***Gratia L. Meyer, Ph.D. Licensed Psychologist***
8751 E. Hampden Ave, Suite B-3
Denver, CO 80231
303.779.5232 FAX 303.221.8493
www.gratiameyerphd.com
gratiameyer@gmail.com

*WELCOME TO THE PRACTICE*
*OF GRATIA L. MEYER. PhD.*

Dr. Meyer is pleased to welcome you as a new client. Please print these forms and complete them as accurately as possible so we can most appropriately address your mental health needs.

The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPPAA).

**If you have any questions regarding the forms, Dr. Meyer can help you with them.**

We thank in advance for your patience and understanding.

# PATIENT REGISTRATION

Today's Date _____

Patient's full name _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ SS#_ _ _/ _ _ / _ _ _ _

Home address _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ City _ _ _ _ _ _ _ ZIP _ _ _ _ _

Home Phone # ( _ _ _) _ _ _- _ _ _ _ Cell Phone # ( _ _ _) _ _ _- _ _ _ _

Sex: __ Age: ____ Date of Birth: _ _ / _ _ / _ _ Email: _____

Credit Card#: _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _

Exp Date _ _ /_ _ V-Code _____

Driver License # _____ State _____

Patient Employer _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Phone # ( _ _ _) _ _ _- _ _ _ _

Primary Care Physician _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Phone # ( _ _ _) _ _ _- _ _ _ _

Person to contact in Emergency: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Phone # ( _ _ _) _ _ _- _ _ _ _

**INSURED/RESPONSIBLE PARTY INFORMATION**
Please complete this section regardless of insurance coverage.

Full Name of Insured: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Relationship to patient_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Home address _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Phone #_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Work # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Employer:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Address: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ City: _ _ _ _ _ _ _ _ _ _ _ _ _ _

Insured SS# _ _ _ _ _ _ _ _ _ _

Full Name of spouse: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Phone #:_ _ _ _ _ _ _ _ _ _ _ _ _ _

Spouse's Employer: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Phone #:_ _ _ _ _ _ _ _ _ _ _ _ _ _

Primary Ins. Co.: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ID

#_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Grp #_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Secondary Ins. Co.: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ID

#_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Grp #_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

**OFFICE BILLING AND INSURANCE POLICY**

Our office will prepare and submit the insurance claims for you. Although we will aid you in obtaining reimbursement, it is understood that ultimately it is your responsibility to keep your bill current

1. I authorize the release of appropriate information to my insurance company(s).
2. I understand that I am responsible for the full allotted amount of my bill for services provided.
3. I authorize direct payment to the provider and if I receive the insurance check, I will reissue to the provider.
4. I hereby permit a copy of this to be used in place of an original.

Signed:_____ Date _ _ / _ _ / _ _ _ _

## COLLECTION AND FEES

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance. You are responsible for co-payment amounts and deductibles as set by your benefit plan. If you have dual mental health coverage, estimated patient responsibility will be based on your primary benefit. We will file a claim with the secondary insurance for you. Your insurance company does not cover missed/no show appointments and you are responsible for No Show fee of $50 per session. If you cancel less than 24 hours and Dr. Meyer's office cannot fill your cancelled **appointment,** you will be assessed a fee of $50.00. For a Monday appointment, you need to cancel by noon on Friday. You will be expected to pay for each session at the time it is unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed upon.

At any time during treatment should you become ineligible for insurance coverage, please notify Dr. Meyer and please understand you *will* become responsible for l00% of the bill. **Initial here:** _____

If your account is more than 90 days or insurance denial incur, Dr. Meyer has the option of using legal means to secure the payment. This may involve hiring an attorney. If such legal action is necessary, the costs will be $200 for attorney fees, plus court costs and interest at the rate of 2 l % per year.

**INSURANCE REIMBURSEMENT**

To set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have mental health insurance, it will provide some coverage and I will fill out the necessary forms. Some Managed Health Care plans often require authorization before initial therapy. Please contact them for authorization and the number of session available.

For time to time, an insurance will require clinical notes. I will only provide them with electronic notes. This information will become part of the insurance company's files. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company.***

It is important to remember that you always have the right to directly pay for my services to avoid any insurance problems.

