Lifeway Adult Information Form

Date______/______/________

Patient Name: First_________________________MI ______ Last____

Date of Birth: ______/______/________ Gender: M ☐ F ☐ Marital Status: M☐ S☐ D☐ ___________________

Address:__________________________________City______________________ State: _____ Zip: ___________________________

Primary Contact Phone: __________________________Secondary Contact Phone: ____

Please circle home cell work home cell work

Primary Care Physician/Pediatrician:

Name: ____

Address: ____

Phone: ____

Emergency Contact:

Name: ____

Phone: ____

Relationship:____

Health Insurance/Guarantor Information

(Please bring your card to your first appointment)

Health Insurance Company:_________________________________

Policy/Member ID ____________________**Group#**____________

Policy Holder/Subscriber: (if different from patient)

Name:____

Date of Birth______/_______/__________

Address: ____

___________________________Phone:_______________________

Relationship to Patient: ☐Self ☐ Spouse ☐Parent ☐Other

Guarantor: Parent or party financially responsible, if insurance claims are denied. **Complete the following only if different from patient or policy holder:**

Name: ____

Address: ____

_____________________Phone:________________________

Relationship to Patient: ☐Self ☐ Spouse ☐Parent ☐Other

LIFEWAY REFERRAL INFORMATION

Please check the answer(s) that best describe how you first heard about LifeWay Counseling Centers

☐Insurance Company:
Please Specify:___________________________________

☐Medical Provider:
Name: ____

☐Hospital:
Name: ____

☐Church/Pastor: (please specify names)
Church____

Pastor____

☐ Employer:
Name:____

☐Friend or Family Member
Name:____
Relationship ____________________________________
Is she/he a former or current Lifeway patient?
Yes_____No____

☐Website
lifewaycenters.com? Yes____No____
mystar933.com? Yes____No____
Other: ______________________________________

☐ Radio Star 93.3 FM? Yes____No____

☐Other Please explain:___________________________

Authorization for Release of Confidential Information

I understand and acknowledge that without exception, information regarding scheduling, finances, or prescriptions will not be released to family members or others without my written consent in accordance with this document.

____

(Print name of the parent, guardian, or other individual & indicate his/her relationship to you.)

____

(Print name of another parent, or guardian, or other individual & indicate his/her relationship to you.)

_____I give the above-named individual(s) permission to act on my behalf to resolve claims and health benefit coverage issues.

_____ I give the above-named individual(s) permission to contact any physician, therapist or member of the staff at LifeWay to schedule appointments.

_____I give the above-named individual(s) permission to request refills and pick up my prescriptions.

I understand that I can withdraw consent at any time by providing written notice indicating the changes in permissions.

______________________________ ______________________

Patient Printed Name Date

____

Patient Signature

Important Information About Provider/Patient Email

As a patient of LifeWay Counseling Centers, Inc., you have the right to request that we communicate with you by electronic mail (email). It is also your right to be informed in sufficient detail about the risks of communicating via email with your healthcare provider or office, and how LifeWay Counseling Centers, Inc. will use and disclose provider/patient email.

If you have an urgent or an emergency situation, call 911 or go to your nearest emergency room for treatment. Email should not be used to request assistance or to describe an urgent or emergency situation since response to emails between you and your health care provider may be hours or days apart. Email messages may be inadvertently missed, and a response is not guaranteed.

Email messages have inherent privacy risks, because they may be transmitted over many networks that are not guaranteed to be secure. Communications over the Internet and/or using the email system are usually not encrypted and are inherently insecure. You should not communicate any information with your health care provider that you wish to remain confidential.

Your email message is not a private communication between you and your doctor or therapist. Office staff at LifeWay Counseling Centers, Inc. may read your email message in order to forward or to process and respond to your email. At your healthcare provider's discretion, your email messages and any and all responses to them may become part of your medical record.

Patient Request for Email Communications

You may request that we communicate with you via email. To do so you must understand and agree to the following terms and conditions:

- I understand LifeWay Counseling Centers, Inc. will not communicate health information that is specifically protected under state and federal law (e.g. HIV/AIDS information, substance abuse treatment records information, mental health information) via email even if we agree to communicate with you via email.
- I certify the email address provided on this request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.
- I acknowledge that I have received a copy of the above ***Important Information About Provider/Patient Email***, and I have read and understand it.
- I understand and acknowledge that communications over the Internet and/or using the email system are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.
- I agree to hold LifeWay Counseling Centers, Inc. and individuals associated with it harmless from any and all claims and liabilities arising from or related to the Request to communicate via email.

Please specify the email address to which communications should be addressed: ______________________

________________________________	__________	____
Signature of patient/personal representative	Date	If personal representative, authority to act on behalf of patient

Payment Authorization Agreement

(If planning on paying with debit or credit card, an optional form for convenience
and automatic payment processing.)

