CARE

I, the undersigned, agree and consent to participate in the mental health care offered and provided by _____, a mental health professional as defined by Indiana law.

I understand that I am consenting and agreeing only to those mental health services that the above named professional is qualified to provide within:

a) the scope of the professional's license, certifications, and training; or,
b) the scope of the license certification and training of those mental health professionals directly supervising the care received by the patient.

Please print patient's name: _____

I have read and understand all of the above: _____

Patient or Guardian's Signature (if patient under age 18): _____ Date _____

Witness Signature: _____ Date _____

COUNSELING AGREEMENT

PLEASE READ AND SIGN THE FOLLOWING PRIOR TO SEEING YOUR THERAPIST

CONFIDENTIALITY

Confidentiality means that your therapist has a responsibility to safeguard information obtained during counseling. All identifying information about your assessment and treatment is kept confidential, except as mandated by law. You must sign a release of information before any information about you is given to anyone, except as mandated by law.

In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your consent. In such situations, your therapist is not required to inform you of his/her actions. Please note the following exceptions to confidentiality:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator or guardian of a minor, with or without minor's consent, of the treatment needed by or given to the minor.

  Insurance and managed care companies require personal identification information, diagnosis, symptoms, treatment goals, prognosis, evaluation of progress, and other information before reimbursement is considered. Such companies may also maintain the right to have a copy of your records.

THE BENEFITS AND RISKS OF COUNSELING

One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to therapy. Other possible benefits may be a better ability to cope with marital, family and other interpersonal relationships, and /or a greater understanding of personal goals and values.

There are certain risks involved in counseling. You may experience a variety of negative emotions during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended. The greatest risk of counseling is that it may not by itself resolve your concerns. Your therapist will do his/her best to assess progress and provide referral to other sources if that is deemed necessary and appropriate. Psychotherapy is a collaborative process and the progress you make will depend in large measure upon your investment in the process.

WRITTEN ACKNOWLEDGEMENT AND CONSENT TO COUNSELING

I have read and accept this agreement and herewith consent to counseling/psychotherapy treatment with my therapist.

_____ _____
Client Signature or Legal Representative Date

_____ _____
Minor Assent Date

_____ _____
Witness Date

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MERIDIAN PSYCHOLOGICAL ASSOCIATES, P.C.

POLICY ON NON-COVERED/ NON-REIMBURSED MENTAL HEALTH SERVICES
(This does not apply to Medicaid recipients.)

In order to offer you consistent quality care and to coordinate this care with other providers or organizations, we may need from time to time to provide services that are not typically covered or reimbursed by your insurance company. A list of many of these services is provided below. When we provide these services, we will bill you directly. You will be responsible for paying for these services which, generally will be billed at the standard hourly rate for your therapist or doctor. If you have any questions regarding this policy, feel free to ask your therapist.

Examples of Non-Covered/Non-Reimbursed Mental Health Services

- Review of records or reports from other providers
- Preparing reports or letters for other providers or organizations
- Completing documents (for disability claims, extended insurance reviews, workers' compensation, etc.)
- Consultations by telephone, email or in person with patients and/or collateral sources
- Duplication of your medical records
- Telephoning prescription renewals to your pharmacy
- Evaluation or treatment services not covered or reimbursed by your insurance
- Appeals to insurance company for either prior authorization or payment if requested by you

COURT ORDERED AND LEGAL RELATED SERVICES
(This applies to all of our clients.)

Please note, forensic services are not a mental health service and are not covered by health insurance, therefore, any time associated with forensic services will be billed on a fee for service basis at your therapist's forensic hourly rate.

I have read and understand this policy. I agree to pay for any such services I may use.

Reviewed and Accepted:

Patient's Name (please print) _____

Patient or Guardian's Signature
(if patient under age 18) _____ Date _____

Therapist or Doctor's Signature _____ Date _____

May 1, 2015

Meridian Psychological Associates
4401 North Central Avenue
Indianapolis, IN 46205
317-923-2333

NOTICE OF PRIVACY PRACTICES OVERVIEW OF KEY ISSUES

Notice of Privacy Practices – Use and Disclosures of Your Personal Health Information; followed by Meridian Psychological Associates'' employees, staff, and other office personnel and business associates.

Uses and Disclosures for Treatment. We will make uses and disclosures of your PHI as necessary for your treatment. For instance, doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also release your personal information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you.

Rights That You Have

Access to Your Personal Health Information. You have the right to copy and/or inspect much of the PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you a nominal fee per page if you request a copy of the information. We will also charge you for postage if you request a mailed copy and will charge for preparing a summer of the requested information if you request such a summary. You may obtain an access request form from the Privacy Officer.
You have the right to obtain an electronic copy of your health information that exists in an electronic format and you may direct that the copy be transmitted directly to an entity or person designated by you, provided that any such designation is clear, conspicuous, and specific with complete name, mailing address, and other identifying information.

Amendments to Your Personal Health Information. You have the right to request in writing that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Please contact the Privacy Officer with any requests.

