Patient Rights and Responsibilities

- Patients have the right to be treated with personal dignity and respect.
- Patients have the right to care that is considerate and respects patient's personal values and belief system
- Patients have the right to personal privacy and confidentiality of information
- Patients have the right to receive information about managed care company's services, practitioners, clinical guidelines, and patient rights and responsibilities
- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability
- Patients have the right to participate in an informed way in the decision-making process regarding their treatment planning
- Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of the cost or benefit coverage
- Patients have the right of members' families to participate in treatment planning as well as the right of members over 12 years old to participate in such planning
- Patients have the right to individualized treatment including:
    - Adequate and human services regardless of source(s) or financial support.
    - Provision of services within the last restrictive environment possible
    - An individual treatment or program plan
    - Periodic review of the treatment of program plan, and
    - An adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan
- Patients have the right to participate in the consideration of ethnical issues that arise in the provision of care and services, including
    - Resolving conflict
    - Withholding resuscitative services
    - Forgoing or withdrawing life-sustaining treatment and
    - Participation in investigational studies or clinical trials
- Patients have the right to designate a surrogate decision maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care
- Patients and their families have the right to be informed of their rights in a language they understand
- Patients have the right to voice complaints or appeals about managed care company or the care provider
- Patients have the right to make recommendations regarding managed care company rights and responsibilities polices
- Patients have the right to be informed of rules and regulations concerning patients' conduct

Continued on Next Page.

- Patients have the responsibility to give their provider and managed care company information needed in order to receive care
- Patients have the responsibility to follow their agreed upon treatment plan and instructions for care
- Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with the provider mutually agreed upon treatment goals
- I will call **at LEAST 24 HOURS in advance to cancel appointments and agree to pay $100.00 for otherwise missed appointments.** I agree to pay my account in FULL before scheduling further services. I accept that my case may be terminated after two (2) otherwise missed appointments in six (6) months. If I decide to stop treatment at any time, I agree to inform my provider. I understand that in case of emergency my provider can be reached at any time; (309) 575-3222, by calling 911 or going to the nearest emergency room.

_____ _____

Patient/ Guardian Signature Date

Clients Informed Consent, Agreement and Authorizations

Informed Consent For Treatment

I am aware that Lakeview Medical & Psychiatric Healthcare LLC and staff will conduct all or part of my care. I have been informed of the services offered and understand the risks and benefits inherent in the services provided by the Lakeview staff. I understand my participation in treatment may generate stress and/or emotional discomfort as I address issues identified in treatment. I understand that my treatment may be revised periodically with my prior knowledge of my progress or lack of progress. I recognize that the practice of mental health treatment is not an exact science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any treatment. I hereby consent to the treatment provided by Lakeview Medical & Psychiatric Healthcare LLC as well as employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. (____) initials

Client Agreement

I agree that during the time that I am an active client of Lakeview Medical & Psychiatric Healthcare LLC; I will cooperate as best I can to keep the company informed of my place of residence, employment status, and my progress. I understand that my provider has office hours as posted and the office is opened Monday through Friday as listed in the "Hours of Operation" in the office. I will call **at least 24 HOURS in advance to cancel appointments and agree to pay $100.00 for otherwise missed appointments**. I agree to pay my account in **FULL** before scheduling further services. I accept that my case may be terminated after two (2) otherwise missed appointments in six (6) months. If I decide to stop treatment at any time, I agree to inform my provider. I understand that in a case of an emergency my provider can be reached at any time; (309) 575-3222, by calling 911 or going to the nearest emergency room. (____) initials

Authorization for Release of Personal Health Information

I authorize use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or for conducting the healthcare operations. I authorize Lakeview Medical & Psychiatric LLC to release any information required in the process of applications for financial coverage and billing my insurance for services rendered. This authorization provides that we may release the minimal necessary amount of objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or designated agent. (____) initials

Assignment of Insurance Benefits/Payment Guarantee/Collection Fee

I authorize payment to be made directly to Lakeview Medical & Psychiatric Healthcare LLC for insurance benefits that are payable to me. I understand that I am financially responsible to Lakeview Medical & Psychiatric Healthcare LLC **AT THE TIME OF SERVICE** for covered or non-covered services including copays and deductibles; as defined by my insurer. I understand Lakeview Medical & Psychiatric Healthcare LLC accepts cash and credit cards; no personal checks are accepted. I understand that a monthly 1.5% interest charge will be applied to my unpaid account balance after sixty (60) days. I understand that if my account becomes delinquent and requires collection, I am responsible an additional 30% of the balance on the account for the collection including any legal fees. (____) initials

Continued to Next Page

Privacy Policy

I have received a copy of the Clients Notification of Privacy Practices, Clients Rights, and Responsibilities. The information was explained using language that I understand. I have been offered my rights with verbal explanation, including the right to see and copy my records, to limit disclosure of my health information, except to the extent Lakeview Medical & Psychiatric Healthcare LLC has already made with my prior consent. (_____) initials

Medication Refill Policy

Based on the nature of some of these medications possibly prescribed in this office, some may not be able to be refilled without being seen by your provider for an appointment first to discuss the process of treatment or any concerns you may have. A follow up appointment should be made before leaving the appointment in which any medication has been prescribed so that we can better provide your mental healthcare needs.