I understand and abide by the policies as stated above,

_____ _____

Signature Date

# HEALTH HISTORY

Name _____

Date of birth _____

General Health _____

_____

**Please list any illnesses you are currently or have been treated for by year and condition**

| Year | Condition |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**List all medications you are currently taking, include over-the-counter drugs and herbal supplements**

| Medication | Dosage | Reason |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

_____
Signature

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**AUTHORIZATION FOR THE RELEASE OF SECURED INFORMATION**

Patient's Name _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _DOB _ _/ _ _ / _ _ _ _

ID#: _ _ _ _ _ _ _ _ _ _ _ _ _

Doctor/ Clinic _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Address: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

City: _ _ _ _ _ _ _ _ _ _ _ _ _ ZIP: _ _ _ _ _ _ Phone # _ _ _ _ _ _ _ _ _ _ _

***Information to be released:***

___ Chemical Recovery History ___ Court/ Agency Documents

___ Treatment Plans/ Diagnoses from medical and mental health providers

___ Medical Consultation ___ Medical Records

___ Verbal Communication

**This authorization is in effect for _ _ _ days from the date of signature or**

**_ _ _ as long as in treatment.**

**This document serves as both a release and secure of information.**

_____ _____

Signature Date

# Confidentiality

## Email Communication

I will use email only with your permission and only after you have sent me an email requesting a response. The email exchanges with my office should be limited to setting and changing appointments, billing matters and other related issues. If you need to discuss a clinical matter with me, please feel free to call me and we will discuss it on the phone or wait until your next therapy session.

## Text Messaging

If you are comfortable with knowing that text messaging is a very unsecure mode of communication, you can text me and I will respond with a text. I use a paging service that allows you to text me your message. This is secure messaging system by American Messaging.

## Social Media

I do not communicate with, or contact, any patient through social media platforms such as Twitter, Facebook or Instagram.

## Website

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website. If you have any questions, I will be glad to discuss them during your therapy session.

## Web Searches

I will not use web searches to gather information about you without your permission.

Recently patients have reviewed their health care providers on various medical websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you

encounter such reviews of me, please feel free to discuss it with me. Please do not rate my work with you while we are in treatment together on any of these websites. This rating may have a significant potential to damage our ability to work together.

In general, the privacy of all communications between patient and a psychologist is protected by law, and I only can release information about your therapy with your written permission. In most legal proceedings, you have the right to prevent me from providing any information about your treatment.

If I believe that you are threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim and contacting the police. If you threaten to harm yourself, I am obligated to seek hospitalization for you and/or contact your emergency contact. I will attempt to fully discuss it with you before taking any action.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

PATIENT SIGNATURE DATE

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, INCLUDING MENTAL HEALTH INFORMATION, MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

During the process of providing services to you_____(Insert your name), hereinafter referred to as "Patient") Gratia L. Meyer, PhD, (hereinafter referred to as " Practitioner") will obtain, record and use mental health and medical information about you that is Protected Health Information, (hereinafter referred to as "PHI"). Ordinarily, that information is confidential and will not be used or disclosed, except as described below.

## I. USES AND DISCLOSURES OF PROTECTED INFORMATION.

A. General Uses and Disclosures Not Requiring the Patient' s consent. Practitioner will use and disclose PHI in the following ways.

1. Treatment. Treatment refers to the provision, coordination, or management of health care, including mental health care, and related services by one or more health care providers. For example, Practitioner will use your information to plan your course of treatment. As to other examples, Practitioner may consult with professional colleagues or ask professional colleagues to cover her calls and will provide the information necessary to complete those tasks.

2. Payment. Payment refers to the activities undertaken by Practitioner to obtain or provide reimbursement for the provision of health care, including mental health care. Practitioner will use your information to

develop accounts receivable, bill you, and with your consent, provide information to your insurance company or other third-party payer for services provided. The information provided to insurers and other third-party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

2. Health Care Operations. Health Care Operations refers to activities undertaken by Practitioner that are regular functions of management and administrative activities of the practice. For example, Practitioner may use or disclose your health information in the monitoring of service quality, staff evaluation, and obtaining legal services.

3. Contacting the Patient. Practitioner may contact you to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

4. Required bv Law. Practitioner will disclose PHI when required by law or necessary for health care oversight. This includes, but is not limited to, when (a) reporting child abuse or neglect; (b) a court-ordered release of information; (c) there is a legal duty to warn or take action regarding imminent danger to others; (d) the Patient is a danger to self or others or gravely disabled; (e) a coroner is investigating the Patient's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.

5. Crimes on the Premises or Observed by the Practitioner. Crimes that are observed by Practitioner, Practitioner ' s staff, or Practitioner' s office mates or staff thereof that are directed toward Practitioner, Practitioner’s staff, or Practitioner' s office mates or staff thereof, or crimes that occur on the premises, will be rep01ied to law enforcement.

6. Business Associates. Some of the functions of Practitioner may be provided by Business Associates. For example, some of the billing, legal, auditing, and practice management services may be provided by

outside entities to perform those services. In those situations, PHI will be provided to those outside entities as is needed to perform their tasks, and these Business Associates will be required to enter into an agreement maintaining the privacy of the PHI released to them.

7. Research. Practitioner may use or disclose PHI for research purposes if the relevant limitations of the Federal HIPAA Privacy Rule are followed 45 C.F.R. Section 164.512(i).

