Myrtle C. Means, Ph.D.

CLIENT CONTACT & INSURANCE INFORMATION

Name_____Date_____

Address_____City/State_____Zip_____

Home Phone_____Work Phone_____Cell_____

Age_____Birth Date_____SS#_____

Email_____

Emergency Contact_____Relation_____

Emergency Contact Phone _____

Fee Schedule for Private Pay

Household Income	Session Fee*
Under $30,000	$85.00
$30,000-$39,000	$95.00
$40,000-$49,000	$105.00
$50,000-$59,000	$115.00
$60,000 and over	$125.00

***SESSION FEE WILL BE ASSESSED FOR A MISSED APPOINTMENT OR CANCELLATION WITH LESS THAN 48 HOURS ADVANCED NOTICE. PLEASE NOTE THAT INSURANCE COMPANIES DON'T REIMBURSE FOR MISSED APPOINTMENTS OR LATE CANCELLATIONS.**

INFORMED CONSENT FOR TREATMENT

On_____ (date), Myrtle C. Means, Ph.D., informed _____ (client) that any treatment undertaken at this facility is voluntary and he/she knowingly consents. If the client is under the legal age of consent, a parent's/guardian's signature is required. Confidentiality will be maintained to the fullest extent allowable by law and will be explained by the clinician. In case of emergency, I (client), give the above-named clinician permission to contact the individual named above. Furthermore, a signature below also means that you accept the responsibility for all fees accrued on this account. You will be given monthly statements and payment is due at the time that the statement is received.

_____ _____

Client/Parent Date Clinician Date

INSURANCE
INFORMATION

Primary Insurance

Person Responsible for Account:_____

Relation to Client:_____Date of Birth: _____

Social Security #:_____Employed By: _____

Insurance Company:_____Contract #: _____

Group #: _____

Secondary Insurance

Person Responsible for Account:_____

Relation to Client:_____Date of Birth: _____

Social Security #:_____Employed By: _____

Insurance Company:_____Contract #: _____

Group #: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Myrtle C. Means, Ph.D., L.P. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Myrtle C. Means, Ph.D., L.P. to release only information necessary to secure payment of benefits. I understand the Myrtle C. Means, Ph.D., P.C. uses a third party vendor and billing agent who are also bond by confidentiality. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Relationship Date

_____ _____

Client/Parent Date Clinician Date

Note: Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm. Please use technology with discretion. Only communicate limited information such as appointment request, cancellations, or estimated time of arrival.