Initial Client Information Fact Sheet

Today's Date: _____

Personal Information:

Name: _____ **Date of Birth:** _____
Address: _____ **Phone Home#:** _____
_____ **Cell#:** _____
Social Security #: _____ **Work#:** _____
Relationship Status: _____
Emergency Contact Information:
Name: _____ **Relationship** _____ **Phone:** _____
Employer/School Name _____ **:** _____
Address: _____
Occupation: _____ **Length of current employment:** _____

Insurance Information: Please provide copy of insurance card

Primary Insurance Carrier Name: _____
Address: _____
Phone: _____
ID#: _____ **Group#:** _____
Subscriber Name: _____ **Subscriber DOB:** _____
Secondary Insurance? Yes or No, If Yes, Please provide same information as requested above.

Designated Family Physician: _____

Please print legal name clearly: _____
Signature: _____

FOR OFFICE USE ONLY

Insurance Name: _____
Claims Mailing Address: _____
Insurance Phone: _____ **COPAY?** _____
Deductible? _____ **Coverage for Mental/Substance?** _____
What percentage is paid by Ins? _____ **Max number of visits?** _____
Is Auth/Pre Auth needed? _____ **IF YES……..**
Auth #: _____ **Dates Approved?** _____
When ReAUTH? _____

Date and Time of a verification person: _____

Confidential Brief Health 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

Live Well Services, Inc.

Client Rights

1) An individual who is receiving treatment shall retain all civil liberties and rights except as provided by law, no client shall be deprive of any civil rights solely by reason of treatment.
2) Live Well Services, Inc., will not discriminate when providing services on the basis of age, race, ethnicity, color, national origin, sexual orientation, disability, religion, creed, sex, or marital status.
3) Any client at Live Well Service, Inc. may review their file, subject to the following conditions and limitations:

   a. A written request, one week prior to review must be submitted to the treating therapist.

   b. A review of the file will take place with the client at a mutual convenient appointment time.

   c. The therapist, with clearance and approval from the executive director, may remove temporarily, prior to the file review, any information that may be detrimental, if presented to the client.

   d. Live Well Services, Inc. allows a client to appeal a decision that limits access to the client's file. The appeal must be written and needs to detail the reasons for appeal. It should be addressed to the executive director. Within then (10) days of the date of the appeal, the executive director will review it and issue a written reply.

   e. The client can request the correction of inaccurate, incomplete, irrelevant, and outdated information from their file. To request a correction, the client has to submit a written request to the executive director that includes the concerns of the client. The executive director of Live Well Services, Inc., will make the final determination of the corrections are necessary. Within ten (10) days, the executive director will issue a written decision to the client. All correspondence will become a permanent part of the client's file. The executive director will log these communications as a progress note.

f. If any information is removed, the reasons will be documented and kept on file.
g. Any client at Live Well Services, Inc. is entitled to submit a written rebuttal or memoranda to be placed in their file. If a client does not agree with the contents of their file, the client has to, in writing, submit a response to the executive director detailing their issues and concerns. This documentation will become part of the client's file.
h. Clients, or their surrogate decision maker, as allowed by law, have right to refuse treatment services. Clients who refuse treatment are fully informed about the agency's responsibility in accordance with professional standards, and governing laws.

4) Information volunteered during the process of treatment will be kept confidential in accordance with **Federal Regulations (42.C.F.R.-2.31 and 2.35 b and c)** and will not be released without the client's expressed permissions. Additionally, in a medical situation where the client's life is in immediate jeopardy, Live Well Services, Inc. the provider of treatment may release information. In such cases, this information may include: a) if the client is enrolled in treatment, b) the nature of the treatment program, c) the client's prognosis, d) some overview of the client's progress.

5) If consent is not required, the client will be notified of any such disclosure by their primary therapist.