Accounting for Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your PHI for six years prior to the date of your request. If you request an accounting of disclosures of your electronic health record, the accounting will be for three years prior to the date of the request for the accounting. For electronic records acquired by us as of January 1, 2009 these requirements will apply to disclosures made by the organization from such a record on and after January 1, 2014. All requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; you may be charged a nominal fee of for each subsequent accounting you request within the same 12-month period. Please contact the Privacy Officer with any requests.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health care operations on the consent form you sign when you become a patient. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate. Requested restrictions of disclosure of PHI to a health plan may be honored if disclosure is for purpose of payment and pertains solely to an item or service for which you have paid in full. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. Please contact the Privacy Officer with any requests

Complaints. If you believe your privacy rights have been violated, you can submit an oral or written complaint to the Berger Health System Patient Advocate or the Corporate Compliance Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint

Uses and Disclosures for Payment. We will make uses and disclosures of your PHI as necessary for payment purposes. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment. (Including Insurance Carrier)

I HERBY ACKNOWLEDGE: I have reviewed the information above and have received the **NOTICE of PRIVACY PRACTICES.**

Please sign and print your name and date. Return form to the Meridian Psychological Associates, P. C.

Date: _____

Signature: _____ **Print Name:** _____

Welcome to Meridian Psychological Associates, P.C.

We are pleased that you have placed your confidence for your mental health care in us and want you to know that we are, as a practice, committed to developing a working and therapeutic relationship with you that reflects our strong belief in respect and openness. We hope and aim to demonstrate these values in all we do, from your first telephone contact through your final visit. We welcome feedback from you as to the quality of your experiences with us in this regard. We believe that open communication clears up confusion, prevents disappointment and enhances your experience and care. Feel free to ask questions or offer input regarding your treatment or any aspect of your experience with us.

We look forward to working with you and would like to familiarize you with several of our office policies:

Your contact with your therapist and/or doctor is confidential. No one may have access to your records or information shared in therapy sessions without your specific permission. Federal and state laws, however, provide for several exceptions to this rule which we ask you to discuss with your therapist. (Please refer to "Notice of Privacy Practices".)

Financial Responsibility:

- **Payment is expected each time you come to an appointment whether it be payment in full or your co-pay.** Due to the increased complexity of health insurance in recent years, you are welcome to schedule a brief meeting with our billing person prior to your second appointment to fully clarify all important issues related to fees and financial responsibilities. We ask that you notify us immediately as to any change in your health insurance, place of employment, home address or other information pertinent to our records. (Failure to do this may result in our no longer being able to process insurance claims for you and could disrupt your treatment.) Also, please ask us if at any time you have any questions regarding your monthly billing statement or insurance reimbursement.
- **The financial responsibility for your treatment is ultimately yours.** If required, we will file claims for insurance reimbursement as allowed by your policy. **We file primary insurance only.** We file your insurance as a courtesy and therefore we will file only two times for any given date of service. Any monies remaining owed beyond this will be due from you (this does not apply to certain managed care insurance companies and federal/state funded agencies). We will make available to you any documentation necessary to assist you in filing claims for reimbursement purposes (and/or for secondary insurance).
- **Please note that any insurance benefits quoted to you by our staff is not a guarantee of payment.**
- Please be aware that any review of documents or requests for written letters must be paid directly by you. These services are not covered by insurance companies. (Please refer to "Non-Covered Services")
- Please be aware, for any check returned for "Insufficient funds", you will be charged an additional fee of $20.00
- In the event any fees for which you are responsible are not paid, please understand that your account may be forwarded to a collection agency and you will be responsible for all fees associated with this transaction including any legal fees.

Cancellation Policy:

- It is our policy to **require a 24 hour cancellation notice**. When we reserve an appointment for you, we are unable to schedule other clients. Accordingly, we will charge for appointments not cancelled 24 hours in advance of the scheduled appointment time and insurance companies will not reimburse for this fee. **We would appreciate a copy of your charge card to keep on file in the event this should occur. Please see the receptionist at time of registration to give her this information.**
- We realize that there may be emergency situations where a 24 hour cancellation notice is not possible, and those situations will be dealt with individually.

Childcare:

- Please provide childcare while you are in with your therapist. We cannot have children unattended in the waiting room.

Cell Phones:

- We request that you please use your cell phone outside the office. Cell phone use in the waiting rooms or offices is disturbing to others.

Hours: Our front desk is open 8:00 a.m. until 5:00 p.m. Monday through Friday. (Your therapist and/or doctor may offer different and/or additional appointment times as well.) Voicemail is available to leave messages when the office is closed. Messages left overnight or on the weekend will be attended to the next business day. *For non-confidential messages to the administrative staff (not your therapist) you may use the general MPA email address: meridianpsych@mpaindy.com.* **In the case of an emergency, please contact the local Crisis & Suicide Hotline at 251-7575 or go directly to the hospital emergency room.**