New Patient Form

The Meridian Group of Chesterfield
MeridianHelp.com
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_____ Clinician:
Time and Date of First Appointment

___ John Dwyer, PhD
___ David Epstein, PsyD
___ Melissa Findlay, LCSW
___ Jill Sexton-Newton, LCSW
___ Elizabeth Novak, LCSW

Please complete this form along with either the Adult or Child and Adolescent Intake Form and bring to your first appointment. If you have any questions, you can ask your clinician or office staff.

Name of Patient: _____ Gender: M F Other
first middle initial last

Date of Birth: _____ Age: _____ Parent/Guardian Name: _____
(if patient is a minor):

Address: _____
street city state zip

Cell Phone: _____ cell home work
Please list only phone numbers your clinician may call

Second Phone Contact: _____ cell home work

Email: _____
By providing email you give consent for email communication.

Primary Care Physician: _____ May we contact you PCP as needed? Yes No

Agreement to allow direct insurance payment to The Meridian Group and/or specific clinician seen for services rendered.

I authorize medical payments from: _____
Insurance Company

_____
Insurance Member/Subscriber Number Group Number

List any secondary insurance: _____
Insurance Member/Subscriber Number Group Number

HIPAA Privacy Practices and Policies and Office Policies

HIPAA Privacy Practices and Policies: https://www.meridianhelp.com/docs/HIPAA.pdf
Office Policies: https://www.meridianhelp.com/docs/Office-Policies.pdf

[ ] I have reviewed the HIPAA Privacy Practices and Policies and agree to all Office Policies including being responsible for any payments not covered by insurance. Copies are also available from you clinician or the front desk.

_____ _____
Signature Date