At your appointment, your provider will discuss with you when to return for regular visits and provide you with enough medication to last for that interval. The interval between office visits depends on the stability of the medical problem and medications prescribed.

Medication refills can take up to five (5) business days to process. It is your responsibility to contact your pharmacy when refills are needed.

I understand Lakeview Medical and Psychiatric Healthcare LLC all mentioned above and that policy states that it is my responsibility to make any arrangements needed to follow up with my provider to obtain any updated refills necessary. (_____) initials

_____ _____

Client Signature Date

_____ _____

Parent/Authorized Person Signature Date

_____ _____

Witness Signature Date

No Show/Cancellation/ Balance Owed Policy

Credit Card Authorization Form

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient visit. Since appointments with Lakeview providers are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to improve the availability of appointments, we maintain a No Show/ Cancellation Policy for consultation with our providers. To promote efficient access to our clinic, we require that an appointment that is no longer needed or unable to be kept be cancelled at least 24 hours in advance. Cancellations must be made between 9:00am- 5:00pm on workdays at least one full business day before a scheduled appointment.

In the event you do not cancel any confirmed appointment with appropriate notice and/or do not arrive for the visit, we will charge you credit card a non-refundable fee of $100. This document services as authorization to charge for any missed appointment, without 24 hours notification, throughout your course of care.

As of September 1st, 2019, Lakeview Medical and Psychiatric Healthcare is offering a repayment plan of one third (1/3) of the patients total from the most recent invoice along with 1.5% interest and their copay for the next three (3) visits or months depending on their individual treatment plan and appointment schedule, per the patient/guardians request, by contacting the office.

In addition to the authorization given for the No Show/ Cancellation Policy, this document also gives Lakeview Medical and Psychiatric Healthcare authority to charge entire overdue amount if no payment plan has been established before the sixty (60) days of most recent invoice.

Patient Name: _____ Date of Birth: _____

Patient Phone: _____

Credit/Debit Card Type (circle one): VISA MasterCard Discover

Card Holder Name: _____

Card Number: _____

Security Code: _____ Expiration Date: _____

By signing below, I have read and understand the policies set forth above. I further understand and authorize Lakeview to process a non-refundable fee of $100 and/or the balance owed to the able credit card in the event I do not follow the No Show/ Cancellation/ Balance Owed Policy described above.

_____ _____

Signature of Patient/Guardian Date

Insurance Policy Holder Information

Policy Holder Name: _____

Policy Holder Address: _____

City _____ St _____ Zip: _____

Policy Holder Phone: _____

Policy Holder Social Security No.: _____

Policy Holder Date Of Birth: _____

Relation to Policy Holder: _____

Please attach front and back copy of Insurance card

Lakeview Medical and Psychiatric Healthcare

New Patient Child and Adolescent Confidential Personal History Form

To be completed by minor and/or legal guardian

Client's name: _____ Date: _____ Date of birth: _____Age: _____
Grade in school: _____Gender: ___ F ___ M

Form completed by (if someone other than client): _____

Family History

Parents

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If Yes, who has legal custody? _____
_____

Were the child's parents ever married? _____ Yes _____ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? _____ Yes ___ No

If Yes, describe:

_____
_____

Client's Mother

Name: _____Age: _____ Occupation: _____ Hours worked per week _____

Where employed: _____

Mother's education: _____

Is the child currently living with mother? _____ Yes _____ No

____Natural parent _Stepparent ___Adoptive parent ___Foster home _____ Other (specify):
_____

Is there anything notable, unusual or stressful about the child's relationship with the mother?__ Yes __ No If Yes, please explain: _____

_____

How is the child disciplined by the mother? _____

_____

For what reasons is the child disciplined by the mother? _____

_____

Client's Father

Name: _____ Age: _____ Occupation: _____Hours worked per week _____

Where employed: _____

Father's education: _____

Is the child currently living with father? _____ Yes _____ No

___Natural parent ___Stepparent ___Adoptive parent ___Foster home ___Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the father? __Yes __No If Yes, please explain:

_____

How is the child disciplined by the father? _____

_____

For what reasons is the child disciplined by the father? _____

_____

Client's Siblings and Others Who Live in the Household

Quality of relationship

Names of Siblings Age Gender Lives with the client

_____ ___ ___F ___M ___home _____away ___poor ___average _____good

_____ ___ ___F ___M ___home _____away ___poor ___average _____good

_____ ___ ___F ___M ___home _____away ___poor ___average _____good

_____ ___ ___F ___M ___home _____away ___poor ___average _____good

Others living in Relationship

the household (e.g., cousin, foster child)

_____ ___ ___F ___M _____ ___poor ___average ___good

_____ ___ ___F ___M _____ ___poor ___average ___good

Additional Comments:

_____

_____

What are the family's favorite activities? _____

_____

How are problem behaviors generally handled? _____

_____

Has the child experienced any physical abuse sexual abuse or neglect? ___Yes ___No

