meda
multi·service
eating disorders
association

CLIENT REGISTRATION FORM

Please be aware that while we will do our best to give you referrals of specialists in your area and under your insurance, this is not always possible. Certain areas and insurances have fewer providers that specialize.

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone (home/work/cell): _____
Email: _____ MEDA should contact me by: ☐ Phone ☐ Email

Would you like to be added to MEDA's e-mail list? ☐ YES ☐ NO
Would you like to receive US postal mail from MEDA? ☐ YES ☐ NO

What are your main goals for your appointment today (check all that apply):
☐ Referrals for outpatient treatment
☐ Information on local/national treatment centers
☐ Register for a support group
☐ Schedule a skills session with a clinician
☐ Information about research opportunities
☐ Other

Annual Income (check all that apply): ☐ Student ☐ Unemployed ☐ Retired
☐ <$20,000 ☐ $20,000-50,000 ☐ $51,000-100,000 ☐ >$100,000

Gender: ☐ Male ☐ Female ☐ Prefer not to answer ☐ Other_____
Pronouns: ☐ She, her ☐ He, his ☐ They/their ☐ Other _____

Race/Ethnicity:
☐ American Indian or Alaska Native
☐Asian
☐Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other/Prefer not to answer: _____

How did you learn about MEDA? ☐ Referral from PCP/Therapist ☐ MEDA Presentation

☐ Web search ☐ Friend/Family ☐ Facebook ☐ Other:_____

Have you sought treatment for an eating disorder before?: ☐ Yes ☐ No

Health Insurance Provider: _____

Emergency Contact: _____ Phone: _____

Relationship to you?: _____

A) Consent

I come to MEDA by my own free will and desire on (date) _____ for an eating disorder assessment/ group intake. MEDA is not responsible in any way for me and / or actions taken by me upon leaving the office.

B) Payment

I understand that I am responsible for payment to MEDA and acknowledge that MEDA has discussed all fees with me. I hereby authorize MEDA to release clinical information to its billing agency and accounting agency solely for billing and accounting purposes. This authorization is limited to the release of only that information necessary to process billing and accounting and excludes confidential information, which by law may only be released by specific consent.

C) Referral Disclaimer

Referral information I receive at MEDA is supplied solely by the facilities and providers themselves and is not guaranteed or endorsed in any way by MEDA. The MEDA referral list includes service providers that have registered as MEDA members and pay uniform annual membership dues as well as eating disorder specialists who are not MEDA members. I am responsible for interviewing and selecting a suitable provider, and I should contact providers directly. By accepting referral information from MEDA, I understand and agree that MEDA is in no way responsible for the acts, omissions, results or services of any of the providers, or for any other actions I or anyone else takes based upon the information provided by MEDA.

* I have read and accepted the above mentioned (A, B, and C).

(X) _____ Date: _____

Client or Legal Guardian

(X) _____ Date: _____

Witness