

Medical History Packet Sheet

Today's Date: \_\_\_\_\_

Personal Information:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address: \_\_\_\_\_ Phone Home # \_\_\_\_\_  
Social Security # \_\_\_\_\_ Phone Cell # \_\_\_\_\_

Employer/ School Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Length of Current Employment: \_\_\_\_\_

EMERGENCY CONTACT INFORMATION:

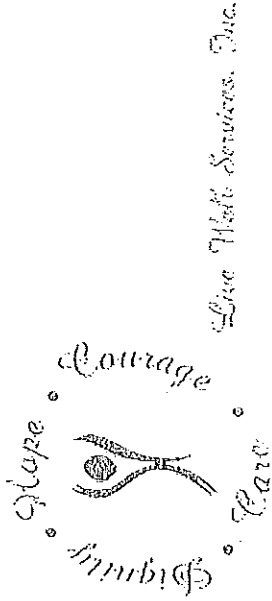
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_

Designated Family Physician: \_\_\_\_\_

Designated Pharmacy \_\_\_\_\_  
Pharmacy Phone # \_\_\_\_\_

Please Print Legal Name Clearly: \_\_\_\_\_  
Signature: \_\_\_\_\_



CHILDREN'S BIRTH RECORD - MEDICAL 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: \_\_\_\_\_

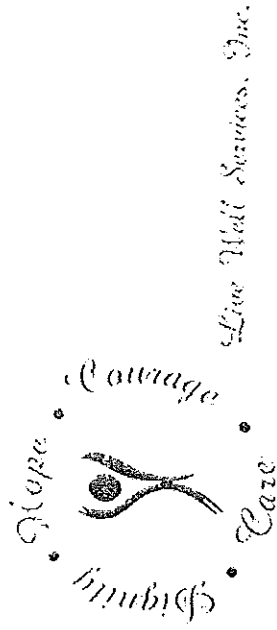
Please describe any medical concerns not listed above that you believe relevant:

\_\_\_\_\_  
\_\_\_\_\_

Signature

Date





### **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**

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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 RESPONSIBILITY** 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 SERVICES, INC.  
POLICY EFFECTIVE IMMEDIATELY 02/26/2014!

ANY REQUEST TO WRITE OR SEND DOCUMENTATION TO A  
THIRD PARTY WILL HAVE AN INDIVIDUAL COST ATTACHED.  
YOU MUST ALLOW 7-10 DAYS TO PROCESS YOUR REQUEST.  
*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 \_\_\_\_\_ 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: \_\_\_\_/\_\_\_\_/\_\_\_\_