Lakeview Medical and Psychiatric Healthcare

NEW PATIENT ADULT HISTORY QUESTIONAIRE

DEMOGRAPHIC INFORMATION

Name_____ Social Security #: _____
Age_____ Ethnicity _____ Birthdate_____
Current address _____City_____
Current phone numbers_____ May we leave a message? _____

Please list all persons with whom you are currently living:

Name	Age	Relation

Name any children and ages to whom you are a parent figure_____

_____

_____

EMPLOYMENT HISTORY

Do you currently work?

If no, are you: __Disabled__Retired__Home with Children__Other (Describe)_____
If yes,

Name of Employer	Position	Length of Employment

Please list your past employment for past ten years:

Employer	Position	Period of Employment	Reason for Leaving

Please describe any work related problems: (e.g., Harassment, Conflicts)

_____

_____

_____

_____

EDUCATIONAL HISTORY

What is the last grade you completed?

Do you have a history of Special Education (If so, what grades?)

Have you ever been held back a grade (If so, which grade?)
Have you attended any college? _____ Where?_____

What degrees do you hold?

What other training have you obtained?

Do you have any further education planned? If yes, describe below.

Have you had any learning problems? If yes, please explain

LEGAL HISTORY

Have you ever been arrested? NO YES If Yes, list all charges below.

Date	Charge	Disposition (dropped, convicted, not guilty)	Sentence	Length of Probation/Parole

Are you currently on probation or parole? NO YES: Probation Parole
If Yes. please explain conditions _____

Have you ever filed a lawsuit or had one filed against you? No Yes
If Yes. please explain _____

MARITAL/RELATIONSHIP HISTORY

List all significant relationships (marriage cohabitation, long term boy/girlfriends)

Name	Dates (begin – end)	Why did it end?	Children produced

Have you ever been the victim or perpetrator of spouse abuse? NO YES
If yes please describe. _____

CHILDHOOD HISTORY

Where were you born? _____

Did you have any developmental delays? _____

Please list all parent figures in your life.

Name	Relation	Age or age at death

Please list your siblings (brothers & sisters):

Name	Relation	Age or age at death

Were there any problems with your birth or prior to birth? NO YES
If yes, please describe.

Please list all significant events in your family (divorce, separation, death serious illness, etc.):

Event	Age at time	Effect upon you

Describe your experience growing up.

What was your mother like? How did she treat you?

What was your father like? How did he treat you?

What were your siblings like? How did they treat you?

What was your experience with friends?

Describe the most positive relationship you had growing up.

Where you every physically, sexually, or mentally abused? If yes, describe.

Describe any other traumas, tragedies, or difficult circumstances you experienced.

MILITARY HISTORY

Were you in the military? NO YES

If yes, please describe the dates of service, branch, and discharge status: _____

_____

_____

SUBSTANCE ABUSE HISTORY

Do you currently drink alcohol? NO YES Have you ever drank alcohol? NO YES

If yes, Age at first drink?_____ Last time you drank alcohol? _____

How often?_____

How much? _____

Do you currently use illicit or non-prescribed drugs? NO YES Have you ever? NO YES

If yes, Age at first use? _____ Last time you used drugs? _____

What drugs? _____

How often? _____

How much? _____

Have you ever attended substance abuse counseling? If so, for how long?

MEDICAL HISTORY

Please list all current medical illnesses.

Please list all your current medications

Have you ever attended counseling for mental health concerns? If so, when and for how long? Please list all your current Psychiatrists, Psychologist, and Counselors

Have you ever been hospitalized on a psychiatric unit? If so, when and for how long?

Please list all your past surgeries.

Have you ever experienced a head injury? If so, when? Did you lose consciousness?

OTHER INFORMATION: Please list any other information that you see as important

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

Signature: _____ Date: _____

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

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- 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

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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