Metis Center for Psychological Services
www.metiscenter.net • (720) 387-8458

Today's Date______________ Name:________________________________ DOB:____________

Social Security Number: _________________

May we contact you via email? Email Address: _____________________________________

** Would you like to receive appointment reminders? If yes, by:

Please be aware that computers and unencrypted email can compromise the privacy and confidentiality of such communication. Please notify us if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted email we will assume that you have made an informed decision, will view it as your agreement, and will honor your desire to communicate on such matters.

Please do not use texts or email for emergencies as we cannot guarantee timely receipt of such communication.

Party responsible for billing: _____________________ DOB: _____________ SSN: ________________

Emergency contact person: ____________________ Phone number: _________________

Relationship:___________________ * Can this person make/cancel appointments for you?
* Can we discuss billing with this person?

~ If you would like us to bill through insurance, please include the following for the Policy Holder~

If you are the policy holder, skip to insurance specifics

Name:____________________________ DOB: ____________ Relationship to Patient: ___________

Phone:____________________________ Administrative Sex (as listed with insurance):

Full Address:____

Insurance Co:_________________ Member ID:___________________ Group Number:______________

IF YOU HAVE HMO OR EAP, YOU MUST SET UP AUTHORIZATION PROR TO FIRST APPOINTMENT

Payment Contract and Late Cancelation Fee

Payment for services is due in full at the time of the appointment. Once an appointment is scheduled, you will be expected to pay for it in full unless you provide 24 hours advance notice of cancellation. If notice is not given, a $65 fee will be charged. You are responsible for payment of services for claims denied by your insurer for any reason. *IF a balance on the account exceeds $300 – further dates of service will be suspended until the balance is paid*

I understand, and agree to, the policies stated above

Signature: ____________________________________ **Date:**__________________________

CONSENT FOR TREATMENT

I have been informed of my provider's degrees, credentials and practice policies in writing. I have read the preceding information and understand my rights as a consumer of mental health services.

When applicable, the Metis Center is happy to assist by submitting billing for our services to insurance carriers for reimbursement. Any balance not paid in full by the insurance carrier will become my responsibility and I agree to pay for any services billed to but not covered by insurance for any reason.

I understand and agree to the policies described herein. A copy of this document has been offered to me for my records. I consent to therapy, including assessment, evaluation, treatment and/or referrals as appropriate.

____

Patient Name (print)

____

Patient Signature Date

____

Parent/Guardian/Representative Signature (if applicable) Date

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS.

I consent for the Metis Center for Psychological Services to disclose my Protected Health Information (PHI) when necessary for treatment, billing, and operations. I have a right to request a restriction on this and revoke this consent if needed. I have been provided with the Notice of Privacy Practices for the Metis Center for Psychological Services and can request a revised copy at any time.

____

Patient Name (print) Date

____

Patient Signature Date

____

Parent/Guardian/Representative Signature (if applicable) Date