Meadowlark Psychiatric Services
Client Information

Please Print: Today's Date:_____

First Name:_____ MI:____ Last Name:_____ Nickname:_____

Social Security Number:_____ Sex: M [ ] F [ ] Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Circle the number you would like to receive reminder calls at:

Home Phone ( )_____ May we identify ourselves: Yes [ ] No [ ]

Work Phone ( )_____ May we identify ourselves: Yes [ ] No [ ]

Cell Phone ( )_____ May we identify ourselves: Yes [ ] No [ ]

Single [ ] Married [ ] Widowed [ ] Divorced [ ] Partner [ ] Name of significant other:_____

Primary Care Physician:_____City/Clinic:_____

Referred to our office by:_____Relationship:_____

Emergency Contact:

Name:_____ Phone:_____Releationship:_____

Signature:_____Date:_____

If Client is a Minor:

Father: Name_____Address:_____

Home Phone:_____ Cell Phone:_____Date of Birth:_____

Mother: Name_____Address:_____

Home Phone:_____Cell Phone:_____Date of Birth:_____

Guardian if not Father or Mother:

Name_____Address:_____

Home Phone:_____Cell Phone:_____Date of Birth:_____

Signature of Parent/Guardian:_____Date:_____

Meadowlark Psychiatric Services
320 W. Cherry Street
North Liberty, IA 52317
319-626-3300

CONSENT TO TREAT A MINOR

☐ **If not applicable please check box and continue to next page**

DATE: _____

PARENT/LEGAL GUARDIAN INFO

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ SS#: _____

I HEREBY AUTHORIZE:

The above named doctors or any doctors associated with the above named practice, and whomever he/she/they may designate as assistants, to administer the required care as deemed necessary to my (indicate relationship of child) _____

(Name of Child) _____

SIGNED: _____

WITNESSED: _____

Meadowlark Psychiatric Services - 320 West Cherry Street - North Liberty, IA 52317 - P319.626.3300 - F319.626.3084

Informed Consent Statement

Thank you for choosing Meadowlark Psychiatric Services. We want you to know what to expect as you participate in treatment at this facility. We offer both medication management and counseling for the treatment of psychiatric and psychological disturbances. In addition we offer psychological testing if your clinician feels that it is necessary. If you see a provider that can prescribe medications, he/she may see fit to prescribe one to you for the treatment of your symptoms. This is something that you and your provider will discuss and decide together. For treatment to be effective, medications must be taken as prescribed. With any medication, there are always risks of side effects that you and your provider will discuss. Results cannot be guaranteed for everyone, however with patients in continued care, excellent results are often achieved.

If you choose counseling or if one of the providers in our office refers you to counseling, you will meet with one of our therapists. Most likely, your therapy will involve discussion of personal issues. At times these may feel somewhat uncomfortable to discuss. Counseling relationships take time to develop just like any other relationship. Often it is important to see your therapist several times before you make a decision about whether or not it is a good fit. Therapy or counseling is not helpful to everyone but frequently, if given a chance can be extremely beneficial.

All of your treatment at Meadowlark Psychiatric Services is kept confidential. No information will be released without your written consent unless your clinician feels you are a danger to yourself or others. Releasing information to any agency or individual will require a signed release of information. Please ask for a HIPAA brochure if you have further questions about our privacy policy. We want you to feel comfortable and satisfied with your care. If you have questions or concerns do not hesitate to ask any of our staff.

I have read, understand and agree with the above informed consent statement. I have discussed any issues with staff that have been raised by this document.

Signature (client, parent or guardian as needed) **Date**

Meadowlark Psychiatric Services - 320 West Cherry Street - North Liberty, IA 52317 - P319.626.3300 - F319.626.3084

Client Information and Office Policies

Welcome to Meadowlark Psychiatric Services. We are glad you chose to receive care from us. We will treat you in a professional, courteous and timely manner. If you are pleased with the care you receive in our office, the highest compliment you can give is to refer your friends and family.

