LifePointe
Counseling, LLC

Healing Hearts ✧ Restoring Hope

NEW CLIENT INFORMATION

Welcome to LifePointe Counseling, LLC and thank you for choosing us for your counseling or medical needs! We are committed to providing you the best possible care. We hope your relationship with us will bring you hope and healing with whatever concern you are currently dealing with. Please carefully read the following information before signing at the bottom of each page.

LifePointe Counseling, LLC is a group of independent mental health providers. While the providers share a name and office space, we want you to know that the provider you see is fully responsible for his/her services. Their professional records are the property of LifePointe Counseling, LLC. However, no other member of the group can have access to them without your specific written permission. In addition, your provider is solely responsible for matters concerning your clinical care and all questions about that care should be addressed to them. However, if you feel your concerns are not being heard or addressed, you should contact Lanny McFarland, Owner and Clinical Director at LifePointe Counseling, LLC. He can be reached at 314-266-1424.

Appointments: Your time is valuable – and so is your providers'. If you need to cancel an appointment, we require a minimum of 24 hours notice so that we can offer your time slot to another waiting client. If you are not able to call and cancel during normal business hours **(9-5, Mon-Thu)** we do have an automated voice mail system where you can leave a confidential message. Otherwise, you will be charged a **late cancellation/no show fee of at least $50 per missed session.**

Emergencies: In case of an after-hours emergency, please go to the nearest emergency room or dial '911' for help. LifePointe Counseling, LLC does not provide emergency services. We do not have 24-hour staff. Arrangements for after hours or nontraditional services must be discussed and established in writing with your provider. Or you can call the Behavioral Response Hotline at **1-800-811-4760 in the event of an emergency.**

Financial Responsibility: You are fully responsible for payment of all services provided to you at the time of your visit. This includes, but not limited to insurance **co-pays and co-insurance payments.**

Please make all checks payable to **"LifePointe"** or **"LifePointe Counseling, LLC".** You also may pay via credit and debit cards (please note an additional 3% is charged with all credit card payments). **We do require a credit, debit, or HSA card to be on file.** Payments made by cash must be made in **exact change**, as no cash money is kept on site. Please note that accounts which become delinquent by sixty (60) days or more will be subject to a fee surcharge as allowed under Missouri law. Past due accounts are subject to 5% interest on the balance after sixty (60) days. For details on our financial policies, please see the front staff or visit our website at www.lifepointecounseling.com and click on the "FORMS" tab, which will direct you to a webpage where you can download our document entitled "Financial Policies".

Communication: By initialing the following blank spaces, you agree that LifePointe has your permission to email_____, text_____ or phone_____ to confirm or to reschedule an appointment. (Be sure to respond on next page for email and best number to be reached).

I have read and understand all the above information, agree to the terms/conditions set herein, and consent to receive treatment LifePointe Counseling, LLC.

_____ _____

Client/Guardian Signature **Date**

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If any payments are made by check and returned as "insufficient" your account will be billed a $40 charge for banking fees. The fee may exceed $40 if insurance is involved and a claim must be resubmitted. Keep in mind that we are only able to discuss your account with you, your guarantor, your insurance company, or someone else you have designated in writing, due to medical privacy laws. **Should any of your accounts at LifePointe Counseling, LLC become delinquent beyond 60 days, you will no longer be able to schedule an appointment or receive prescription refills.** If any of these financial procedures present a problem for you, please discuss your concerns with your LifePointe Provider or office Staff.

Insurance Billing: LifePointe submits insurance claims to in-network companies only. If you choose to see a provider that is not in your network, you are required to make full payment at the time of service. We can provide you with a copy of your paid bill to submit to your insurance for out-of-network reimbursement.

We also strongly recommend that you know and verify all your benefits; specifically, your co-pays/co-insurance, deductibles, authorization requirements, etc., prior to your first visit.

If your insurance coverage/plan changes, you must contact us with this information prior to your next visit, if possible. That way, both you and your provider can be sure that the visit will be covered and what benefits/payments apply. You are responsible for the co-payment(s), deductible, and non-covered expenses as determined by your insurance plan. Please know that an insurance company's quotation of benefits is **not a guarantee of payment** and you are responsible for any fees/services refused by your insurance plan.

Confidentiality: Your patient records are the property of LifePointe Counseling, LLC and are treated as confidential. Your records will not be released without your executed written consent unless special circumstances arise. For example, we are obligated to release certain information to get claims processed by your insurance company. Please talk to our administrative staff if you have any further questions.

