MetPsych

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

Metrolina Psychotherapy Associates, P.A.

Child / Adolescent

Client Registration Information
Dietitian Services

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

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

Parents / Caretakers Name: Mom: _____ Dad: _____
Step dad: _____ Step Mom: _____
Other (s): _____

Current Address: _____ **Phone Numbers**: Please check which is preferred
_____ Home: _____
Cell: _____
Grade Level: _____ **School Attending**: _____ Work: _____
Email: _____

How were you referred to this office? _____

Primary Care Provider: _____ **Psychiatrist**: _____
Office / phone: _____

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, and Dietitian.

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.

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 within 24 hours prior to that appointment. 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 with optimal wellness. With dietetic services, we pledge to optimize your health and wellness.

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:

_____

_____

_____

List people your child lives with: _____

Any major medical problems: _____

_____

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

_____

Has your child seen a dietitian before? _____Never

_____Yes

What are your main health goals for your child?

1.)_____

2.)_____

3.)_____

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