metanoia ranch

125 E Pearl Ave., #207
Jackson, WY 83001
601 454 6505

Today's Date _____

Patient Name

_____

Last First Middle

Date of Birth _____ Age _____

Address _____

Street City State Zip

Mailing Address (If different from above)

_____

Street City State Zip

Email address _____

(Parent's email if patient is a minor)

Home Phone _____ Cell _____

Marital Status _____ Spouse's Name _____

Employer (or School) _____

Referred By _____

If patient is a minor, please provide names and phone number of both parents:

Father _____ Cell _____

Mother _____ Cell _____

Person responsible for payment _____

Address _____

(If different from above)

Person to contact in an emergency _____ Phone _____

Previous Psychological treatment _____

Briefly describe the nature of this visit _____

Practice Policies

The following are our general policies and office procedures. Please read them carefully and sign the bottom of this sheet. Thank you.

Scheduling

Our sessions at Metanoia Ranch are 50 minutes in duration, and are set up in advance with our office personnel. Since your appointment is set aside for you alone it is important to give us a 24 hour advance notice if you need to cancel your session. This notice allows us time to reorganize our schedule to fill an open time slot. Except in the case of emergencies, failure to give us this notice will result in our charging you for the missed session.

Any contact with staff should be directed through the office at 601-454-6505.

Confidentiality

We maintain absolute confidentiality with regard to our patients' identities and the content of their therapy. However Wyoming law requires a potential breach of this privacy in some limited situations such as danger to self or others or abusive situations involving a minor. If you have any concerns whatsoever regarding the confidentiality policies of this office, please feel free to discuss them with your doctor.

Financial Considerations

We ask that you be prepared to pay for your visits our doctor at the time of service. If you have any concerns about payment issues, please address them with your doctor.

Agreement:

I have read, understood and accepted the above policies, procedures and conditions.

_____

(Signature of patient or legal representative)

_____

(Date)

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

: a basis for planning my care and treatment
: a means of communication among the many health professionals who contribute to my care
: a source of information for applying my diagnosis and surgical infromation to my bill
: a means by which a third-party payer can verify that services billed were actually provided
: and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the rigth to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address. I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action un reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____

Signature of Patient or Legal Representative

Date _____