MERIDIAN
PSYCHIATRIC PARTNERS

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Gender Listed on Insurance:
Female ☐ Male ☐

LEGAL NAME

Female ☐ Male ☐ Other ☐

PREFERRED NAME AND GENDER (if different from above)

SSN _ _ _ _ BIRTHDATE AGE

ADDRESS

CITY STATE ZIP

Ok to leave a voicemail? Yes ☐ No ☐

HOME PHONE WORK PHONE MOBILE PHONE

EMAIL

RELATIONSHIP STATUS: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

EMERGENCY CONTACT INFORMATION

NAME RELATIONSHIP PHONE NUMBER

EMPLOYER INFORMATION

EMPLOYER NAME OCCUPATION

EMPLOYER ADDRESS EMPLOYER PHONE NUMBER

REFERRED BY

NAME EMAIL PHONE NUMBER

INSURANCE CARRIER INFORMATION (Choose One)

☐ BCBS PPO ☐ Northwestern University Student ☐ SAIC Student ☐ Self Pay

PATIENT/GUARDIAN SIGNATURE DATE

625 North Michigan Avenue, Suite 2550, Chicago, IL, 60611 Phone: 312-640-7740 Fax: 312-640-7736 www.meridianpsychiatricpartners.com

ACKNOWLEDGEMENT OF BILLING POLICY

- Payment is due at the time of service.
- Payment may be made by Cash, Check or Credit Card.
- You must provide a credit card number to be kept on file. In the event that a balance is outstanding more than 60 days, this card will be automatically charged.
- Once an account is more than 90 days past due, it is subject to Collections action.
- The fees for the Initial Evaluation and subsequent sessions are as discussed at intake or with your clinician.
- Statements for outstanding balances are generated monthly.
- If your check is returned NSF (non-sufficient funds), a $30 charge will be added to the outstanding balance.
- It is your responsibility to provide the office with up-to-date billing information, including changes to address, credit card, and Insurance information.
- Meridian will only bill directly to our Contracted Provider Plans.

CANCELLATION POLICY

At least 24 business hours' notice of cancellation is required to avoid being charged the cancellation fee. If you do not cancel your appointment within the 24 business hour requirement, you will be charged the **FULL FEE** ($200, $150 OR $125 depending on the type of appointment and provider) **Cancellation fees cannot be billed to Insurance**.

SIGNATURE

I have read the above information and agree with these conditions.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

APPOINTMENT REMINDER

☐ Text ☐ Phone ☐ Email: _____ PT Initials: _____

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INSURANCE

- Insurance Cards are required at every visit. We will verify your insurance coverage at the time of your first visit if possible.
- Depending on your insurance, Meridian will be reimbursed based on a percentage of the amount billed. We do not know the exact amount until we receive payment. All co-payments, deductibles, and payments for non-covered services are due at the time of the service or when balances become known. As the recipient of services, you are ultimately responsible for all services provided. Not all services may be covered by insurance, and you will be fully responsible for those uncovered charges. Meridian is under no obligation to pursue reimbursement on the patient's behalf.
- If payment from your Insurance Provider is not received in full within thirty (30) days after submission of the request for payment, it is your responsibility to pay. If payment is not received in full within sixty (60) days, by providing your credit card and receiving provided services, you are authorizing Meridian to charge your provided credit card for any unpaid bills or claims. Without a card on file, payment is due in full at the time services are rendered. Any claims paid after your credit card has been billed will be refunded to you.

If you are covered by either a Blue Cross/Blue Shield PPO, SAIC Student Insurance, or Northwestern Student Insurance plan:

- We will bill at an in-network level for those plans.
- It is your responsibility to contact your insurance carrier to discuss your plan's mental health benefits, including any deductibles, co-payments, annual and lifetime limits, **and if pre-authorization is required**. We will bill the carrier for you.
- Your co-pay is due at the time of service.
- You are responsible for all charges not paid by your insurance, including deductibles, co-payments, any uncovered charges, charges for missed appointments, etc.
- You are responsible for informing the front desk of any changes to your insurance coverage.

If you are covered by an Out of Network Provider Plan:

- The out of pocket payment is **due at the time of service**.
- After payment has been made and applied towards the billed services, we will provide you with an Insurance Invoice to submit to your insurance plan.

SIGNATURE

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above mentioned Health Insurance Providers, and hereby assign and convey directly to Meridian all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

PATIENT/GUARDIAN SIGNATURE DATE

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MERIDIAN CREDIT CARD AUTHORIZATION

I,_____ hereby authorize Meridian Psychiatric Partners, LLC, to charge my credit/debit card for any account balance that is more than 60 days past due.

Patient Initials: _____

I understand my card will be charged on a regular basis for these amounts. I also understand that in the event that my card is declined, I will be required to provide a different method of payment. I will also be expected to pay for any previously unpaid charges resulting from the decline, in addition to the current charges.

I authorize my card to be charged for fees as indicated above.

Patient Initials: _____

CREDIT CARD INFORMATION

_ _ _

CREDIT CARD NUMBER | EXP. DATE | CVV CODE

BILLING ADDRESS (for the Debit/Credit Card listed above)

CITY | STATE | ZIP

PATIENT NAME (please print) | PATIENT/GUARDIAN SIGNATURE | DATE

AUTOMATIC BILLING

Additionally, for your convenience, if you wish to have your balance charged to your credit/debit card for any patient responsibility from services rendered (deductibles, co-payments, and co-insurances) and/or fees incurred (cancellations within 24 hours or no-show appointments) after each visit, please check the auto charge box and initial below.