8. Involuntary Treatment. Information regarding Patients who are being treated involuntarily, pursuant to law. will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

9. Family Members. Except for certain minors, incompetent patients, or involuntarily treated Patients, PHI cannot be provided to family member ' s without the Patient's consent. In situations where family members are present during a discussion with the Patient, and it can be reasonably inferred from the circumstances that the Patient does not object, information may be disclosed in the course of that discussion. However, if the Patient objects, PHI will not be disclosed.

10. Emergencies. In life threatening emergencies, Practitioner will disclose information necessary to avoid serious harm or death.

B. Statements that Certain Uses and Disclosures Require Authorization. Practitioner must obtain your Authorization in order to use or disclose your PHI as follows: (1) for marketing purposes; (2) to sell your PHI to a third party; and (3) most uses and disclosures of your psychotherapy notes.

C Individual Authorization or Release of Information. Practitioner may not use or disclose PHI in any other way than set forth in this Notice without a signed Authorization. When you sign an Authorization, it may later be revoked, provided that the revocation is in writing. The revocation will apply, except to the extent Practitioner has already taken action in reliance thereon.

## II. YOUR RIGHTS AS A PATIENT.

A. Access to Protected Health Information. You have the right to inspect and obtain a copy of the PHI that the provider has regarding you, in the designated record set. If records are used or maintained as electronic health records, you have a right to receive a copy of the PHI maintained in the electronic health record in an electronic format. However, you do not have the right to inspect or obtain a copy of psychotherapy notes. There are other limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask Practitioner.

B. Amendment of Your Record. You have the right to request that Practitioner amend your PHI. Practitioner is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you, if any. To make a request, ask Practitioner.

C. Accounting of Disclosures. You have the right to receive an accounting of your disclosures that the Practitioner has made regarding your PHI. However, the accounting does not include disclosures that were made for the purpose of Treatment, Payment or Health Care Operations. In addition, the accounting does not include disclosures made to you, disclosures made pursuant to a signed Authorization, or disclosures made prior to April 14, 2003. There are other exceptions that will be provided to you, should you request an accounting. To make a request, ask Practitioner.

D. Additional Restrictions. You have the right to request additional restrictions on the use or disclosure of your health information. Unless you pay for your services out of pocket, Practitioner does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. If you pay for a service out of pocket, you are permitted to demand that information regarding the services not be disclosed to your health plan or insurance. To make a request, ask Practitioner.

E. Alternative Means of Receiving Confidential Communications.

You have the right to request that you receive communications of PHI from Practitioner by alternative means or at alternative locations. For example, if you do not want Practitioner to mail bills or other materials to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be provided to you at the time of the request process. To make a request, ask Practitioner.

F. Breach Notification. In the event of any breach of your unsecured PHI, Practitioner will notify you of such breach within sixty (60) days of the date Practitioner learns of the breach.

G. Copy of this Notice. You have a right to obtain another copy of this Notice upon request.

## III. ADDITIONAL INFORMATION.

A. Privacy Laws. Practitioner is required by State and Federal law to maintain the privacy of PHI. In addition, Practitioner is required by law to provide individuals with notice of Practitioner's legal duties and privacy practices with respect to PHI. This is the purpose of this Notice.

B. Terms of the Notice and Changes to the Notice. Practitioner is required to abide by the terms of this Notice, or any amended Notice that may follow. Practitioner reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all PHI that it maintains. When the Notice is revised, the revised Notice will be posted at Practitioner' s service delivery site and will be available upon request.

C. Complaints Regarding Privacy Rights. If you believe that your privacy rights have been violated by Practitioner, you have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to:

Regional Manager, Office for Civil Rights

U.S. Department of Health & Human Services 999 18th Street, suite 417
Denver, Colorado 80294
Phone: (800) 368-1019
TDD: (800) 537-7697
FAX: (303) 844-2025

It is the policy of Practitioner that there will be no retaliation for your filing such complaints.

D. Contact Information. If you have questions about this Notice or desire additional information about your privacy rights, please discuss with Practitioner.

_____ _____
Signature Date

_____ _____
Signature Date

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Denver, CO 80231
303.779.5232 FAX 303.221.8493
gratiameyer@gmail.com

## Accreditation

Licensed Psychologist, CO 1661
American Psychological Association, 16129771
Fellow, American Academy of Psychologist Treating Addictions

**EMDR, Lic#8143**

Board Certified, Diplomate-Fellow in Advanced Geriatric Psychology

## Education

Ph.D. University of Pittsburgh

## Expertise

Mindfulness Therapy, Attachment Disorder
Alcohol and Substance Abuse
Dual Diagnosis/Bipolar Disorder
Depression/PTSD
Separation and Generalized Anxiety Disorders/ Panic Disorder
Adoption
Chronic Pain and Illnesses