Lifespan Services, Inc. 5207 Trouble Creek Rd. New Port Richey, Fl 34652
Office 727-847-0069 / Fax 727-849-3780

CLIENT INF0RMATION (PLEASE PRINT)

DATE: __/__/__

CLIENT'S NAME: _____DOB:_____SEX_____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP CODE:_____ SSN:_____

HOME PHONE:_____-_____ WORK PHONE:_____-_____OTHER:_____

CAN WE LEAVE A MESSAGE AT HOME? Y ___N___ AT WORK? Y ___N___ OTHER? Y____N____

EMAIL ADDRESS: _____

MARITAL STATUS: M___S___D___ DRIVER'S LIC#_____

EMPLOYER: _____ ADDRESS: _____

NAME / ADDRESS / PHONE OF RELATIVE NOT LIVING WITH YOU:_____

_____

RELATIONSHIP OF ABOVE: _____

PRIMARY CARE PHYSICIAN NAME & PHONE NUMBER: _____

DO YOU WANT TO SHARE INFORMATION WITH YOUR PHYSICIAN? Y_____N_____

ARE YOU SEEING ANY OTHER MENTAL HEALTH PROVIDER? Y___ N___ NAME_____

RELEASE OF INFORMATION:

IN ORDER TO PROCESS MY CLAIM, I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY FOR THIS PURPOSE ONLY.

I hereby assign all medical, including Major Medical benefits to which I am entitled, to the above named PROVIDER.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
THERAPIST SIGNATURE DATE

Thank you
We appreciate the opportunity to help enhance the quality of your life.

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INSURANCE INFORMATION:

IS SCHOOL BOARD PAYING? ___YES ___NO
DOES CLIENT HAVE PRIVATE INSURANCE? ___YES ___NO
IS THE CLIENT A MINOR? ___YES ___NO
DOES CLIENT HAVE MEDICAID? ___YES ___NO
DOES CLIENT HAVE MEDICARE ?___YES ___NO
IF YES, PLEASE COMPLETE SECONDARY INSURANCE INFORMATION.

PRIMARY INSURANCE:

PRIMARY INSURED NAME:_____ DOB:_____ SEX:_____

SS# OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____ INSURANCE CO:_____

ADDRESS:_____

GROUP #:_____ POLICY #:_____

MEMBER ID #:_____

SECONDARY INSURANCE (IF APPLICABLE):

INSURED NAME:_____ DOB:_____ SEX:_____

SS# OF INSURED:_____ RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____ INSURANCE CO:_____

ADDRESS:_____

GROUP #:_____ POLICY #:_____

NAME AS PROVIDED ON CARD:_____ BILL ZIPCODE_____

Valid Credit Card: Number:_____ Expiration:_____/____

__ DEBIT __ CREDIT __ DISCOVER __ MASTERCARD __VISA

"***ALL APPOINTMENTS MUST BE CHANGED OR CANCELLED 24 HOURS IN ADVANCE TO AVOID A*** **$40.00** ***CHARGE****"*

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS). I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I WILL NOTIFY YOU OF ANY CHANGES TO THIS INFORMATION. FOR YOUR CONVENIENCE, AFTER VISITS ARE DISCONTINUED, ANY REMAINING BALANCES WILL BE CHARGED TO YOUR CREDIT CARD ON FILE. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
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Intake Questionnaire

Name: _____ Date: _____

Prior to beginning therapy with me, I request that all my clients complete this form. The questions are designed to help you clarify the changes you want to make in your life, and the expectations you have of the following counseling relationship. Please give these questions much thought.

1. Make a list of things you want to change in your life:

_____

_____

_____

_____

_____

2. Rewrite the above list from most important (#1) to least important (#12):

1. _____ 7. _____

2. _____ 8. _____

3. _____ 9. _____

4. _____ 10. _____

5. _____ 11. _____

6. _____ 12. _____

3. What are some your self-defeating behaviors? That is, what do you do that seems to make things worse? (or just does not help you): _____

_____

_____

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INITIAL INTAKE

Client Name: _____ DOB: _____ Age: _____

How did you hear about us: _____ Education: _____

Problems with housing or daily living activities (eg: transportation, etc.) _____

Legal Problems: _____

Financial Problems: _____

Family Names Age Living/ Deceased

Parents _____.....____..... _____

_____.....____..... _____

Spouse _____.....____..... _____

Children _____.....____..... _____

_____.....____..... _____

_____.....____..... _____

_____.....____..... _____

Siblings _____.....____..... _____

_____.....____..... _____

Please answer the following statements how you feel: Strongly Disagree=SD, Disagree=D, Neutral=N, Agree=A, or Strongly Agree=A
(*The following items concern how you feel about your life in general*)

1. I am satisfied with my life: 1. _____
2. I feel good about myself: 2. _____
3. I am happy with the way I look: 3. _____
4. I have a good relationship with my family: 4. _____
5. I have supportive friends: 5. _____
6. My health is good: 6. _____
7. I experience little physical pain: 7. _____
8. I have adequate physical strength: 8. _____
9. I enjoy my leisure time 9. _____
10. I am happy with my job/work 10._____

