MEIER CLINICS
One of the most trusted names in Christian Counseling

CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS

Please initial all items below, then sign and date this section.

PRIVACY POLICY: I acknowledge having been offered Meier Clinics' "Notice of Privacy Policies and Clients Rights" form. Initials_____

CONSENT FOR TREATMENT: I hereby consent to treatment provided by Meier Clinics and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. Initials_____

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Meier Clinics. I authorize Meier Clinics to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Meier Clinics may release objective clinical information related to my diagnoses and treatment that may be requested by my insurance company or its designated agent.

MAILINGS: I agree to have my name placed on a mailing list to receive follow-up contact from Meier Clinics, including but not limited to the Meier Clinics E-newsletter, seminar information, and/or educational information, etc. Initials_____

Client or Authorized Person Signature	Relationship	Date
Witness Signature	Date	

CHILD AND ADOLESCENT CONSENT FOR TREATMENT (if applicable)

Patient (please print): _____ Birth date: _____
(last name) (first) (middle)

I certify that I am the ❒ father, ❒ mother, ❒ legal guardian of the above named child/adolescent and that I do have legal custody of the above named child/adolescent. I, hereby, give my authorization and consent for the above named child/adolescent to receive outpatient assessment/therapy from _____

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

DIVORCE/LEGAL SEPARATION COLLECTION POLICY (if applicable)

It is the policy of Meier Clinics that the parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. You will be responsible for payment of the child's/adolescent's treatment regardless of any financial arrangement for payment of the child's/adolescent's medical care, either oral or written, with the child's/adolescent's other parent or responsible party. Meier Clinics assumes no responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for your child's/adolescent's medical care.

I have read, understand, and agree to the above policy:

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

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