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) (call) Home Work Email

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) (call) Home Work Email

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 #_____

Name_____ Date_____

Who suggested you contact us_____

Briefly describe reason for your appointment today_____

_____

_____

Occupation_____ Education_____

Emergency contact_____Phone_____

Religious Preference_____

Church attending_____

Date last examined by physician_____

Name of Physician_____

Purpose of exam_____

List any major health problems_____

_____

_____

List any medications you are currently taking _____

_____

Received psychiatric or psychological services of any kind before? Y N

If yes, please explain_____

_____

Immediate family members living with you:

Name	Age	How Related	Occupation
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Check any problems that pertain to you:

___ Nervousness
___ Shyness
___ Separation
___ Drug Use
___ Anger
___ Sleep
___ Relaxation
___ Grief & loss
___ Legal matters
___ Energy
___ Loneliness
___ Education
___ Temper
___ Children
___ Bowel troubles
___ Guilt
___ Depression
___ Sexual problems
___ Divorce
___ Self-control
___ Stress
___ Headaches
___ Feeling unattractive
___ Memory
___ Insomnia
___ Inferiority feelings
___ Career Choices
___ Nightmares
___ Appetite
___ Being a parent
___ Being overweight
___ Fears
___ Suicidal thoughts
___ Finances
___ Friends
___ Unhappiness
___ Work
___ Tiredness
___ Being overbearing
___ Ambition
___ Making decisions
___ Concentration
___ Health problems
___ Marriage
___ Stomach trouble
___ My thoughts
___ Religion
Other_____
_____

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:_____