I hereby authorize LifeWay Counseling Centers, Inc. to keep my debit or credit card information on file to initiate appropriate payment entries against the debit or credit card referenced below, as applicable and authorized by me, for amounts owed on my Patient Account or on Patient Account for which I am guarantor.
I acknowledge that the initiation of all such entries to make payments on the Patient Account must comply with the provisions of U.S. law and any applicable state laws. I also agree to notify LifeWay Counseling Centers, Inc. if my debit or credit card information changes for any reason.
This authorization shall remain in effect until I communicate to LifeWay my intention to cancel this authorization by calling the office at 513-769-4600 or writing to LifeWay Counseling Centers, Inc.
LifeWay does not charge service fees in the event of returned ACH or a declined charge; however, I understand that I will be expected to provide an alternate form of payment. I acknowledge receipt of a copy of this authorization form.

After we enter this credit card* to be stored in Bill Flash (our credit card processing system), they will also require an authorization agreement. You can authorize this via email entered below;
A link will be sent to you via the email below. Click on the link and follow the instructions to authorize charges to your credit card.

Patient's Name: ____

Name on Credit/Debit Card: _______________________________________

Card Holder Email: ____

Card Holder Signature: ____

Card #: ___________-____________-____________-____________

Expiration Date: _______/________   Billing zip code:____________

*PLEASE NOTE; THIS FORM WILL BE SHREDDED ONCE STORED PAY AUTHORIZATION PROCESS IS COMPLETE

Consent to Email, Text, Voicemail Usage for Appointment Reminders

Patients at LifeWay may be contacted via email, text and/or voice messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, or to provide general health reminders/information. If at any time I provide an email or phone number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or phone number from LifeWay.

____ (Patient Initials) **I consent to receive email messages** from LifeWay at my
email address: ______________________________________ and any address forwarded or transferred to that email to receive communication as stated above.

____ (Patient Initials) **I consent to receive text messages** from LifeWay at my
cell phone: _______________________________ and any number forwarded or transferred to that number or emails to receive communication as stated above.

____ (Patient Initials) **I consent to receive calls/voice messages** from LifeWay at my cell phone and any number or address forwarded or transferred to that number to receive communication as stated above.

I understand that this request to receive emails, texts, and/or voice messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

LifeWay does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

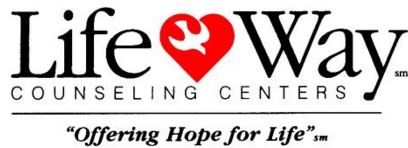
Revocation
____I hereby revoke my request for future communications via email and/or text messages.
____I hereby revoke my request to receive any future appointment reminders, feedback, and general health via voicemail.
Note: This revocation only applies to appointment reminder communication from LifeWay.
Patient Name: ___________________________________

Patient/Patient Representative Signature: _____________________________

Date: Time:

_____________________________________ __________ ____

Signature of patient/personal representative Date If personal representative, authority to act on behalf of patient



LIFEWAY ADULT QUESTIONAIRE

Name:____

Marital Status:_____________________Children? Names and Ages:______________________________________

____

What problems or concerns have you come here to address? ___________________________________

____

____

Are there any relationships you are unhappy with at the present time?_________________________

____

Have you seen a counselor before? If so, who and when?______________________________________

____

What would you like to achieve from treatment?____

____

Do you have a history of mental illness, substance abuse, or eating disorder? (If you answer yes to substance abuse, please fill out the drug and alcohol assessment.)_____________________________________

____

Does anyone in your extended family have a history of mental illness, substance abuse or eating disorder?_____

____

Do you have any history of childhood abuse or trauma? ______________________________________

____

Have you ever felt like seriously hurting someone? If yes, please explain:__________________________

____

Have you ever attempted suicide? If yes, please explain:______________________________________

____

Have you ever been hospitalized psychiatrically? If so, when and where?________________________________

____

Do you currently have a psychiatrist? If so, when was your last appointment?____________________________

____

Do you have another appointment scheduled with him/her? Yes____ No____ Date ___/___/______________

Please list any medications that you currently take:____

____

____

Do you have any medical conditions? Yes_____ No_____ If yes, please explain:__________________________

____

____

Do you have a military history? Yes_____ No_____ If yes, please describe:_____________________________

____

Are you having financial problems? Yes_____ No_____ If yes, please explain:__________________________

____

Do you have, or have you had, any legal problems? Yes_____ No_____ If yes, please explain:_______________

____

____

Are religious or spiritual values important in your life? Yes _______ No ______ Somewhat_______

Are you aware of any religious or spiritual resources in your life that could be used to provide support to you? If so, please describe: ____

____

What is your current religious affiliation (if any?)____

Would you be interested in coaching, or phone sessions? Yes_____No_____

Thank you for answering these questions. It will assist us in your treatment.

Medication and Drug Assessment

Please provide a history of use for any and all following:

Chemical	Type/Amount/Frequency/Route	Age of First Use	Date Last Used
Alcohol			
Cocaine/Crack			
Marijuana			
Anti-Anxiety medicines (Valium, Xanax, Ativan etc…)			
Opiates Heroin, Morphine, Codeine			
Other Narcotics (Vicodin, OxyContin, Percocet etc…)			
LSD			
Amphetamines			
Inhalants			
Other- Includes over the counter			