LifePointe Counseling, LLC providers do not have encrypted email. Text messages are **NOT** secure and therefore should not be used to transfer private or sensitive information. If you choose to communicate with your provider via electronic means, you do so with the understanding that your privacy may not be guaranteed electronically. Also, a copy of email or written communication sent to providers working with LifePointe Counseling, LLC will be maintained in the clinical record of the person served and may not be released to other providers. Please ask your provider for the secure fax number, voicemail number, and mailing address to send information. Best practice for electronic communication is to schedule or reschedule appointments only.

Contact Information: It is vital that you keep your contact information up to date with our office. If any of your information changes, please let us know so we can update your records. This would include any changes to your surname, address, home/cell/work phone numbers, marital status, employer/school, emergency contact information, primary care physician, and/or financial responsible party (Guarantor of your account balances). Without up-to-date information we may be unable to contact you to confirm, reschedule or cancel an appointment, file your insurance claims properly, and/or refill your prescriptions.

Services Rendered: I understand that seeing a provider today is not a guarantee that future medication management and/or therapy services will be provided. I understand that the first few sessions with my therapy provider are a time for both the provider and client to discuss and assess the issues that the client wants to address. During this time both parties will also determine whether the therapeutic relationship is a good fit for both parties. Because there are many different types of providers who specialize in a variety of areas, I understand that I may be referred to another provider for more specialized care.

I have read and understand all the above information, agree to the terms/conditions set herein, and consent to receive treatment at LifePointe Counseling, LLC.

_____ _____

Client/Guardian Signature **Date**

CLIENT REGISTRATION

1. Patient Name _____
(Last) (First) (Middle Initial) (Nickname)

2. Address (Street, City, Zip) _____

3. Primary Phone: ( ) _____ ☐ Cell ☐ Home ☐ Work 4. Secondary Phone: ( ) _____ ☐ Cell ☐ Home ☐ Work

5. Gender: ☐ M ☐ F ☐ Other _____ 6. Marital Status: S M D W 7. Birthdate _____ Age: _____

8. Email Address: _____ 9. Soc. Sec. # : _____

10. Employer: _____ Occupation: _____ 11. Student/School: _____ ☐ Full-Time ☐ Part-Time

12. If dependent child, are custodial parents: ☐ Married ☐ Separated ☐ Divorced ☐ Other _____

13. Primary Care Physician: _____
(Name) (Phone)

14. IN CASE OF EMERGENCY NOTIFY: Name _____ Relationship _____ Phone ( ) _____

Full Address _____

~ Financially Responsible Party (Guarantor) Information ~

If same as patient, please complete only question #1 in this section.

1. Guarantor Name _____
(Last) (First) (Middle Initial) (Nickname)

2. Guarantor Address (Full) _____

3. Guarantor Relationship to Patient (check one): ☐ Spouse ☐ Mother ☐ Father ☐ Sibling ☐ Friend ☐ Other _____

4. Primary Phone: ( ) _____ ☐ Cell ☐ Home ☐ Work 5. Secondary Phone: ( ) _____ ☐ Cell ☐ Home ☐ Work

6. Special Financial Arrangements: _____

~ Insurance Information ~

1. Do you have insurance? ☐ YES ☐ NO (If yes, please complete below) ** **LifePointe does not provide Out-Of-Network billing**

2. *Primary Insurance Co. Name: _____ Claims Phone #: _____

Insurance Claims Address: _____

3. Subscriber's Name: _____ 4. Relation to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Employer: _____ Subscriber SSN: _____

5. Member ID # _____ 6. Group ID # _____ 7. Subscriber Birthdate: _____

8. *Secondary Insurance Co. Name: _____ Claims Phone #: _____

Insurance Claims Address: _____

9. Subscriber's Name: _____ 10. Relation to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Employer: _____ Work Phone: ( ) _____

11. Member ID # _____ 12. Group ID # _____ 13. Birthdate _____

IF YOUR LIFEPOINTE COUNSELING, LLC PROVIDER IS CONTRACTED TO BILL YOUR INSURANCE PLAN, PLEASE SIGN THE FOLLOWING SECTION: ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to LifePointe Counseling, LLC the amount due for services rendered to me or my dependents. RELEASE OF INFORMATION: I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to my dependent or me. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

SIGNED: _____ _____ DATE: _____
Insured Patient/Guardian

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by LifePointe Counseling, LLC. If the provider is contracted with the insurance company, I will be responsible only for the co-pay, deductible, and non-covered services as determined by the insurance plan:

Guarantor Signature (Patient signature, if patient is guarantor) _____ DATE: _____

WHO REFERRED YOU? / HOW DID YOU HEAR ABOUT US?