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Please answer the following statements how you feel: <u>Strongly Disagree=SD, Disagree=D, Neutral=N, Agree=A, or Strongly Agree=SA</u>

(*The following items concern feelings you may have had <u>during the last month.)</u>*

11. I have a feeling of hopelessness about the future: 11._____
12. I feel worthless: 12._____
13. I feel blue: 13._____
14. I feel weak in parts of my body: 14._____
15. My heart pounds and races: 15._____
16. I have to avoid certain things, places, or situations because the frighten me 16._____
17. I feel that people, in general , are unfriendly and dislike me: 17._____
18. I have urges to beat, injure, or harm someone: 18._____
19. I feel that I am watched or talked about by others: 19._____

(*The following items describe difficult or stressful situations you may have experienced <u>during the last month)</u>*

20. I have recently had a physical fight with someone: 20._____
21. I have recently tried to harm myself or had a plan to do so: 21._____
22. I have recently become upset or angry: 22._____
23. I have recently broken things or destroyed property: 23._____
24. I am able to get around in the community on my own: 24._____
25. I can get help when I need it: 25._____
26. I take care of my home and living space: 26._____
27. I am functioning well at my work/school: 27._____

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MEDICAL HISTORY

Client: _____ Age: _____ Sex:_____

Family Physician: _____ Date of last physical: _____
Previous Hospitalizations:
Where (hospital/city) When How Long Reason
_____ _____ _____ _____

_____ _____ _____ _____

Are you presently taking medications? _____ Please list names & how often taken:

_____

_____

Any known allergies: _____
Please list any previous Psychological/Psychiatric treatment, or counseling:

_____

_____

Females: Any discontinued pregnancies? _____ How many? _____
Full term pregnancies? _____ How many? _____
Has anyone in your family (parents, brothers, sisters, cousins, aunts, uncles) had any of the following?
Please check all that apply:
_____ Kidney Disease _____ Tuberculosis
_____ Heart Disease _____ Mental Illness
_____ Cancer _____ Drug/Alcohol Abuse
_____ Tumors _____ Epilepsy
_____ Diabetes _____ Nervous Disorders

Please check any of the following of which you had in the past, or are now experiencing:

PROBLEM	PAST	PRESENT	PROBLEM	PAST	PRESENT
Blurred Vision.....	_____	_____	Chest Pain.....	_____	_____
Double Vision.....	_____	_____	Blackouts.....	_____	_____
Severe Headaches.....	_____	_____	Seizures.....	_____	_____
Dizzy Spells.....	_____	_____	Hepatitis.....	_____	_____
Head Injury.....	_____	_____	Allergies.....	_____	_____
Vomited Blood.....	_____	_____	Pneumonia.....	_____	_____
Back Pain.....	_____	_____	Diabetes.....	_____	_____
Hearing Loss.....	_____	_____	Sleeping More.....	_____	_____
Mood Swings.....	_____	_____	Sleeping Less.....	_____	_____
Compulsions.....	_____	_____	Confusion.....	_____	_____
Excessive Blood Loss..	_____	_____	Extreme Sadness.....	_____	_____
Loss of Consciousness.	_____	_____	Stomach Pains.....	_____	_____
Jaundice.....	_____	_____			

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PROBLEM PAST PRESENT

Shortness of Breath..... _____ ..... _____
Blood in Bowel Movements..... _____ ..... _____
Heart Attacks..... _____ ..... _____
Tuberculosis..... _____ ..... _____
Smoker's Cough..... _____ ..... _____
Kidney or Urine Infection..... _____ ..... _____

Blood in Urine..... _____ ..... _____
Menstrual Difficulties..... _____ ..... _____
Swollen Ankles..... _____ ..... _____
Bruise Easily..... _____ ..... _____
Weakness in Arms and Legs..... _____ ..... _____

Venereal Disease..... _____ ..... _____
Reactions to Medications..... _____ ..... _____
Blood Transfusions..... _____ ..... _____
Broken Bones..... _____ ..... _____
Sinus or Frequent Colds..... _____ ..... _____

Weight Loss ..... _____ ..... _____
Weight Gain ..... _____ ..... _____
Appetite Changes..... _____ ..... _____
Drug/Alcohol Abuse..... _____ ..... _____
Irritability..... _____ ..... _____
Excessive Worries..... _____ ..... _____

Crying Spells..... _____ ..... _____
Fears or Phobias..... _____ ..... _____
Hallucinations..... _____ ..... _____
Difficulty Concentrating..... _____ ..... _____
Frequent Loss of Temper..... _____ ..... _____

Extreme Nervousness..... _____ ..... _____
Frequent Job Changes..... _____ ..... _____
Bedwetting past age 6..... _____ ..... _____
Fingernail Biting..... _____ ..... _____
Blaming Others Frequently..... _____ ..... _____