Client Responsibilities

1. To be honest about facts, feelings, and/or ideas that relate to your care.

2. Supplying up to date insurance information to Live Well Services, Inc. to determine appropriate benefit coverage.

3. Taking active role in your treatment planning and therapy.

4. Keeping clinical appointments.

5. Knowledge of the names of the therapists at Live Well Services, Inc. providing your care.

6. Reporting changes in your condition to your therapist.

7. Informing your therapist if you anticipate problems in the following your prescribed treatment.

8. Asking for clarification if you do not understand issues related to your care.

9. Being considerate and respectful of the rights of other clients and staff.

10. Honoring the confidentiality and privacy of other clients.

11. Communicating, concerns, complaints and/or grievances through appropriate channels.

12. Meeting any financial obligations for services such as co-pays.

Signature of Clients Date	Signature of Therapist Date
Copy Accepted ( )	**Copy Declined ( )**

Live Well Services, Inc.
Client Orientation Form

Criteria for Admission

In order to be admitted to Live Well Services, Inc, an individual must have a substance abuse and/or a mental health issue and agree to treatment under the policies and regulations of the agency. Anyone seeking treatment must be at least ten (10) years of age. No one who is actively psychotic or has a severe hearing or speech impairment will be admitted.

Treatment Approach

Once an assessment of the client is completed, the therapist will develop an individualized treatment plan. This will include an action plan and goals. This will be accomplished through all the modalities of treatment offered at Live Well, including individual, group, and family therapy.

Completion of Treatment

1. Mutual agreement of the therapist and client that the person has accomplished all or most clinical goals and maximum clinical benefit has been achieved in the outpatient setting.
2. Therapist and client agree to transfer to another program.
3. If a client is stipulated as a condition of probation, completion of treatment will be coordinated with the referring agency.

Involuntary Discharge/Termination Criteria

Any acts of physical violence, selling or using drugs on premises, continued unexcused absences, not following the on-going agreed upon treatment plan and non-payment of services are causes for termination from the agency.

Hours of Operation
9 am to 9 pm – Monday through Thursday
9 am to 5 pm – Friday
10 am to 2 pm – Saturday Dr. Basil
Saturday hours are scheduled by appointment only.

Fee Schedule
$185.00 Initial Evaluation
$90.00 per individual therapy session
$60.00 per group session

Insurance payments are handled on an individual policy basis. We accept cash, check, or money order.

Client Orientation Form

I, _____, agree to and understand the policies and procedures of Live Well Services, Inc.

I, _____, agree to have Live Well Services, Inc. bill my insurance company for consultations, emergency phone sessions and any other services rendered regarding my care. There will not be a copayment charged for these services which are not face to face sessions.

_____ _____

Client's Signature **Date**

_____ _____

Therapist's Signature **Date**

Copy Accepted ( ) **Copy Refused ( )**

Live Well Services, Inc.
Client Consent to Treatment

I, _____, agree to receive therapeutic treatment at Live Well Services, Inc.

I consent to follow my treatment plan and participate as my therapist recommends. This consent shall remain in place throughout my duration here at Live Well Services, Inc.

_____ _____

Client's Signature **Date**

_____ _____

Therapist's Signature **Date**

Copy Accepted ( ) **Copy Refused ( )**

Live Well Services, Inc. HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Understanding Your Protected Health Information (PHI)

When you visit us, a record is made of your symptoms, examinations, test results, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of the medical health care provider. The information within belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosures to others. In using and disclosing your PHI, it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirement of state law.

Your Mental Health and/or Medical Record Serves as:

- A basis for planning your care and treatment.
- A means of communication among the health professionals who may contribute to your care.
- A legal document describing the care you received.
- A means by which you or a third-party payer can verify that services billed were actually provided.
- A source of information for public health officials charged with improving the health of the nation.
- A source of data for facility planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of Live Well Services, Inc.

We are required to:

- Maintain the privacy of your PHI as required by law and provide you with notice of legal duties and privacy practices with respect to the PHI that we collect and maintain about you.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the reception room and provide you with a copy.
- Notify you if we are unable to agree to a requested restriction.
- Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health Information (PHI) Rights

You have the right to:

- Review and obtain a paper copy of the notice of information practices and your health information upon request. A few exceptions apply. Copy charges may apply.
- Request and provide written authorization and permission to release PHI for purposes of outside treatment and health care. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission for training purposes.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.

- Request a restriction on certain uses and disclosures of PHI, but we are not required to agree to the

restriction request. You should address your restriction in writing to the Privacy Officer by asking for name of Privacy Officer, address, and phone. We will notify you within 10 days if we cannot agree to the restriction.

