

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

CLIENT INFORMATION (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.

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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. _____

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

(The following items concern feelings you may have had during the last month.)

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 during the last month)

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. _____

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.....	_____		

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
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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