Lack of Self-Confidence..... _____ ..... _____
Low Self-Esteem..... _____ ..... _____
Indecisiveness..... _____ ..... _____
Sexual Problems..... _____ ..... _____
Extreme Loneliness..... _____ ..... _____
Frequent Accidents..... _____ ..... _____

_____ _____
CLIENT SIGNATURE DATE

_____ _____

THERAPIST SIGNATURE DATE

Health Care Consulting 🕐Geriatric Care Management 🕐Counseling/Psychotherapy - all ages
Children and Family Services 🕐Parent Education 🕐Child Care Consulting

CLIENT ORIENTATION

Program Rules :

1. Lifespan Services, Inc. will provide outpatient counseling, evaluation, information and/or referral.
2. No drug or alcohol screening or "search and seizure" methods will be employed.
3. Client is expected to pay for services when services are rendered. If for any reason payment of services is received back from clients financial institution (e.g. NSF fee from bank) there will be a $20.00 fee collected prior to next appointment.
4. Clients must not be under the influence of alcohol or illegal substances at the time of the scheduled session. Should client be under the influence of substances other than prescribed medication, the session will be cancelled by the counselor and the client will be expected to pay for the session at the usual, agreed upon fee.
5. Except in cases of emergency, **cancellations must be made 24 hours in advance**; failure to give 24 hour notice will be considered a "no show" and billed a **$40.00 fee**.

Program Procedures :

1. Client's rights to confidentiality will be observed at all times, with the following exceptions:

- In cases of probable imminent danger to self or others.
- In cases of child abuse, including sexual abuse.
- Communicable diseases must be reported by the counselor to the appropriate county health department.

or

- When you, the client, request that we release information. Information is only shared with other entities (ie: doctors, insurance companies, etc.) when you request it by signing an Authorization to Release Information form. In accordance with HIPPA privacy regulations, any information shared will reveal only the basic minimum information necessary.

2. We reserve the right to release only a Treatment Summary instead of detailed case notes.
3. A minimum requirement of 72 hours is needed for medical records, once a written request is received.
4. The undersigned will neither individually nor jointly involve the therapist or Lifespan Services (and it's staff) in any litigation. The undersigned will neither request nor require that Lifespan Services or the therapist provide testimony in court. The reason for this is so that treatment is not compromised, the therapeutic relationship with the family is maintained, and a child can experience his or her play therapist in a clear, consistent, therapeutic role and not as an assessor or detective. If the services of a mental health professional are desired for court purpose, the services of a person outside of Lifespan Services, Inc. must be enlisted.

Counseling Recordings/Artwork: The use of video taping or photography is sometimes necessary in therapy. Any type of recording is used to provide feedback to you, the client, or for therapist training purposes. Your confidentiality is protected and recordings are erased after each session unless your permission is given for another use. In the case of video or audio taping, you would be informed ahead of time and your written permission would be needed. The use of photography typically involves pictures of children's play structures (ie: sand trays, block building, etc.) or pictures of the children with our therapy pet. Children are offered copies of the pictures and this often helps them extend the therapy program to home and school. Art work is sometimes used for training purposes, but the child's identity is protected. If you have any questions about this, please ask your therapist.

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Hours of operation : Business office hours are M-F from 9:30am-4:00pm and closed for lunch from 12:00-1:00pm. Available hours vary with each therapist and some nights and weekends may be available.

After Hours Emergencies: In the event of a behavioral health emergency, contact 911, National Suicide Prevention Line at: 1-800-273-TALK or go to the nearest crisis center:

BayCare Behavioral Center
West Pasco Outpatient / Inpatient
8002 King Helie Blvd.
New Port Richey, Fl 34653
(727) 841-4430
(727) 841-4439

BayCare Behavioral Center
Children's Treatment Center
8132 King Helie Blvd.
New Port Richey, Fl 34653
(727) 834-3959

Hernando County Outpatient / Inpatient
7074 Grove Road
Spring Hill, Fl 34609
(352) 540-9335
Crisis number (727) 849-9988

HCA Community Hospital Morton Plant Mease Behavioral Health Care
of New Port Richey 300 Pinellas Street
(Adults Only) Clearwater, Florida 33756
5637 Marine Parkway 24 hour inpatient intake line (727) 298-6402
New Port Richey, Florida 34656
727-845-9180

Payment of Fees for Service:
1. We accept cash, check, Visa, or insurance reimbursement.
2. If a check is returned for insufficient funds, you will be required to pay any bank service charges in addition to the check amount.
3. All co-pays and private pay fees are due at the time counseling services are provided.

Acknowledgement/Consent:

I authorize the Release of Medical information necessary for my insurance company to process my claim. I also authorize the payment of benefits to Lifespan Services, Inc.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

I certify all information on the counseling intake forms is true and correct to the best of my knowledge. I will notify Lifespan Services of any changes to my insurance information, address, telephone numbers, and any other relevant changes.

By signing this form I am acknowledging receipt of a copy of this paper and agreement to the Orientation terms and conditions as provided by Lifespan Services, Inc.

_____ _____
Client Name, Print Client's Legal Signature

_____ _____

Parent/Guardian/Representative Date