☐ **Physician** ☐ **LifePointe Staff Member** ☐ **Friend** ☐ **Church:** _____

☐ **Facebook** ☐ **Psychology Today** ☐ **JoyFM/Radio** ☐ **Other:** _____

CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS

Please note that a copy of our Payment Policies, HIPAA Statement, Notice of Privacy Policies and Client Rights Statement, and other important documents are available on our website at www.lifepointecounseling.com. You may access these documents by going to our homepage, selecting "FORMS", then clicking on the corresponding document.

******Areas within (_____) are to be initialed by the client or authorized person.******

FINANCIAL POLICIES: I acknowledge having been offered LifePointe Counseling, LLC's Financial Policies document. (_____)

PRIVACY POLICY: I acknowledge having been offered LifePointe Counseling, LLC's Notice of Privacy Policies and Client Rights Statement. (_____)

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by LifePointe Counseling, LLC and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of LifePointe Counseling, LLC. I authorize LifePointe Counseling, LLC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that LifePointe Counseling, LLC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (_____)

_____ _____ _____

Client or Authorized Person Signature Relationship Date

_____ _____

Witness Signature Date

~ Child and Adolescent Consent for Treatment (If Applicable) ~

Patient Name (printed): _____ Birthdate: _____

Last Name *First Name* *Middle Initial*

I certify that I am the (check one) ☐ father ☐ mother ☐ legal guardian of the above-named child/adolescent and that I do have legal custody of the above-named child/adolescent. I, hereby, give my authorization and consent for the above-named child/adolescent to receive outpatient assessment/therapy from (therapist name) _____.

Printed Name: _____

_____ _____

Signature Date

~ Divorce/Legal Separation Collection Policy (If Applicable) ~

It is the policy of LifePointe Counseling, LLC that the parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. You will be responsible for payment of the child's/adolescent's treatment regardless of any financial arrangement for payment of the child's/adolescent's medical care, either oral or written, with the child's/adolescent's other parent or responsible party. LifePointe Counseling, LLC. assumes no responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for your child's/adolescent's medical care. **I have read, understood and agree to the above policy:**

Printed Name: _____

_____ _____

Signature Date

_____ _____

Witness Date

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CLIENT QUESTIONNAIRE

Please complete as much of this information as possible and give this form to your health care provider at your first visit. Please note that if the provider you are seeing is on your insurance panel, we must have a copy of your current insurance information prior to your first visit. Some insurance companies will not cover your visit if it has not been pre-certified. Please make every effort to know and understand your mental health insurance benefits prior to your visit(s) to LifePointe Counseling, LLC.

Name: _____ Date: _____

Please give us a brief description of your need for counseling or psychiatric care:

_____

_____

_____

_____

Please answer the following questions by circling either Yes or No. If Yes, please provide a brief description of the problem area:

Anxiety/Stress – Yes or No

_____

_____

Uncomfortable in Social Settings – Yes or No

_____

_____

Compulsions/Addictions – Yes or No

_____

_____

Appetite Changes – Yes or No

_____

_____

Sleep Changes – Yes or No

_____

_____

Concentration/Focus Problems – Yes or No

_____

_____

Work/School Impairment – Yes or No

_____

_____

Difficulty Caring for Self/Family/Home/Children – Yes or No

_____

_____

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CLIENT QUESTIONNAIRE *(continued)*

Family Conflicts – Yes or No

_____

_____

Spiritual Problems – Yes or No

_____

_____

Depression – Yes or No

_____

_____

Feelings of Hopelessness/Despair – Yes or No

_____

_____

Self-Harm – Yes or No

_____

_____

Suicidal Thoughts – Yes or No

_____

_____

Suicidal Plans – Yes or No

_____

_____

Suicidal Attempts – Yes or No

_____

_____

Previous Hospitalization – Yes or No

_____

_____

Previous Counseling – Yes or No

_____

_____

Current Counseling – Yes or No

_____

_____

Medication History (List **current** medications here, and provide your complete history on separate page)

_____

_____

_____

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THOROUGH MEDICATION HISTORY

Medication Name (Please Include Dosage/Mg)	Date(s) Prescribed/Taken	Side Effects