☐ **YES**, charge this credit card for my balance regularly.

Patient Initials: _____

STATEMENT INFORMATION

You will receive statements from Meridian Psychiatric Partners by U.S. Mail or email (unless otherwise requested).

PATIENT/GUARDIAN SIGNATURE | DATE

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize _____ (clinician) to:

☐ Release my health information to the below facility/clinician.

☐ Receive my health information from the below facility/clinician.

OUTSIDE FACILITY/CLINICIAN | PHONE NUMBER

ADDRESS | FAX NUMBER

CITY | STATE | ZIP

☐ I understand that this information may be transmitted via written word, facsimile, or over the phone.

☐ I understand authorization for this release of information can be revoked at any time. To revoke this authorization, I understand that I must provide a statement in writing with my request.

☐ I understand that if I do not revoke this consent at any time, the consent will expire one year from the date of signing below.

☐ I understand that after completing this form, I do not have to sign additional consents for the release of my information.

Comments regarding the release of information (i.e. specific information you do not wish to be released):

SIGNATURE

PATIENT NAME | DATE OF BIRTH

PATIENT/GUARDIAN SIGNATURE | DATE

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NOTICE OF PRIVACY PRACTICES

This notice describes how Mental Health information about you may be used and disclosed, and how you can get access to this information. Please read it carefully.

REGARDING MENTAL HEALTH INFORMATION

The privacy of your (i.e. you and your child's) mental health information is important to us. We understand that your mental health information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need this record to provide you with quality of care and continuity of care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share mental health information about you. We also describe your rights and certain duties we have regarding the use and disclosure of mental health information.

OUR LEGAL DUTY

The law requires us to:

- Keep your mental health records private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your mental health records.

We have the right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the privacy practices and the new terms of our notice effective for all mental health records that we keep, including information previously created or received before the changes.

NOTICE OF CHANGE TO PRIVACY PRACTICES

Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MENTAL HEALTH INFORMATION

The following section describes different ways that we use and disclose mental health information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose mental health information. We will not use or disclose your mental health information for any purpose not listed below without your specific authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment/Evaluation:

We may use mental health information about you or your child to provide you with psychiatric, psychotherapy or evaluation services. We may disclose mental health information about you to your primary care physician if it is required by your insurance or managed care company. Also, we may disclose mental health information about you to a referring or referred mental health provider if you require additional services. From time to time, it is helpful for us to consult with other professionals regarding your treatment. In such events, our consultants are also legally bound by the privacy practice policies.

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For Payment:

We may use and disclose your mental health records for payment purposes. We may need to supply your health insurance plan with information about treatment you received at our practice so that your health plan will pay for services that were incurred. We may also tell your health plan about a treatment that you are going to receive to get approval or to determine if your plan will pay for the treatment.

Additional Uses and Disclosures:

In addition to using and disclosing your mental health information for treatment, payment, and health care operations, we may use and disclose mental health information for the following purposes:

- **Notify or help notify a family member, a personal representative, or another person responsible for your care about your location, general condition, or death**. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of an emergency and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement.
- **Specialized Government Functions**. Subject to certain requirements, we may disclose or use your mental health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for governmental programs providing public benefits.
- **Court Orders and Judicial and Administrative Proceedings**. We may disclose your mental health records in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your mental health records with law enforcement officials concerning the mental health records of a suspect, fugitive, material witness, crime victim, or missing person.
- **Public Health Activities**. As required by law, we may disclose your mental health records to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also, when we are authorized by law to do so, notify a person who was exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
- **Victims of Abuse, Neglect, or Domestic Violence**. We may disclose your records to appropriate authorities if we have reason to believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may share your mental health records if it is necessary to prevent a serious threat to your health or safety or the health and safety of others.
- **Worker's Compensation**. We may disclose your mental health records when authorized and necessary to comply with laws relating to workers compensation or other similar programs.
- **Health Oversight Activities**. We may disclose your mental health records to any agency providing health oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure, or disciplinary actions, or other authorized activities.

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YOUR INDIVIDUAL RIGHTS

- You have the right to look at or receive copies of your mental health records. You must make your request in writing. You may request access by sending your request to the contact person(s) listed at the end of this notice. For evaluations, raw data (i.e., test forms/responses) can only be released to a qualified mental health professional. If you request copies, there will be a $1.00 per page fee. There is also an additional postage charge if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
- You have the right to receive a list of all of the times we or our business associates shared your records for purposes other than treatment, payment and health care operations and other specified exceptions.
- You have the right to request that we place additional restrictions on our use or disclosure of your records. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
- You have the right to request that we communicate with you about your mental health information by different means or to different locations. Your request that we communicate your mental health records to you by different means or at different locations must be made in writing to the contact person(s) listed at the end of this notice.
- You have the right to request that we change your mental health record information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may reply with a statement of disagreement that will be added to the information that you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others of the change, including people you name, and to include the changes in any future sharing of the information.
- If you have received this notice electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request to the contact person(s) listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, please contact:

Meridian Psychiatric Partners, L.L.C.
ATTN: Dr. Flavio Arana, Director
625 N. Michigan Ave., Ste: 2550, Chicago, IL 60611

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and clinician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the “Notice of Privacy Practices”.

SIGNATURE

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