Confidentiality: Your confidentiality is one of our highest priorities. We are required by law to provide you a copy of specific privacy policies. These policies were enacted under the legislation called HIPAA which stands for *Health Insurance Portability and Accountability Act.* At your first visit, you will be offered a copy of our HIPAA brochure that explains our privacy policies in detail.

Insurance Payments: It is your responsibility to know who administrates your mental health benefits. **Please contact your insurance company for authorization to receive treatment.** Insurance companies often require *preauthorization* for mental health related services. As a courtesy, we will make reasonable attempts to get authorization for your services through your insurance company. However, it is your responsibility to make sure you have authorization for your services through your insurance company. Insurance companies will often deny payment for services because there is not a preauthorization for the service. **You will be responsible for payment of all services that are not paid by your insurance company, including denials for no preauthorization.**

Payment of Services: You are responsible for the timely payment of all services rendered, even if health insurance will pay for a portion of the charges. It is our policy that the person who seeks treatment is responsible for payment of those services. Our policy is to charge $25.00 for any returned check. This charge will be included on your statement at the end of the month. Accounts with balances that are 90 days or older will be sent to a collection agency. Payment plans are available upon request.

Scheduling and Keeping Appointments: If you are unable to keep an appointment for any reason, please call us as soon as possible. **Appointments not kept and not cancelled by closing the day before the appointment, will be assessed a "No Show Charge" of $65. After two missed appointments or late cancellations, action may be taken to terminate care.** Keeping appointments is an important part of treatment as well as a necessary business practice. We will not charge for late cancellations due to weather.

Release of Information: Information will not be released without a signed release of information. Please ask the front desk for a release for any individual or agency that you would like involved in your care. Any paperwork or correspondence that you need completed will require a signed release of information.

Prescription Refills: We require **72 hours** advance notice to call in prescriptions with no refills remaining and for writing scripts for controlled substances. If you have refills, please contact your pharmacy to request a refill.

Forms and Paperwork/Attorney Work: We charge for forms and paperwork/attorney work. Our primary business is to provide psychiatric care to our clients. Requests to handle forms and paperwork/legal matters take away from this responsibility. There will be fees associated with this work including but not limited to; attorney correspondence, interviews, depositions, copies of records, subpoenas, all office time, FMLA paperwork, insurance forms, clinician and physician time. We will not charge for medical records sent to physicians, hospitals and other clinicians.

Emergency/After Hours: If you have an emergency need for a physician after hours, please go to the nearest emergency room, or call 911. If you have an urgent need for a physician after hours, please listen to the entire voicemail. It will have options for you. Also communicate with your physician at your appointment how they handle after hours needs as they do differ.

Signing below indicates that I have read, understand and agree to the policies in this document.

Signature:_____ **Date:**_____

Meadowlark Psychiatric Services
Client Information

Meadowlark Psychiatric Services - 320 West Cherry Street - North Liberty, IA 52317 - P319.626.3300 - F319.626.3084

Please Print: Today's Date:_____

First Name:_____ MI:____ Last Name:_____ Nickname:_____

Social Security Number:_____ Sex: M [ ] F [ ] Date of Birth:_____

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

Home Phone ( )_____ May we identify ourselves: Yes [ ] No [ ]

Cell Phone ( )_____ May we identify ourselves: Yes [ ] No [ ]

The Automated System will *only* do 1 of the options below to 1 phone number!

Please check a box below on how you would like to be notified of upcoming appointments:

[ ] I would like a **TEXT** reminder

[ ] I would like an **AUTOMATED VOICE** reminder call

[ ] I **DO NOT** want a remind call or text

Single [ ] Married [ ] Widowed [ ] Divorced [ ] Partner [ ] Name of significant other:_____

Emergency Contact:

Name:_____ Phone:_____ Relationship:_____

If Client is a Minor:

Father: Name_____ Address:_____

Home Phone:_____ Cell Phone:_____ Date of Birth:_____

Mother: Name_____ Address:_____

Home Phone:_____ Cell Phone:_____ Date of Birth:_____

Guardian if not Father or Mother:

Name_____ Address:_____

Home Phone:_____ Cell Phone:_____ Date of Birth:_____

Signature of Parent/Guardian:_____ Date:_____

Insurance Information

If the Subscriber ID# is different from the Subscriber Social Security # please make sure to give us the subscriber social security # and date of birth. Your insurance company requires this information when we call on your behalf to check on a claim.

