Theodore Meltzer, M.A.

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Voice: (314) 997-6463 Fax (314) 997-4423

Patient Name			DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	SS#	Marital Status:
Employer:		Occupation:	
Address:		Phone:	
Responsible Party:	DOB:	Relationship to you:	
Address:	City:	State:	Zip:
Home Phone:	Cell:	SS#:	
Employer:		Phone:	
Spouse:	DOB:	SS#:	

Preferred method of contact:

☐ Call me at (Phone number): ____________________

☐ Text me at (Phone number): ____________________

☐ Email me at (Email address): ____________________

Referred by:	Authorization #:	Copay:
# Visits Authorized:	From:	To:

COMPLETE ONLY IF YOU DID NOT GIVE US A COPY OF YOUR INSURANCE CARD

Insurance Company:		Phone:
Subscriber's name:	ID#	Group #:
Address:	City, State and Zip:	

Assignment of Benefits and Consent for Treatment:

I hereby assign payment of authorized medical benefits and/or psychological benefits, to include major medical benefits, to Mind Care Associates, LLC for any services furnished. I authorize any holder of medical information about me to release any information needed to determine the benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for charges whether or not paid by said insurance. If this account is assigned to an attorney for collection and/or suit, I agree to pay your court cost and your attorney fees. I also understand that a 24-hour notice is required for canceling appointments or I will be charged. I hereby authorize said assignee to release all information necessary to secure payment. I give my consent for this practitioner to render treatment on the above-mentioned patient for mental health services.

Date:	Signature:

I authorize this provider to release pertinent information to my Primary Care Physician (PCP) for purposes of continuity of care. (optional)

Name, address and phone of primary care physician

Signature of Patient or Legal Guardian

I have received a copy of the Notice of Provider Privacy Practices.

Date:	Signature: