

Lighthouse Counseling Center, P.C.

Adult Client Questionnaire

(18 years and older) Rev. 9/14

This information will help your therapist understand you better. This, as well as other communications with your therapist, will be kept confidential to the full extent of Georgia Law.

Proof of insurance coverage & ID is required.

Background information:

Today's Date: _____

Name of Client: _____ Age ____ DOB: _____ M / F

Residing Address: _____ City _____ State: ____ Zip _____

Mailing Address: _____ City _____ State: ____ Zip _____

Home Telephone _____ Cell/Work/ other _____

Contact number for messages from our office : _____
(WE ARE **NOT** RESPONSIBLE FOR CONFIRMING APPOINTMENTS WITH YOU.)

ER Contact Name _____ Tel # _____ Relationship _____

Referral Source: _____ May we send a thank you? Y / N

Marital Status: Single / Married / Remarried / Separated / Divorced / Engaged.

Insurance Information:

PRIMARY

SECONDARY

PLEASE PRINT. COPY OF CARD IS REQUIRED

Insurance Company _____ / _____

Policy Holder's Name _____ / _____

Policy Holder's DOB _____ / _____

Relationship to Client _____ / _____

ID Number _____ / _____

Policy Holder's SS # _____ / _____

Employer _____ / _____

Employer Telephone Number: _____ / _____

CONTINUED ON BACK ↓

Immediate Family Members : Name(s) Age(s) ✓ if lives w/client

Spouse _____

Father: _____

Mother: _____

Children: _____ / _____
_____ / _____
_____ / _____

Others living w/client _____ Relationship _____

_____ Relationship _____

In your own words, briefly describe the main problem, which prompted you to seek counseling at this time. (use back of page if necessary)

Problem Areas: In the following list, place a check mark next to each item which identifies an area of concern to you. Place two checks by those items, which are most important.

- | | |
|---|---|
| <input type="checkbox"/> Anger/Temper | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thoughts of Suicide |
| <input type="checkbox"/> Educational/School work | <input type="checkbox"/> Unhappy most of the time |
| <input type="checkbox"/> Family Problems | <input type="checkbox"/> Use of Alcohol |
| <input type="checkbox"/> Fearfulness/Phobias | <input type="checkbox"/> Use of Tobacco |
| <input type="checkbox"/> Insecure/Timid/Lack of Self Confidence | <input type="checkbox"/> Excessive caffeine |
| <input type="checkbox"/> Marital Problems/Conflicts between parents | <input type="checkbox"/> Work |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Traumatic Stress | |
| <input type="checkbox"/> Physical | |
| <input type="checkbox"/> Religious/Spiritual Concerns | |
| <input type="checkbox"/> Other (Specify) _____ | |

Current substance use: Marijuana, Narcotics Amphetamines

Methamphetamines Cocaine Hallucinogens Acid Prescription

Alcohol Cigarettes _____. If checked, frequency of use: _____

CONTINUED ON NEXT PAGE ↓

Is there anything else, which you believe might be important for your therapist to know about you: _____

Have you ever been a victim of or witnessed any type of traumatic incident? If yes, please explain: _____

Medical History (Please use back of page if necessary)

Has there been any previous counseling or psychological, psychiatric, neurological, or EEG evaluations? _____ If so, please list names, addresses, and dates of contact.

Current Medications: _____

Describe your appetite and eating habits at present. _____

Describe your sleeping pattern now. Are there nightmares or night terrors now or in the past? _____

Describe your level of activity and vigor. _____

Food or drug allergies? _____

Primary Care Physician: or other health care provider name: _____

Address: _____

Telephone: _____ Fax: _____

____ I authorize my therapist to release protected health information related to my evaluation and
(initial) treatment to my primary care physician or other health care provider.

____ I **DO NOT** authorize my therapist to release any information to my primary care physician.
(initial)

I authorize Lighthouse Counseling Center PC to administer counseling and psychological treatment.
Proper ID and proof of insurance is available upon request by Lighthouse Counseling Center.

Signed _____

(Client)

Print Name: _____

Date: _____

FINANCIAL STATEMENT

**THIS IS IMPORTANT – PLEASE READ CAREFULLY AND UNDERSTAND BEFORE
INITIALING IN BLOCKS AND SIGNING WHERE INDICATED**

(Both Parties Initial and Sign for Couple Counseling)

Client(s) Name(s) _____ / _____

Lighthouse Counseling Center PC (LHCC) is owned by Thomas S. Freeman, Psy. D and offers professional out patient behavioral health services by trained and experienced psychologists and psychotherapists. LHCC staffs' goal is to provide quality, caring and professional services to clients, and their family members, regardless of race, ethnic origin, religion, creed, gender, age, disability status, sexual orientation, or source of payment.

Confidentiality: My session with a therapist is confidential. Information about my sessions will not be released without a signed consent for release except in emergencies or when there is a court order, determination, or law requiring the information be released. If I have been referred for counseling by a court order, information about my treatment is not confidential and can be released to the court without my permission. I will *not* hold LHCC liable for such disclosure.

Duty to Warn: Information about dangerous behavior, including serious thoughts of hurting myself or others, as well as information about possible child abuse, is NOT confidential and is required by law to be reported by my therapist to the appropriate authorities.

E-Mail: I understand that email communication with LHCC or its therapist is not secure and may be read by others on the network. I agree to take this risk when I email LHCC.

Social Media: It is the policy of LHCC that our providers do not engage our current or past clients through social media. We will not accept friend requests for Facebook. This is for our privacy and yours. It also helps maintain the therapist/client relationship. Thanks for understanding.

After Hour On-Call and Fees: If I feel I have a life threatening emergency after regular office hours, I will call 911 or go to the closest Emergency Room in my area. LHCC provides 24-hour non-life threatening emergency on-call coverage. I can call 770-251-5873 and follow the instructions. I am responsible for providing my name, number where I can be reached and my regular therapist's name. *I will be billed a telephone consultation fee*, pro-rated and based on the length of the call and therapist's hourly rate. Insurance will not be billed for this service. I agree to pay this charge. (10 minute increments).

For collection actions with an outside agency, LHCC may release the financial party's name, employer info, contact telephone numbers and addresses, social security number, proof of previous communication attempts to settle the account and dates past due charges incurred. Third party information (related to the above) obtained through attempts to settle the account may be disclosed as well.

Professional Phone consults I will be billed a telephone consultation fee, pro-rated and based on the length of the call (10 min. increment) and therapist's hourly rate. Insurance will not be billed for this service. I agree to pay this charge. **Court/Expert Witness Appearance,** fees are billed in advance and explained separately.

Professional letters, written at my request or on my behalf will require a minimum fee of \$15 paid prior to release.

FINANCIAL PARTY RESPONSIBILITIES INSURANCE &/OR SELF-PAY

/ **Missed Appointment or Late Cancellation Fees / 24-Hour Notice**
(Initial)

I WILL BE BILLED, NOT MY INSURANCE

LHCC IS NOT RESPONSIBLE FOR CONFIRMING MY APPOINTMENT WITH ME

I (NOT my insurance) will be billed the amount "allowed" by my insurance carrier for a session **OR** my self-payment fee if I miss an appointment or give late cancellation notice. LHCC requires 24 hours notice. If the client is under the age of 18 years, the parent or legal guardian is responsible for confirming all appointments with LHCC. I may leave a message on voice mail and the date and time of the voice mail will be noted in the system. Reasons given will be considered prior to imposing charges. LHCC will make every effort to extend the same courtesy to me. **Acceptance of an appointment from the call list is considered "a confirmed appointment" and any previous scheduled appointments will remain on the schedule, unless the office is notified otherwise. Fees will apply. No one else can call to schedule or cancel for me without my authorization on file.**

/ If I accept an appointment off the call list, it is a confirmed appointment. All other scheduled appointments I have will remain on the schedule unless I cancel them. Missed Appointment & Late Cancellation charges will apply.

/ I can not schedule if I have a Missed Appointment or Cancellation Charge outstanding on my account and will notify my therapist of reasons for the Missed Appointment or Late Cancellation for consideration.

/ I will pay co-payments, deductibles, and other service charges at the time of request by LHCC staff. I may pay by cash, valid check (\$25.00 returned check fee), Visa or MasterCard (by phone with an authorization). Payment deferral will require approval by my therapist prior to my visit.

/ LHCC may charge my account for reimbursement on fees incurred and/or commission paid for collecting on my past due account with an outside collection or court agency. These charges will be due LHCC upon request to avoid further collection actions. LHCC will proceed with collection actions if the account is past due 60 days from date charges were allocated to the account and/or efforts by LHCC have been exhausted to collect on the account balance (no response to billing, letters, phone calls and/or payment promises verbal or written).

HIPPA NOTICE (Rev. 7/6/04)

(As required by the Privacy Regulations, created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this notice describes how health information about you (a client of this practice) may be used and disclosed, and how you can get access to your protected health information. Please review carefully.)

I understand that LHCC is a healthcare provider and may share my health information for treatment, payment, and healthcare operations. I have been provided with access to a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that LHCC has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer in the office or by phone at 770-251-5873. I decline a copy of my HIPAA / PHI OR I requested and received a copy of my HIPAA / PHI

INSURANCE AUTHORIZATION (please read and initial)

I WILL NOTIFY LHCC 24 BUSINESS HRS OF ANY CHANGES IN MY INSURANCE PRIOR TO MY NEXT SCHEDULED SESSION COVERED UNDER THE NEW INSURANCE OR PAY THE SESSION FEE CHARGE AT TIME OF VISIT.

I will be billed per the quoted insurance information received by LHCC and/or Explanation of Benefits only.

/ I authorize payment directly to Lighthouse Counseling Center PC of insurance benefits, not to exceed the balance due of the charges for my treatment. In the event that insurance remits payment to the "member" for services rendered or if LHCC is notified by my insurance carrier of such remittance, I will notify LHCC and reimburse LHCC for dates of services rendered, not to exceed the balance due of the charges for my treatment.

/ I am required to provide Lighthouse Counseling Center with accurate and detailed insurance information 24 hrs prior to any session to be filed. I will present proof of ID and insurance coverage. LHCC reserves the right to cancel my session(s) or charge for the full session fee without proof of benefits. I am responsible for contacting my insurance carrier(s) to assist with the payment of a claim, upon request by LHCC or my insurance carrier. Delay in contacting my insurance carrier and assistance in getting claims paid will cause my account to become delinquent and LHCC will have no other choice but to refer my account to collections. LHCC is not a third party contractor with my insurance. I will not hold LHCC responsible for denials by my insurance. Insurance is filed as a courtesy to me. I will pay balance upon request for all denials.

/ I am required to pay my *co-payment, deductible, & my patient responsibility portion at each visit*. An authorization or a quote from my insurance carrier is not a guarantee of payment or benefits. I am responsible for any balance due LHCC after insurance and will settle any discrepancies with my insurance carrier(s) upon request by LHCC. LHCC *will not* accept a verbal estimate that my deductible has been met.

ONLY THE BILLED PARTY CAN SIGN. COPAYMENTS ARE DUE AT TIME OF VISIT.

CLIENTS OVER THE AGE OF 18 ARE THE RESPONSIBLE PARTY UNLESS OTHERWISE SIGNED BY PARTY TAKING RESPONSIBILITY FOR BILLING.

FINANCIAL RESPONSIBLE PARTY SIGN: _____ / _____
I (we) have read, understand, and agree with all the above

PRINT NAME(S): _____ / _____ Date: _____

MAILING ADDRESS: _____

TEL #: (_____) _____ Work #: (_____) _____ Other #: _____

EMPLOYER: _____

SELF PAYMENT AGREEMENT Fee \$

I (we) do not wish to have LHCC file claims with my insurance carrier(s). I will pay the amount of the session fee amount at each visit. I will notify, in writing, any change in these agreement 24-hours prior to my visit and provide all the necessary insurance information to assist LHCC with any billing or claims as stated above.

(INITIAL) _____ / _____ SIGN BELOW

BEHAVIORAL HEALTH MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about LHCC its practitioners, services and role in the treatment process.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Member Signature

Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Provider Signature

Date

Lighthouse Counseling Center PC
(LHCC)

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) two days before your scheduled appointments.

Your name: _____

Your email address: _____

Your cell phone number: _____

Your cell phone carrier (circle one):

Alltel AT&T Boost Mobile Nextel Sprint SunCom
T-mobile Verizon VoiceStream Virgin Mobile (Other) _____

Where would you like to receive appointment reminders? (check one)

____ Via a text message on my cell phone (normal text message rates will apply)

____ Via an email message to the address listed above

____ Via an automated telephone message to my home phone

____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature

Date

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
...you felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found that you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
...you had more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? YES NO

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

No problems Minor problem Moderate problem Serious problem

ADULT DEPRESSION SCALE

Name: _____
Date of Assessment: _____ Completed By: _____

No:	Questions:	Answer:
1.	Are you basically satisfied with your life?	Yes/No
2.	Have you dropped many of your activities or interests?	Yes/No
3.	Do you feel that your life is empty?	Yes/No
4.	Do you often get bored?	Yes/No
5.	Are you in good spirits most of the time?	Yes/No
6.	Are you afraid that something bad is going to happen to you?	Yes/No
7.	Do you feel happy most of the time?	Yes/No
8.	Do you feel helpless?	Yes/No
9.	Do you prefer to stay at home, rather than go out and do things?	Yes/No
10.	Do you feel that you have more problems with memory than most?	Yes/No
11.	Do you think it is wonderful to be alive now?	Yes/No
12.	Do you feel pretty worthless the way you are now?	Yes/No
13.	Do you feel full of energy?	Yes/No
14.	Do you feel that your situation is hopeless?	Yes/No
15.	Do you think that most people are better off than you are?	Yes/No