MERIDIAN PSYCHOTHERAPY SERVICES, LLC

Patty Smith, PsyD, LPC ◆ Saulo Ortiz, LCSW

Independent Practitioners:

Tony Foy, LCSW ◆ Regina Carroll, LCSW ◆ Heidi Kulberg, MD ◆ Danielle Gange, NP-C ◆ Leah Sanders, LPC
Sophie Henderson, LPC ◆ Debbie Jones, LCSW ◆ Meg Lubas, LCSW ◆ Sheryl Losick-Smith, LPC ◆ Louis Leone, MD
Sayward McCullough, PMHNP-BC ◆ Sarah McBride, LCSW ◆ Alicia Rose, PMHNP-BC ◆ John Wren, Resident in Counseling

PATIENT INFORMATION:

FIRST NAME____________________MIDDLE____________________ LAST____________________

RACE: ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White ☐ American Indian or Alaska Native ☐ Black or African American

Language Spoken:________________

ETHNICITY: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

ADDRESS____________________ APT____________________

CITY____________________ STATE______________ ZIP______________

SS#____________________ DATE OF BIRTH____________________ AGE________SEX: ☐ M ☐ F MARITAL STATUS____________

HOME PHONE____________________ WORK PHONE____________________MOBILE PHONE____________________

EMPLOYER/SCHOOL____________________OCCUPATION/GRADE____________________

EMERGENCY CONTACT:____________________ RELATIONSHIP TO PATIENT:______________PHONE______________

EMAIL ADDRESS:____________________ COMMUNICATION PREFERENCE: ☐ home phone ☐ cell phone ☐ work phone

WHO REFERRED YOU TO THIS OFFICE?____________________ REASON FOR SEEKING TREATMENT____________________

PERSONAL PHYSICIAN____________________ ADDRESS____________________

PLEASE NOTE ANY CURRENT MEDICAL PROBLEMS____________________

LIST CURRENT MEDICATIONS____________________

PREFERRED PHARMACY PHONE AND/OR ADDRESS____________________

HAVE YOU EVER USED TOBACCO? ☐ NO ☐ YES IF YES, DESCRIBE: ☐ CURRENT DAILY ; ☐ CURRENT SOME DAY; ☐ FORMER

ARE YOU ALLERGIC TO ANY MEDICATIONS?____________________

INSURANCE INFORMATION

INSURANCE CO. ____________________ SUBSCRIBER NAME ____________________

INS. ADDRESS ____________________ SUBSCRIBER DOB____________________

____________________ INS ID#____________________

____________________ GROUP#____________________

INS. PHONE:____________________ PATIENT'S RELATIONSHIP TO SUBSCRIBER______________

FOR TRICARE PATIENTS ONLY: SPONSOR NAME____________________ SPONSOR SS#____________________

BRANCH OF SERVICE____________________ ACTIVE OR RETIRED____________________RANK______________

PERSON RESPONSIBLE FOR BILL:

COMPLETE ONLY IF PATIENT IS UNDER 18 – ALSO MUST SIGN PAGE 2

FIRST NAME____________________ MIDDLE ____________________LAST____________________

SSN____________________ DATE OF BIRTH____________________

ADDRESS____________________ CITY____________________ STATE________ ZIP__________

RELATIONSHIP____________________ HOME PHONE____________________WORK PHONE____________________

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MERIDIAN PSYCHOTHERAPY SERVICES
APPOINTMENT CANCELLATION POLICY

Please notify us at least 24 hours in advance if you need to cancel or reschedule an appointment. If your appointment is on a Monday, we ask that you advise us by 4pm the Friday prior. When a patient doesn't show for their scheduled appointment, another patient loses an opportunity to be seen. If you fail to keep an appointment you scheduled, or if you cancel an appointment without providing at least twenty-four hours notice, you will be subject to a $75.00 fee.

Please be advised that completing preliminary health and insurance questionnaires does not establish a patient-physician relationship with this practice. The provider will conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Any medications maintained at this office via a specialty pharmacy order become the property of the practice if arrangements are not made by the patient for the transfer of the medication within 60 days of the patient's last office visit.

STATEMENT OF AGREEMENT

All fees for services provided to you are due at the time service is rendered. Because appointment hours are reserved for you, **you will be charged for missed appointments**, a charge which is not covered by insurance, unless **24-hour** advance notice is given. The late cancellation or no-show fee is $75 for individual sessions and $20 for group sessions. Additional fees may be billed for services not covered by insurance, such as written reports, lengthy phone calls, or other professional services. You are responsible for supplying correct insurance information, and for payment of any personal portion within 15 days of receiving a monthly bill. An interest charge of 1.5% per month will be charged for balances over 60 days. Patient agrees to pay all costs of collections (currently 35% of total account balance), including reasonable attorney's fees. All payments made for our Outpatient Opiate Recovery program are non-refundable.

Your confidentiality will be honored by the staff of this office unless you sign a consent form giving us permission to speak to a specific person or agency. Substance abuse records are protected under Federal Confidentiality Regulations (42- CFR Part 2) and cannot be released without your written consent unless otherwise provided for in the Regulations. This practice utilizes the Virginia Prescription Monitoring Program and may access information contained in the program files on covered substances dispensed to a patient.

I have read the above policy and agree to comply with its terms as presented. My signature below also constitutes authorization for my insurance company to make payments directly to the healthcare provider rendering services, and for this practice to release information to my insurance company in order to process insurance claims. If I become a group member, I agree to maintain the confidentiality of all group members. My signature authorizes the exchange of information via Community Exchange and release of medication history information via Sure Scripts.

______________________________	______________________________
SIGNATURE OF PATIENT	SIGNATURE OF PARENT/LEGAL GUARDIAN
______________________________	______________________________
SIGNATURE OF RESPONSIBLE PARTY (if other than patient)	DATE