LifeWay COUNSELING CENTERS
"Offering Hope for Life"sm

LIFEWAY PREMARITAL INFORMATION FORM

Date: ____/____/____

Name: First_____MI ____Last_____

Date of Birth: ____/____/_____ Gender: M☐ F☐ Marital Status: Single☐ Engaged ☐ Divorced ☐

Address: _____ City_____ State: _____ Zip: _____

Primary Contact Phone: _____Secondary Contact Phone:_____
(Please circle) home cell work home cell work

Emergency Contact: Name: _____ Relationship:_____

Phone: _____

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: _____

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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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 PREMARITAL QUESTIONNAIRE

Name:_____ Date of Birth:_____

Partner's Name:_____ Date of Birth:_____

Relationship Status: _____ Single ____Engaged ____Divorced _____ (number of years)

Other_____

Children's Names/Ages:_____

_____

For what problems or concerns have you come to LifeWay to seek counseling?

_____

_____

_____

_____

Have you ever been to counseling, as a result of problems with this relationship, prior to coming to LifeWay? _____ If yes, please indicate when/where:_____

_____

How would you describe the outcome?_____

_____

_____

Have you and/or your partner been to individual counseling?_____ If yes, please give a brief summary of the concern(s) addressed in counseling:

_____

_____

_____

_____

What outcome would you like to see as a result of coming to LifeWay?_____

_____

_____

_____

Do you have any medical conditions? _____(If yes, please indicate) _____

_____

Please list any medication you are currently taking (if possible, please identify prescription, date prescribed, and dosage) _____

_____

Do you/your partner have any history of mental illness, eating disorder, or personality disorder? If yes, please describe:_____

_____

Does anyone in your extended family have any history of mental illness, substance abuse, personality disorder, or eating disorder?_____ If yes, please describe:_____

_____

Have you or anyone in your family experienced any kind of physical, verbal or sexual abuse, or trauma? _____If yes, please identify:_____

_____

_____

Have you/your partner ever attempted suicide? _____ If yes, please indicate individual, date and means:_____

_____

Have you/your partner ever been hospitalized psychiatrically? _____ If yes, please indicate individual, date and means:_____

_____

Do you/your partner drink alcohol or use drugs to intoxication? _____If yes, please indicate type and frequency of substance use:_____

_____

Have you/your partner struck physically restrained, used violence or injured the other person in this relationship? _____If yes, please describe (who, when, what occurred)_____

_____

_____

Have you/your partner engaged in a physical or emotional affair, or used pornography while in this relationship? _____ If yes, please identify the nature and frequency of the behavior:

_____

_____

Do you or your partner have a military history? _____ if yes, please indicate: _____

_____

Are you having financial problems? _____

Do you/your partner have any legal issues? _____ If yes, please describe:

_____

_____

_____

Are religious or spiritual values important to your life? ____ yes ____ no ____ somewhat

Do you wish to discuss spiritual matters in counseling when relevant? _____ yes ____no

_____

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

Thank you for answering these questions. It will assist us in determining the best approach to address your issues of concern.