MetPsych

547 A Highland St.
Mt. Holly, NC 28120
Phone: 704-461-8253
Fax: 704-461-8267

Metrolina Psychotherapy Associates, P.A.

ADULT

Client Registration Information

Client Name: _____ **Today's Date**: _____
(last name), (first name), (middle initial)

Date of Birth: _____ **Age**: _____ **Social Sec #:** _____**Sex**: _____ **Race**: _____

Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Other_____

Current Address: _____ **Phone Numbers**: Please check which is preferred
_____ Home: _____
Cell: _____
Level of highest Education: _____ Work: _____
Email: _____

Place of Employment: _____ Position or title: _____
Employment Address: _____Number of years at the job: _____
_____

How were you referred to this office? _____

Primary Care Provider: _____ **Psychiatrist**: _____

Emergency Contact: _____/ relationship: _____ Phone: _____

Insurance Information

I. **Primary Insurance Company**_____ Phone Number**:** _____
Billing Address: _____ Group# _____
_____ Policy #_____
Policy Holder: self____ Other: _____ Relation to client: _____
Authorization Number: _____Policy Holder social security number: _____

II. **Secondary Insurance Company**_____ Phone Number**:** _____
Billing Address: _____ Group# _____
_____ Policy #_____
Policy Holder: self____ Other: _____ Relation to client: _____
Authorization Number: _____Policy Holder social security number: _____

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Informed Consent for Treatment

I give my consent for the staff of Metrolina Psychotherapy Associates, P.A. to provide a mental health evaluation and appropriate treatment to myself. This consent covers the treatment by my Therapist, Psychologist, Nurse Practitioner Psychiatrist.

Client Signature: _____ Date: _____

Legal Guardian Signature: _____

Consent for Treatment of Medical and Psychiatric Emergencies

I give my consent for this office to initiate first aide measures, to contact my Primary Care Physician, or alert the emergency medical system, if needed. I also consent for my emergency contact to be notified in such a circumstance.

Client Signature: _____ Date: _____

Legal Guardian: _____

Financial Policy / Agreement

- I understand that I am ultimately responsible for all charges and fees related to the treatment rendered to me at Metrolina Psychotherapy Associates, P.A. The co-pay, deductible, and / or cost share amounts, as well as any non-covered services from the visit, are due at the time of service. Information we receive from your insurance company is strictly an estimate of benefit and not a guarantee of payment.
- I am responsible for the charges and authorizations with my insurance company. This includes the acquisition of authorization and any issue that results in the insurance company's non-payment for rendered services. I understand that the filing of insurance claims is a courtesy service that Metrolina Psychotherapy Associates provides only for my convenience.
- I hereby authorize payment of medical benefits to Metrolina Psychotherapy Associates, P.A. for services rendered.
- If I feel that my claim has been inaccurately denied for something other than error on Metrolina Psychotherapy Associates behalf, it is my responsibility to dispute this directly with my insurance provider. I will be responsible for any remaining balance on my account at that time. If the claim is later resolved by my insurance provider, Metrolina Psychotherapy Associates, P.A. will refund any amount due.
- Referrals or authorizations required by my insurance company not obtained within five (5) business days prior to the visit will require the full amount of the visit to be paid at that time.

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- If new insurance is presented at the time of the appointment and takes longer than fifteen (15) minutes to verify, I will be given the option of paying for services in full or rescheduling the appointment. If insurance befits are verified once I have been seen and payment has been made, Metrolina Psychotherapy Associates P.A. will file the claim and reimburse the remaining difference.
- I understand that it is my responsibility to notify Metrolina Psychotherapy Associates, P.A. when checking in for my appointment which insurance will be applied for the visit, with a corresponding billing address (that is usually found on the back of your insurance card).
- I understand that if payment from my insurance provider has not been received within sixty (60) days from the initial filing date of claim, it is my responsibility to pay my account balance in full.
- I authorize the release of any medical information necessary to process claims for services rendered.
- **It is our office policy to send accounts over one hundred and twenty (120) days to the collection agency of our choice**.
- I understand that if my account is assigned to an attorney for collection and / or suit, Metrolina Psychotherapy Associates, P.A. shall be entitled to reasonable attorney's fees and costs for collection, and that information regarding my account may be released. Please understand that no Therapy or Treatment information will be released, only that that service was rendered.

Method of Payment

Metrolina Psychotherapy Associates, P.A. will accept cash, Visa, MasterCard, Discover, and personal checks, or Money orders. * Please note that American Express is not accepted.

****Missed Appointments****

Metrolina Psychotherapy Associates, P.A. requests that in the event you are not able to make an appointment for any reason, that you cancel the appointment with 24 hours prior to that appointment to maximize appointment times for all clients. Please be aware that failure to do so will result in a $50 dollar fee that is non-reimbursable by any insurance company and therefore is your direct responsibility.

Client Signature: _____ Date: _____

Returned Checks

Please be aware a fee of $25 dollars will be assessed for any returned checks, limited to two occurrences to cover bank service fees.

******I have read, understand, and agree to all of the above information******

Client Signature: _____ Date: _____

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Personal Information

We thank you for choosing Metrolina Psychotherapy Associates, P.A. We pledge to work with you toward achieving, and enjoying a grounded, well rounded life through emotional growth.
Please take a few moments to help us better understand your situation by filling out these questions. *Please know that this information will be highly respected as part of your protected health information, and will be a part of your* ***confidential*** *file.*

Please describe (from your view) the reason for today's visit:
_____
_____
_____

Do you see yourself as struggling with:

Depression_____ Anxiety_____ Anger_____
Marital stress_____ Substance use problems_____

List people you live with: _____

Any major medical problems: _____

Current medication/doses: to include over-the-counter medications, vitamins, minerals, and herbal supplements: _____

Have you experienced therapy before? _____Never
_____Yes; How many therapists:_____

Have you been admitted to a hospital for psychiatric reasons?
_____No
__Yes, how many times____

What are you main goals for therapy?

1.)_____
2.)_____
3.)_____

****Thank you for your time, effort and patience with this necessary paperwork. Your doctor / therapist will be with you shortly.****