- Request that we amend your health information by submitting a written request with reasons supporting the request to the Privacy Officer. We are not required to agree with the requested amendment.
- Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations, and certain other activities for the past six years but not before April 14, 2003.
- Request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment, and Health Operations

(Name of clinic) will use your PHI, with your consent, in the following circumstances:

Treatment: Information obtained by a nurse, physician, psychologist/counselor, dentist, or other member of your health care team will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.

Disclosure to others outside of the agency: If you give us written authorization, you may revoke it in writing at any time but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except to report a serious threat to the health or safety of a child and/or vulnerable adult.

For payment, if applicable: We may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.

For health care operations: Members of the mental health staff or members of the quality improvement team may use the information in your health record to assess the performance and operations of our services. This information will be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.

We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse/neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners and organ donation, research, or workers' compensation. Under the law, we must make disclosures to you when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements.

For More Information or to Report a Problem

If you have questions and would like additional information, please ask your clinician. He/she will provide you with additional information or put you in contact with the designated Privacy Officer at 215-968-7600. If you are concerned that your privacy rights have been violated or you disagree with a decision we have made about access to your health information, you may contact the Privacy Officer. We respect your right to privacy of your health information. There will be no retaliation in any way for filing a complaint with the Privacy Officer of our agency or the U.S. Department of Health and Human Services.

HIPAA Privacy Authorization for Use and Disclosure of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as amended from time to time. You may refuse to sign this authorization.

By my signature below, I acknowledge that I have received and read the Notice of Health Information Privacy Practices. I have been provided a copy of, read and understand Live Well Services, Inc.'s HIPAA Privacy Notice containing a complete description of my rights, and the permitted uses and disclosures of my protected health information under HIPAA. Further, I acknowledge that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and is no longer protected under HIPAA.

Name: _____
Last First MI

Address: _____
Street City State Zip

Date of Birth: _____

Today's Date: _____

For office use only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained.

Reason: _____

_____ _____
Clinician Signature Date

Live Well Services, Inc.

Client Medication Record

Client Current Medications	Dosage	Frequency/Amts	Time Frame

Attention:

All patients, it is a must that you pay your co pay before your scheduled appointment. If you do not have your co pay you CAN NOT be seen. This will be effective IMMEDIATELY.

Also ALL appointments cancelled without a 24 hour notice or all appointments that you do not show up for there will be a fee. Please see below for fees.

Therapist/Group - $35
Psychologist (Dr. Bill) - $35
Psychiatrist (Dr. Basil) - $50

Thank you for your cooperation

Patient Name: _____

Patient Signature: _____ **Date:** _____

Attention:

All patients,

If any of your appointments are missed and/or cancelled to a point where termination from our program is imminent, you may be permitted to have one last appointment with our psychiatrist for medication management only. It will be "Your" responsibility to find another psychiatrist.

Thank you for your cooperation

atient Name: _____

Patient Signature: _____ **Date:** _____

LIVE WELL SERVICES INC.

203 Floral Vale Blvd.
Yardley, PA 19067
Phone #: (215) 968-7600
Fax #: (215) 968-7609

Patient Name: _____ Date: _____
Date of Birth: _____ Sex: _____ Marital Status: _____
Telephone Numbers: Home: (__) _____ Work: (__) _____
Home Address: _____
City: _____ State: _____ ZIP: _____

Initial Pain Assessment

By answering the following questions, you will help your physician better understand and treat your pain.

When and how did your pain problem start? _____
_____
_____

As far as you know, what is the cause of your pain (i.e., the diagnosis)? _____
_____
_____

