Mefford, Vuagniaux & Associates, P.C.

NEW PATIENT FORM

PATIENT INFORMATION:

First/Last Name: _____ MI: _____

SS#: _____ Date of Birth: _____ Sex: ____ M ___ F

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer/School: _____ Referred by: _____

Family Physician: _____ Psychiatrist: _____

Emergency Contact: Phone: Relation: _____

PARENT/GUARDIAN INFORMATION: *(Must be filled out if patient is under age 18 or has a guardian)*

First/Last Name: _____ MI: _____

SS#: _____ Date of Birth: _____ Sex: ___ M ___ F

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer/School: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

INSURANCE INFORMATION: I agree to pay co-pay amount of $ _____

Name of Insurance/3rd Party/Private Party: _____

Subscriber ID / Policy #: _____ Group ID #: _____

Name of Primary Insurance Provider: _____ Relationship : _____

Date of Birth: _____ SS#: _____ Employment: _____

Address: _____ City/State Zip: _____ Phone: _____

SECONDARY INSURANCE INFORMATION:

Name of Insurance/3rd Party/Private Party: _____

Subscriber ID / Policy #: _____ Group ID #: _____

Name of Primary Insurance Provider: _____ Relationship : _____

Date of Birth: _____ SS#: _____ Employment: _____

Address: _____ City/State Zip: _____ Phone: _____

TREATMENT CONSENT/PAYMENT AGREEMENT

1.) I have read and agree/consent to treatment and authorize the use of this form/signatures on all billing submissions and authorize the release of this information to my insurance company(s)/third party payer. I authorize direct payment of benefits to the service provider.

2.) I understand that I am the responsible party for the full amount of my bill for services provided. Nonpayment of fees may result in termination of treatment and a 20% collection fee added to my account balance.

3.) I hereby permit a copy of this to be used in place of an original.

4.) I have been made aware of the Notices of Privacy Practices and that I am entitled to a copy. If I have questions I will contact the Security Officer, Tim D. Vuagniaux at (660) 826-2380.

5.) I understand all appointments are to be scheduled and if, for any reason, I cannot attend my scheduled appointment, I will **call at least 24 hours before scheduled appointment to avoid a $25.00 no show fee.**

Responsible Party Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Mefford, Vuagniaux & Associates, PC
Psychological and Counseling Services

121 East Broadway
Sedalia, MO 65301
(660) 826-2380
facsimile: 660-827-6277
e-mail: mvapc@sbcglobal.net

STATEMENT ON CONFIDENTIALITY

As a client of mine, I want you to be informed of your rights and the limits of confidentiality. The confidentiality of personal information shared with me as your psychologist/counselor is the cornerstone of a good therapeutic relationship. Only in this way can you feel free to work with me to discuss and explore problems and arrive at solutions. In most circumstances information shared is considered **privileged communication** and will *not* be shared with anyone, unless you first provide your written consent to do so.

There are, however, some circumstances that require the disclosure of information. They are as follows:

1. When mandated by state or federal law, that is, child abuse/neglect and elderly abuse/neglect.
2. When specifically ordered by a court of law.
3. When there is a serious threat of physical harm to self or others.
4. For the purpose of professional supervision.

If it becomes necessary to release information, it will be made in such a way as to protect as much confidentiality as possible.

I want to assure you as my client of my commitment to maintaining confidentially and that your case will be handled professionally and with the highest degree of confidentiality possible.

Your signature below verifies that you have received information about your rights concerning an Advanced Directive.

If age 18 or older, do you have an Advanced Directive (Living Will) ____Yes ____No

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ACKNOWLEDGEMENT

I, _____, hereby acknowledge that I have read and understand the above Statement on Confidentiality including the provisions of the statement addressing the extent to which my psychologist/counselor is permitted to disclose information about me.

_____ _____
Signature Date

Witness: _____

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SERVICES CONTRACT/TREATMENT AGREEMENT

I consent to psychological treatment with ***Mefford, Vuagniaux, & Associates, P.C.*** I understand that treatment may involve psychological therapy, counseling, consultation, evaluation, assessment or testing and fees I will be responsible for as stated in the services contract agreement.

I will provide *Mefford, Vuagniaux & Associates* all information needed to process services to my insurance. I hereby authorize *Mefford, Vuagniaux, & Associates* to release all information necessary to secure payment. If my health insurance offers complete or partial payment of fees; I will assign the insurance payments to *Mefford, Vuagniaux, & Associates*. I understand that I am financially responsible for all charges not paid by said insurance. I understand that nonpayment of fees will result in termination of professional services and collection activity for amounts owed.

Professional services are available through prior scheduling. **Should the need arise to cancel my scheduled appointment I will call at least 24 hours before the appointment to reschedule.**

Any variation from this consent/agreement will require a separate written agreement. *I have read and reviewed the services contract and this agreement and agree to its terms.*

Client	Date
Responsible Party *(if different)*	Date
Witness	Date

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Release of Information Consent

Name of Patient: _____ DOB: _____ SS#: _____

I _____, authorize ***Mefford, Vuagniaux & Associates, P. C.*** to:

____ (send) ____ (receive) the following ___ (to) ___ (from) the following agencies or people;

Name/Organization: _____ Phone: _____
Attn: _____ Fax: _____
Address: _____ City/State/Zip: _____

Name/Organization: _____ Phone: _____
Attn: _____ Fax: _____
Address: _____ City/State/Zip: _____

Name/Organization: _____ Phone: _____
Attn: _____ Fax: _____
Address: _____ City/State/Zip: _____

I agree that these providers (listed above) may share the following information about my mental healthcare. I understand that this is to help them cooperate in mental healthcare given to me or my child/dependant. The kind of mental healthcare information that may be shared is:

_____ Testing Results
_____ Case Notes
_____ Psychological Reports
_____ Progress Reports / Summary Reports
_____ Behavior Programs
_____ Other/Specify: _____

The above information will be used for the following purpose:

_____ Planning / Continuing appropriate treatment or program
_____ Determining eligibility for benefits or programs
_____ Case Review
_____ Other/Specify: _____

I understand that I may revoke this consent at anytime by providing written notice to Mefford, Vuagniaux & Associates, P.C. and after one year, of date signed, this consent automatically expires. I have been informed that information will be given, its purpose and who will receive information.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____