MEIER CLINICS
One of the most trusted names in Christian Counseling

CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS

PRIVACY POLICY: I acknowledge having been offered Meier Clinics "Notice of Privacy Policies" and their "Clients Rights Statement". (_____)

CONSENT FOR TREATMENT: I hereby consent to the 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. (_____)

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, which 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 Newsletter, Seminar information, and/or educational information, etc.(_____)

_____	_____	_____
Client or Authorized Person Signature	Relationship	Date
_____	_____	
Witness Signature	Date	

(Areas within (_____) are to be initialed by client or authorized person.)

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

Patient (please print): _____ Birthdate:_____
(last name) (first) (middle)

I certify that I am the (check one) ❒ 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

_____.

Name (please print): _____

Signature: _____ Date: _____

DIVORCE/LEGAL SEPARATION COLLECTION POLICY

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, understood and agree to the above policy:

Name (please print): _____

Signature: _____ Date: _____

Witness: _____ Date: _____