Meadowlark Psychiatric Services - 320 West Cherry Street - North Liberty, IA 52317 - P319.626.3300 - F319.626.3084

Primary Insurance Name of Insurance Carrier: _____

Subscriber ID# _____ Group # _____ Relationship to Patient: _____

Subscriber Name: _____ DOB: _____

Subscriber Address: _____

Subscriber Social Security #: _____ Employer: _____

Secondary Insurance Name of Insurance Carrier: _____

Member ID# _____ Group # _____ Relationship to Patient: _____

Member Name: _____ DOB: _____

Member Address: _____

Social Security #: _____ Employer: _____

Guarantor Information: (Who will be receiving the bill)

Name: _____ Social Security # _____

Relationship to Patient: _____ Male ☐ Female ☐ DOB: _____

Address: _____

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

Employer: _____

Authorization:

I hereby authorize Meadowlark Psychiatric Services to furnish the insured's insurance company information, which said insurance company, may request concerning my present circumstances. I further authorized Meadowlark Psychiatric Services to release diagnostic information relative to my treatment, to a laboratory or hospital of my choice, for billing purposes only. I hereby assign Meadowlark Psychiatric Services all money to which I am entitled for expenses relating to the services performed from time to time, but not to exceed my indebtedness to Meadowlark Psychiatric Services. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Meadowlark Psychiatric Services for charges not covered by this assignment. I further authorize photocopies to be made of this authorization and assignment for attachment to any insurance form and authorize the insurance company to accept the photocopy. The authorization shall continue and be in force and effect until revoked in writing by me.

_____ _____

Responsible Party **Date**

Health Insurance Portability and Accountability Act (HIPAA)

Meadowlark Psychiatric Services - 320 West Cherry Street - North Liberty, IA 52317 - P319.626.3300 - F319.626.3084

I acknowledge that I have received a copy of the *Meadowlark Psychiatric Services* **HIPAA** brochure.

Signature:_____ **Date:**_____

AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Meadowlark Psychiatric Services
320 West Cherry Street
North Liberty, IA 52317
PHONE 319-626-3300/FAX 319-626-3084

Please complete this form in its entirety. Items not checked or blank spaces are assumed to be non-applicable or specifically not authorized for release. This release is invalid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient.

Patient: _____ DOB: _____ SS#: _____

Person/Place Releasing Information: Meadowlark Psychiatric Services

Address: 320 West Cherry Street Phone: 319-626-3300

City: North Liberty State: IA Zip: 52317 Fax: 319-626-3084

Where Information Is To Be Sent: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Check here if both parties will be receiving and releasing information: ☐

Information Requested: ☐ Complete Records/Demographics ☐ Notes Other: _____

Purpose of Release: ☐ Continuity of Care ☐ Transfer of Care Other: _____

I understand that this will include information relating to (all three boxes must be checked):

☐ Substance Abuse (Alcohol/Drug)

☐ Mental Health (Includes Psychological Testing)

☐ HIV – Related Information (AIDS-Related Testing)

☐ I give my consent to fax and/or mail my records.

☐ I understand that Meadowlark Psychiatric Services may receive compensation for disclosure of information released pursuant to this authorization.

I give Meadowlark Psychiatric Services or the named agency my permission to release only the information I have selected on this form to the individual(s) or agency(ies) I have named and only for the purpose I have checked. I understand that this release is valid up to the expiration date stated below, and I may refuse to sign this authorization at any time. Any revocation or refusal to sign this authorization will not effect my ability to obtain treatment, payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient, I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment for copying cost. I further understand that if the person or entity that receives the above specified information is not a health provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

Signature of Patient/Legal Representative: _____ Date: _____

If not patient, print name: _____ Relationship: _____

Witness: _____ Expiration Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

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Person/Place Releasing Information: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Where Information Is To Be Sent: Meadowlark Psychiatric Services

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