# Lifeway Child/Adolescent 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:_____

# 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: _____

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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

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"Offering Hope for Life"sm

# 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

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# LIFEWAY CHILD/ADOLESCENT QUESTIONNAIRE

Child's Name_____ Date_____

Why are you seeking counseling for your child at this time? _____

_____

Legal Status: Please put name(s) next to option chosen:

☐Mother is sole custodian_____ ☐Father is sole custodian_____

☐Ward of the Court_____☐Other_____

With whom does the child live? Please list all the people that live in the same household.

_____

_____

## Physical History

Were there any out of the ordinary circumstances surrounding the pregnancy or birth of your child?

If yes, please explain: _____

_____

_____

Overall, at which rate do you feel your child developed? Slow_____ Normal_____ Rapid____

Does your child's doctor have any concerns about your child's physical health? _____

If yes, please explain_____

_____

Are childhood immunizations up to date? _____

Does your child have any identified physical disabilities (hearing or sight problems, seizures, etc.)?

_____

What childhood illnesses did your child have? _____

Is your child currently being treated for any illness? _____

Does your child have any eating or sleeping problems? If yes, please explain:

_____

_____

Is your child taking any prescribed or over the counter medications? If so, please list: _____

_____

## EDUCATIONAL HISTORY

What school does your child attend? _____ Grade_____

Please list any extra-curricular activities in which your child participates: _____

_____

Do you know your child's IQ? _____

Does your child struggle with any particular subjects?_____

_____

Has your child had any problems at school academically or with peers and staff? _____

_____

Does your child have an IEP? Yes_____ No_____

## BEHAVIORAL HEALTH HISTORY

In your own words, please describe your child and what your expectations are for treatment.

_____

_____

_____

Has your child been in treatment before either on an inpatient or on an outpatient basis? Yes _____No_____

Please list places, dates and treating professionals:

_____

_____

_____

What was the problem and do you feel it was resolved? _____

_____

_____

Has your child experienced any of the following? ____domestic violence ____physical abuse _____sexual abuse ____emotional abuse ____rape/sexual assault ____death of a loved one ____divorce/separation ____other/please explain: _____

_____

Has your child ever expressed a desire to seriously hurt him/herself or any one else? Yes _____No_____

If yes, please explain:_____

_____

If your child is 12 years old or younger, what does your child know about drug, alcohol or tobacco use?

_____

_____

As far as you know, has your child ever experimented with drugs, alcohol or tobacco? Yes_____ No_____
If yes, please complete the **Alcohol and Drug Assessment form** in this packet.

## SEXUALITY

To the best of your knowledge, is/has your child been:

____sexually active ____using birth control _____fathered a child ____had an abortion ____been pregnant

If female, does she have periods? _____When was her last period? _____

## FAMILY HISTORY

List any siblings not living in the household: _____

Is there any family history of mental illness, substance abuse problems or an eating disorder? If yes, please explain: _____

_____

_____

Is your child having a problem with any specific member or members of the family? If yes, please explain:

_____

_____

Are you/your child's parents having problems at this time? _____If so, is your child aware of them?

_____

Is the family having financial concerns at the present time? _____

Is there anything about your family which you feel is important for the therapist to know at this time?

_____

_____

Thank you for taking the time to answer these questions. It will assist us in the treatment of your child.

# 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 | | | |
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