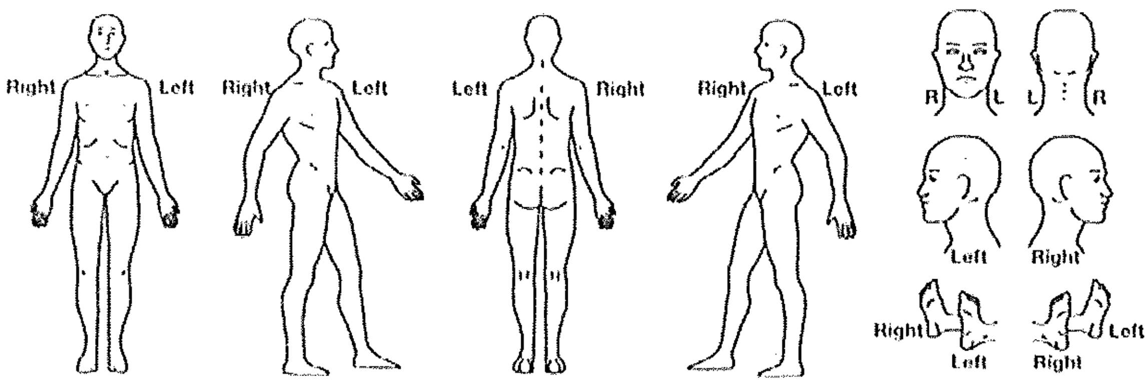
What doctors have you seen? When did you see them? What did they do?

Doctor's Name	Month/Year Seen	What was done? (For example: Doctor did physical exam, ordered tests, prescribed medication)

What tests and studies have been done?

Tests & Studies (for example: MRI, CT-Scan, X-Rays)	Month/Year Seen	Results

On the diagram below, shade the area(s) where you feel pain. "X" the area(s) that hurt the most.



What pain treatments or medications are you receiving now – or have received in the past? (For example, pain medications, physical therapy, acupuncture, TENS, ect.) Circle the number next to the treatment to signify the amount of pain relief that treatment has/is providing.

Treatment or Medication	**No Relief**										**Complete Relief**		**Check If Receiving Now**	
____________	0	1	2	3	4	5	6	7	8	9	10	________	☐	______
____________	0	1	2	3	4	5	6	7	8	9	10	________	☐	______
____________	0	1	2	3	4	5	6	7	8	9	10	________	☐	______
____________	0	1	2	3	4	5	6	7	8	9	10	________	☐	______
____________	0	1	2	3	4	5	6	7	8	9	10	________	☐	______
____________	0	1	2	3	4	5	6	7	8	9	10	________	☐	______
____________	0	1	2	3	4	5	6	7	8	9	10	________	☐	______

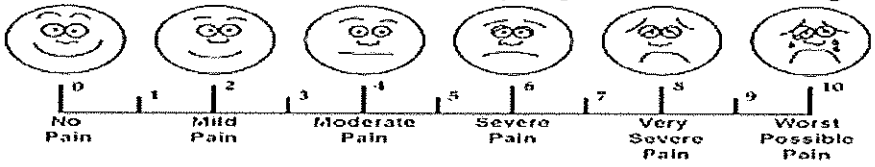
List the body sites where you experience pain and circle the words that best describe the pain at that site. Also, indicate the intensity of the pain and those things that make your pain better or worse. Use a separate sheet for each body site.

Body Site: _____

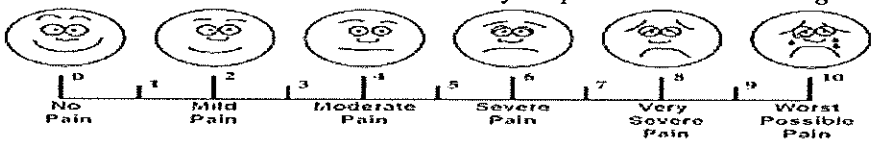
Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Intermittent	Continuous	

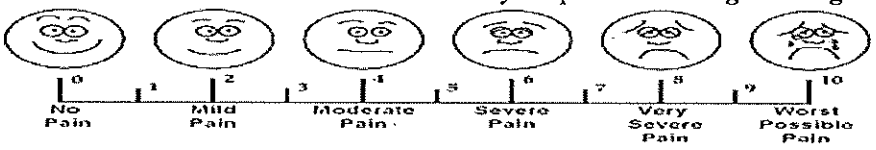
Circle the number/face that best describes your pain at its **worst during the last month.**



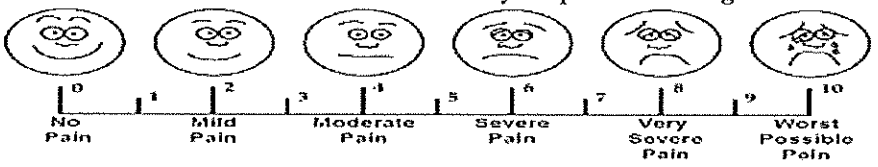
Circle the number/face that best describes your pain at its **least during the last month.**



Circle the number/face that best describes your pain **on average during the last month.**



Circle the number/face that best describes your pain as it is **right now.**



What sorts of things make this pain feel **better** (for example: heat, rest, medicine)?