If Yes, describe: _____

_____

_____

Has the child/adolescent experienced death? (friends, family pets, other) _____ Yes _____ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

___ Yes ___ No If Yes, describe: _____

_____

Early Childhood History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? ___Yes ___No

If Yes, describe: _____

Was the pregnancy with child planned? _____ Yes _____ No

Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

While pregnant did the mother smoke? _____ Yes _____
No If Yes, what amount:

Did the mother use drugs or alcohol? ___ Yes ___ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) - __Yes __No If Yes, describe: _____

Length of labor: _____ Induced: ___ Yes ___ No Caesarean? ___ Yes ___ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

_____

Describe any complications for the mother or the baby after the birth: _____

_____

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

___Breast fed ___Milk allergies ___Vomiting ___Diarrhea ___Bottle fed ___Rashes ___Colic ___Constipation ___Lethargic ___Not cuddly ___Cried often ___Rarely cried ___Overactive ___Resisted solid food ___Trouble sleeping ___Irritable when awakened

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoe laces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: _____ slow _____ average _____ fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., inadequate nutrition, neglect, etc.)

_____

_____

Medical/Physical Health

___Abortion ___Hayfever ___Pneumonia ___Asthma ___Heart trouble ___Polio ___Blackouts ___Hepatitis ___Pregnancy ___Bronchitis ___Hives ___Rheumatic Fever ___Cerebral Palsy ___Influenza ___Scarlet Fever ___Chicken Pox___ Lead poisoning ___Seizures ___Congenital problems ___Measles ___Severe colds ___Croup ___Meningitis ___Severe head injury ___Diabetes ___Miscarriage ___Sexually transmitted disease ___Diphtheria ___Multiple sclerosis ___Thyroid disorders ___Dizziness ___Mumps ___Vision problems ___Ear aches ___Muscular Dystrophy ___Wearing glasses ___Ear infections ___Nose bleeds ___Whooping cough ___Eczema ___Other skin rashes ___Encephalitis ___Paralysis ___Fevers ___Pleurisy

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____

Name of current pharmacy: _____

Immunization record: Has the child received all immunizations? ___Yes ___No

Name of Physician:_____ Phone Number: _____

Nutrition

Meal	How often	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	___ No ___ Low ___ Med ___ High
Lunch	____ / week	_____	___ No ___ Low ___ Med ___ High
Dinner	____ / week	_____	___ No ___ Low ___ Med ___ High
Snacks	____ / week	_____	___ No ___ Low ___ Med ___ High

Comments: _____

Describe any concerns regarding your child's weight or eating habits: _____

Education

Current school: _____

Type of school: ___Public ___Private ___Home Schooled ___Other
(specify):_____

Grade: _____ Teacher: _____ School Counselor: _____

In special education? _____ Yes _____ No If Yes, describe: _____

In gifted program? ___ Yes ___ No If Yes, describe: _____

Has child ever been held back in school? _____ Yes _____ No If Yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? _____ Yes _____ No

If Yes, describe: _____

Has the child been tested psychologically? _____ Yes _____ No

If Yes, describe: _____

Check the descriptions which specifically relate to your child.

Feelings about School Work:

___Anxious ___Passive ___Enthusiastic ___Fearful ___Eager ___No Expression ___Bored ___Rebellious

___ Other (describe): _____

Approach to School Work:

___ Organized ___ Industrious ___ Responsible ___ Interested

___ Self-directed ___ No initiative ___ Refuses ___ Does only what is expected

___ Sloppy ___ Disorganized ___ Cooperative ___ Doesn't complete assignments

___ Other (describe): _____

Performance in School (Parent's Opinion):

___ Satisfactory ___ Underachiever ___ Overachiever

___ Other (describe): _____

Child's Peer Relationships:

___ Spontaneous ___ Follower ___ Leader ___ Difficulty making friends

___ Makes friends easily ___ Long-time friends _____ Shares easily

___ Other (describe): _____

Who handles responsibility for your child in the following areas?

School: __ Mother __ Father __ Shared __ Other (specify): _____

Health: __ Mother __ Father __ Shared __ Other (specify): _____

Problem behavior: __ Mother __ Father __ Shared __ Other (specify): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? ___Poor _____ Average ___ Good _____ Excellent

Current employer: _____ Position: _____ Hours per week: ____

How have the child's grades in school been affected since working? _____ Lower ___ Same _____ Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

_____

_____

_____

Chemical Use History

Does the child/adolescent use or have a problem with alcohol or drugs? ___Yes _____ No

If Yes, describe: _____

_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Overall experience
Counseling	___	___	_____	_____	_____
Psychiatric	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Psych. Testing	___	___	_____	_____	_____

Additional Comments: _____

_____

_____

Legal History

Has your child ever been involved in the legal system? ___Yes ___No

If Yes, describe: _____

Is your child currently involved in the legal system? ___Yes ___No

If Yes, describe: _____

Are there any criminal and/or civil cases pending? (e.g. custody issues) ___Yes ___No

If Yes, describe: _____

All information provided above is true to the best of my knowledge

Signature: _____ Date: _____