Initial Client Fact Sheet

Today's Date:_____

Personal Information:

Name:_____ Date of Birth_____
Address:_____ Phone Home #_____
_____ Phone Cell #_____
Social Security #_____

Employer/ School Name:_____
Address:_____
Occupation:_____Length of Current Employment:_____

EMERGENCY CONTACT INFORMATION:
Name:_____ Relationship:_____Phone:_____

Insurance Carrier Name:_____

Designated Family Physician:_____

Designated Pharmacy_____
Pharmacy Phone #_____

Please Print Legal Name Clearly:_____
Signature:_____

Hope Dignity Compassion Care

Live Well Services, Inc.

[illegible] Information Form

Name: _____ Birth Date: _____/_____/_____

Address: _____ Phone: (H) _____

_____ SSN: _____

Primary Care Physician: _____

Today's Date: _____/_____/_____

Month and year of last physical: _____

Please check any of the following for which you have received care:

___ allergies	___ headaches	___ heart disease	___ asthma
___ irritable bowel	___ diabetes	___ sleep problems	___ chronic pain
___ epilepsy/seizures	___ emotional problems	___ arthritis	___ hearing problems
___ vision problems	___ stomach problems	___ cancer	___ thyroid problems
___ blood pressure	___ head injury		

Please list any hospitalizations (dates and reasons): _____

Currently under the care of a physician? If so, for what? _____

Please list any prior mental health services received: _____

For children who are the primary identified client, list immunizations, all developmental milestones, any medications, and health concerns: _____

_____

Please check any area where you think you have a problem:

___ anxiety, nervousness	___ dental health	___ work/academic
___ behavioral problems	___ depression	___ ADHD
___ parenting	___ sleep	___ stress
___ physical health	___ reproduction	___ anger
___ guilt	___ relationships	___ eating/nutrition
___ weight/body image	___ self-esteem	___ alcohol/other drugs
___ compulsive behavior		

Briefly describe your:

Eating habits: _____

Sleep/rest: _____

Use of alcohol/other drugs: _____

Caffeine intake: _____

Smoking: _____

Physical exercise: _____

Hobbies/play: _____

Please describe any medical concerns not listed above that you believe relevant:

_____

_____

_____ _____

Signature Date

[illegible]

Client Medication Record

Client Current Medications	Dosage	Frequency/Amts	Time Frame

Live Well Services, Inc.

Attention Clients:

If you are unable to make it to an appointment, you must give the office 24 hours' notice. If you do not give at least 24 hours' notice prior to your appointment, you will be responsible for a fee:

$50.00 fee for a missed therapy session

$95.00 fee for a missed psychiatry

All fees must be paid in full before future services are rendered. If your balance is not met within 60 days of the fee you will be discharged from Live Well Services.

Thank you for your cooperation.

I have read and understand the above:

Name:_____Signature_____Date_____

ATTENTION ALL CLIENTS:

IMPORTANT PAYMENT INFORMATION

Please be advised that a quote of benefits and/or authorizations that are provided to us does not guarantee payment or verify eligibility. Payments of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at time of service. Please be aware that your dues may change once we receive Explanation of Benefits from your provider and must be paid in full to continue treatment at Live Well Services. You are welcome to request a copy of the Explanations of Benefits for your consideration if this should happen.

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services preauthorized by your health insurance company. If your insurance company feels that a particular service are not "necessary" or that particular services are not covered under the plan they will deny payment for that service.

OTHER IMPORTANT INFORMATION REGARDING PAYMENTS:

- All co-pays and/or deductibles are due at the time of service
- Live Well Services participates with many insurance plans. If we participate with yours that means that we will accept the fee schedule agreed upon Live Well Services and the insurance company. You are, however, responsible for any co-pay, coinsurance and/or deductible as deemed by your policy.
- It is YOUR RESONPSIBLITY to let us know either your deductible or Out of Pocket Max with your insurance company. If payments have been made after you reached a maximum, we will need up to 30 days from your request to reimburse for any overpayments you have made. Also, we will apply your payments to any future services if you choose to do so instead.
- If you do not cancel an appointment within 24 hours there will be a fee of $95.00 for the Psychiatrist and $50.00 for all therapists. This charge will be due before any further services are rendered at Live Well Services. Furthermore, any fees/dues that are billed to you by this office may furnish an additional $10.00 invoice fee.

Your account balance is your responsibility. All balances are due prior to your next appointment. Any outstanding balance over 60 days will be turned over to our collection agency along with a $25.00 collection service fee. You are always welcome to set up payment arrangements with our office within the first 30 days of an outstanding balance

By signing below, I am confirming that I have read and fully understand the above information regarding my responsibility for payment.

Name:_____ Signature_____Date:___/___/_____

TO ALL CLIENTS OF LIVE WELL SERVIES, INC.

POLICY EFFECTIVE IMMEDIATELY 02/26/2014!

ANY REQUEST TO WRITE OR SEND DOCUMENTATION TO A THIRD PARTY WILL HAVE AN INDIVIDUAL COST ATTATCHED.

YOU MUST ALLOW 7-10 DAYS TO PROCESS YOUR RESQUEST.
Plan accordingly!

Document Examples	
Disability Forms	Letters to Court
Notes to Probation	Notes to another Facility
Phone Calls to Schools	Phone Calls to Probation

These services are billed out at the rate of $150.00 per hour. The minimum charge is $75.00.

Examples:

If the Staff completes a form in under half an hour, the charge is $75.00

If the Staff completes a form in one hour, the charge is $150.00

If the Staff completes a form in over an hour, the charge is a flat fee of $220.00

If you have any questions, please ask a staff member for clarification!

Patient name _____

Patient Signature _____ Date: _____

Last Name _____ First Name_____ Middle initial_____ Date of Birth_____Address_____

Telephone _____

I, _____ hereby authorize the release & disclosure of the following clinical and/or therapeutic records for the following purpose(s):

[ ] Authorization to release information regarding counseling and therapy care and Treatment.

[ ] Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL-92255), and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

[ ] Authorization to release information related to Suicide Risk/Harm and/or Homicidal Risk/Harm to Self or Others.

Release to:

Name of Provider/Person: _____

Address: _____

Phone: _____

Specific information to be released (client's initials to approve release):

_____Assessments and evaluations (specify:) _____Psychosocial history

_____Entire mental health records _____Discharge Summary

_____Summary of treatment

Correspondence (specify): _____

Other (specify): _____

Purpose(s) for which information is to be released (check all that apply):

_____ Continuity of care _____ Referral

_____Consultation _____ Personal

_____ Other (please describe): _____

I do not authorize the release of the following information: _____

Revocation/Expiration: I understand that I may revoke this authorization in writing at any time, except for actions that have already been taken prior to this request. (Forms are available from the therapist.) This authorization will expire _90_ days after the signature below. This agency is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Client/Guardian's Name: _____ Signature: _____ Date: ___/___/_____

Witness Name: _____ Signature: _____ Date: ___/___/_____