_____

_____

_____

_____

_____

What sorts of things make this pain feel **worse** (for example: walking, standing, lifting)?

_____

_____

_____

_____

Circle the number below that best describes how pain has interfered with your daily functioning.

General Activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

Walking Ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

Normal Work Routine

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

Relations With Other People

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

Enjoyment of Life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

Ability to Concentrate

0 1 2 3 4 5 6 7 8 9 10

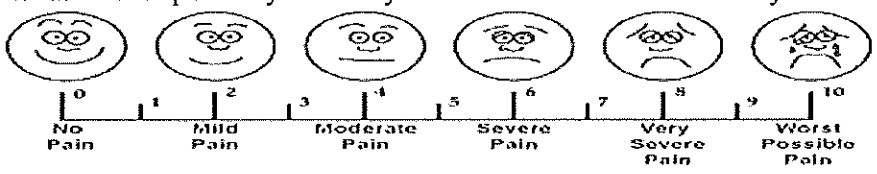
Does not interfere — Completely Interferes

Appetite

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

What level of pain do you think you could function with on a daily basis?



Patient Comfort Assessment Guide

Name: _____ Date: _____

1. **Where is your pain?** _____
2. **Circle the words that describe your pain.**

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

Circle One: Occasional Continuous

What time of day is your pain the worst? Circle one.

Morning Afternoon Evening Nighttime

3. **Rate your pain by circling the number that best describes your pain at its <u>worst</u> in the last month.**
   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. **Rate your pain by circling the number that best describes your pain at its <u>least</u> in the last month.**
   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. **Rate your pain by circling the number that best describes your pain on <u>average</u> in the last month.**
   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. **Rate your pain by circling the number that best describes your pain <u>right now</u>.**
   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. **What makes your pain <u>better</u>?** _____

8. **What makes your pain <u>worse</u>?** _____

9. **What <u>treatments</u> or <u>medicines</u> are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.**

Treatment or Medication	No Relief										Complete Relief
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10

10. What <u>side effects</u> or <u>symptoms</u> are you having? Circle the number that best describes your experience during the past week.

a. Nausea	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10 Severe Enough to Stop Medicine
b. Vomiting	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10 Severe Enough to Stop Medicine
c. Constipation	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10 Severe Enough to Stop Medicine
d. Lack of Appetite	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10 Severe Enough to Stop Medicine
e. Tired	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10 Severe Enough to Stop Medicine
f. Itching	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10 Severe Enough to Stop Medicine
g. Nightmare	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10 Severe Enough to Stop Medicine
h. Sweating	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10 Severe Enough to Stop Medicine
i. Difficulty Thinking	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10 Severe Enough to Stop Medicine
j. Insomnia	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10 Severe Enough to Stop Medicine

11. Circle the one number that describes how during the past week <u>pain has interfered</u> with your:

a. General Activity	Does not Interfere	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** Completely Interferes
b. Mood	Does not Interfere	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** Completely Interferes
c. Normal Work	Does not Interfere	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** Completely Interferes
d. Sleep	Does not Interfere	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** Completely Interferes
e. Enjoyment of Life	Does not Interfere	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** Completely Interferes
f. Ability to Concentrate	Does not Interfere	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** Completely Interferes
g. Relations with Other People	Does not Interfere	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** Completely Interferes

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 $134.00 per hour. This fee is prorated based on the amount of time it takes the Staff Therapist to complete the document. The minimum charge is $33.50.

Examples: **If the Staff completes a form in 10 minutes, the charge is *$33.50***

If the Staff completes a form in 20 minutes, the charge is *$67.00*

If the Staff completes a form in 45 minutes, the charge is *$100.50*

If the Staff completes a form in 1 hour or less, the charge is *$134.00*

If the Staff completes a form in 1 hour and 10 minutes, the charge is *$167.50*

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

Patient Name _____

Patient Signature_____ Date:_____