



Adolescent/Teenager Questionnaire Individual Client Questionnaire

Your cooperation in completing this questionnaire
will be helpful in planning services for you.

Name: _____ Date: _____

Birth Date: _____ Gender: Male _____ Female _____ Age: _____

School Attending: _____ Grade: _____

Briefly Describe The Reason For Your Appointment Today: _____

Please Circle Any Issues Which Affect You

Nervousness

Depression

Fears

Shyness

Boyfriend / Girlfriend

Suicidal Thoughts

Separation

Parents Divorce

Anger

Alcohol Use

Friends

Sleep Problems

Drug Use

Unhappiness

Relaxation

Self-Control

Chores

Sadness

Stress

Tiredness

Lack of Motivation

Headaches

Feeling Unattractive

Loneliness

Memory

Making Decisions

Brother/Sister

Energy

Inferiority Feelings

Stomach Trouble

Concentration

Nightmares

Being Overweight

Temper

Guilt

Control

Body Size / Shape

Popularity

Sexuality

My Thoughts

Step Parents

Religion

Parents

School

Grief / Loss

Appetite

Individual Questionnaire Regarding Your Child

Life Skills Psychological Services, P.C.
805 S. Carmel Street, Cadillac, MI 49601
(231) 775-6517

Patient Information

First Name _____ Int. _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip _____

Birthdate: _____ Age: _____

Social Security # _____

Gender: _____ Marital Status: _____

() _____ () _____

Phone Home Cell

() _____ () _____

Work Email

Do you want an appointment reminder? (circle one)

Cell (text) Home Work Email
(call)

Primary Care Physician: _____

Employer: _____

Length of Employment: _____

Responsible Party

(Complete if patient is a child/dependent)

First Name _____ Int. _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip _____

Relationship to Patient: _____

() _____ () _____

Phone Home Cell

() _____ () _____

Work Email

Do you want an appointment reminder? (circle one)

Cell (text) Home Work Email
(call)

Birthdate: _____ Age: _____

Social Security # _____

Gender: _____ Marital Status: _____

Employer: _____

Length of Employment: _____

Primary Insurance

(We need to copy your insurance card)

Policy Holder _____

Social Security # _____

Birthdate: _____ Relationship to Patient _____

Employer: _____

Insurance Name: _____

Contract: _____ Group # _____

Secondary Insurance

(We need to copy your insurance card)

Policy Holder _____

Social Security # _____

Birthdate: _____ Relationship to Patient _____

Employer: _____

Insurance Name: _____

Contract: _____ Group # _____

AGREEMENT FOR PARTICIPATION with LIFE SKILLS PSYCH. SVCS. PC

We would like to welcome you to our office and inform you that hours of operation are by appointment from 8:00 a.m. to 5:00 p.m. Monday through Friday. Some evening hours are available and those vary depending upon the therapist. We can be contacted after hours and on weekends by calling our office number (231) 775-6517 where you can leave a general message such as appointment cancellations or for emergencies you will be given instructions on how to contact the "on-call" therapist. If you find it necessary to cancel an appointment, we require 24 hour notice because a specific time has been set aside for you. Broken appointments, without 24 hour notice, may be charged a full fee. Please be aware that your insurance company will not pay for missed appointments. LSPS reserves the right to discharge you from treatment due to excess of late cancel or no-show appointments.

We participate with most insurance companies and will make every effort to bill the insurance company on your behalf. Your insurance company requires co-pays to be made at the time of service. Payment can be made in cash, by check or credit card. We cannot assume responsibility for accuracy in estimation of insurance benefits or for success in collection of claims.

The initial counseling/therapy session is billed at \$195 and will last 60 minutes. The following counseling/ therapy sessions are billed at \$160 and typically last 50 - 60 minutes. If psychological testing is required, there are additional fees for those tests.

A fee of \$30 will be added to your account for checks returned to us from the bank. A fee of \$10.00 will be added to your account for checks that need to be re-deposited.

Any unpaid balances that are sent to collection will be assessed a fee of 25% of the balance.

The parent or guardian of a minor child who brings that child in for counseling is responsible for any charges incurred.

Please advise us of any changes in address, telephone or insurance coverage.

CONSENT FOR PARTICIPATION

I hereby authorize Life Skills Psychological Services, PC, through its staff, to provide the following services: outpatient psychotherapy/counseling, psychological testing/evaluations. I understand my participation is voluntary. Your case may be discussed internally during peer supervision and consultation, while keeping your privacy as our utmost concern.

PRIVACY NOTICE / RECEIPT RIGHTS

I have read and understand my rights as they have been written in the Privacy Notice and the Recipient Rights document. I understand that I may contact the Privacy Officer or the Recipient Rights advisor with any questions or concerns. Please see green HIPAA sheet for contact information.

RELEASE OF INFORMATION

I hereby authorize Life Skills Psychological Services, PC to release medical and other information as may be required by my insurance company, or case management company utilized by my insurance company, to obtain benefits for charges for treatment received by me or my dependent. I also authorize a quality-assurance review of my file contents, if required by my insurer, by an appropriate member of the clinical staff.

Initials _____.

I UNDERSTAND THE ABOVE POLICIES AND AGREE TO THE TERMS OF THESE POLICIES.

Name: (please print) _____

Signature: _____ Date: _____

I UNDERSTAND THAT REGARDLESS OF MY INSURANCE STATUS I AM ULTIMATELY RESPONSIBLE FOR TOTAL CHARGES INCURRED.

Signature: _____ Date: _____