

Credit Card Information

JBMealy and Associates, LLC accepts major credit cards. A valid credit card number is required. You may choose to pay some or all fees by credit card. An appointment missed without 24 hour notice will be charged (full fee) immediately to your credit card. All accounts with an outstanding balance that have been inactive for more than thirty days will be billed directly to your credit card account.

Credit Card type: _____

Account Number: _____ Date of Expiration: _____

I authorize JBMealy and Associates, LLC, to bill for accounts unpaid beyond thirty days and to bill for specific dates of service when I give verbal authorization.

Responsible Party Signature: _____

Date: ____/____/____

Please read carefully

I hereby authorize representatives for JBMealy and Associates, LLC to release the information requested to the insurance company named hereon. I hereby assign insurance payment directly to JBMealy and Associates, LLC of benefits otherwise payable to me.

Responsible Party's Signature: _____

I understand that I am financially responsible for charges not covered by this authorization, and further agree to pay these fees in a timely fashion via cash, check, or credit card. I agree that in the event of the bounced checks or if my account is turned over for collection, I will be responsible for bank fees, collection fees, interest, court costs and attorney's fees.

I accept the above policies.

Responsible Party Signature: _____

Date: ____/____/____

**JBMealy and Associates, LLC
PATIENT REGISTRATION**

PATIENT'S NAME: _____
First Middle Last Nickname

Date of Birth: ___/___/___ **Social Security No.** _____

Employer/School: _____ **Work Phone:** _____

Email: _____ **Cell Phone:** _____

PATIENT'S NAME: _____
First Middle Last Nickname

Date of Birth: ___/___/___ **Social Security No.** _____

Employer/School: _____ **Work Phone:** _____

Email: _____ **Cell Phone:** _____

Address:

Street Address, P.O. Box, Apartment Number

City State Zipcode Home Phone:

Immediate Family Members	DOB	Sex	Occupation or Grade	Employer or School	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

JBMealy and Associates, LLC
15817 Crabbs Branch Way
Rockville, MD 20855
301-948-2280

Referred By: _____

Family Physicians	Address	Phone Number
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List any Current Medications being taken: _____

List any Significant Health Problems: _____

Other Human Service and/or Psychotherapy Involvements:

Service Provider	Dates Seen
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If you are seeking counseling in relationship to a legal matter, please give the name(s) and phone numbers of all attorneys involved in your case(s).

Attorney's Name	Person Represented	Phone Number
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Signature of Person Completing Form

Today's Date

JBMealy and Associates, LLC
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NOTICE OF PRIVACY PRACTICES – BRIEF VERSION

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

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. These laws are complicated, but we must give you this important information. This document is a shorter version of the full, legally required NPP (Notice of Privacy Practices) which is available for more information. However, we can't cover all possible situations so please let us know of any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to sue or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will make every attempt to keep your health information private but there are some times when laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. For Worker's Compensation and similar benefit programs.
3. If an insurance company, HMO or third party having a financial interest in payment for claim asks for information.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP, which are posted in the office.

_____ I have received this practice's Notice of Privacy Practices in plain language

Full Name of Patient

Date of Birth

Signature of patient, parent or guardian

**JBMealy and Associates, LLC
15817 Crabbs Branch Way
Rockville, MD 20855
301-948-2280**

Identified Patient's Name: _____

Please be advised that you are responsible for paying the full fee for psychological services rendered by JBMealy and Associates, LLC if you have not obtained pre-authorization from your insurance company.

A 24 hour notice is required for all canceled appointments, or else full charges will apply. (Insurance companies do not cover missed appointments.)

I have read the above statement and accept full responsibility for fees for services not authorized by my insurance company. Additionally, I understand that I will be charged for all missed appointments unless I provide a 24 hour notice of cancellation.

Signature of Responsible
Party: _____

Date: ____/____/____

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Please inform JBMealy and Associates, LLC if your insurance information has changed or your insurance company has sent a new card to you. If your insurance plan requires you to obtain a referral/authorization (or a renewal for such) you are responsible for bringing in this information at the time of visit. Some insurance companies no longer offer providers written information regarding when authorizations need to be renewed. The authorization information is sent directly to you so it is your responsibility to provide us with this information.

Please assure that we have the most recent copy of your insurance card (front and back). If you fail to provide us with insurance updates you will be responsible for the full psychological service fee.

Thank you for your cooperation.

JBMealy and Associates, LLC

John Burke Mealy, Ph.D.

Nicole Stern, Ph.D.

Debra Anderson, Ph.D.

Susan Van Ost, Ph.D.

Stephanie Palmer, Ph.D.

Melissa Phillips, Psy.D.