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

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.

Name on Credit/Debit Card: ____

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: ______________-______________-______________-______________

Expiration Date: ________/_________ CVV: _____________

Patient's Name: ____

Patient Signature: ____ Date: ___________________

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

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

LIFEWAY CHILD/ADOLESCENT QUESTIONNAIRE

Child's Name: ____Age:___________

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

____

____

Parental Information (Check All that Apply): ☐Parents Together ☐Parents Separated ☐Parents Divorced

☐Mother Remarried ☐Father Remarried ☐ Mother is sole custodian ☐ Father is sole custodian

☐Child Has a Guardian ☐Other_____________________________

Child's Living Situation: ☐House ☐Apartment ☐Condo ☐Living with Family/Friend ☐Other:____________________

Family and Household Member Names:	Relationship to Child:	Age:	Resides w/ Child:
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

Physical/Medical History

Were there challenges or traumatic circumstances surrounding the pregnancy or birth of your child? ☐Yes ☐No

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? ☐Yes ☐No

If yes, please explain____

____

Child and Family Medical History:	**Child**	**Family**	**Which Family Member?**
Depression	☐	☐	
Anxiety	☐	☐	
ADHD	☐	☐	
Bipolar	☐	☐	
Substance Abuse	☐	☐	
Eating Disorder	☐	☐	
PTSD	☐	☐	
Disorganized Thinking/Paranoia/Schizophrenia	☐	☐	
Asthma/respiratory problems	☐	☐	
Autoimmune disease (type)_____________________	☐	☐	
Cancer (type)_________________________________	☐	☐	
Chronic Fatigue	☐	☐	
Chronic Pain	☐	☐	
Diabetes	☐	☐	
Epilepsy or Seizures	☐	☐	
Head Trauma	☐	☐	
Heart Disease	☐	☐	
Stomach or intestinal problems	☐	☐	
Other: ____________________________________	☐	☐	

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? ☐Yes: ____________ ☐No

Does your child struggle with any particular subjects? ☐Yes ☐No

If yes, please explain____

____

Has your child had any problems at school academically or with peers and staff? ☐Yes ☐No

If yes, please explain____

____

Does your child have an IEP? ☐Yes ☐No ☐Don't Know

Does Your Child have a 504 Plan? ☐Yes ☐No ☐Don't Know

BEHAVIORAL HEALTH HISTORY

Previous care child has been involved in:	Current	Past- How long ago (i.e. '10 years ago')
Child Counseling/Therapy	☐	☐ How long ago:______________________
Family Counseling/Therapy	☐	☐ How long ago:______________________
Outpatient Services	☐	☐ How long ago:______________________
Psychiatric Hospitalization Hospital name:	How long ago	Reason (suicidal, depressed, etc.)

Has your child experienced any of the following? ☐Domestic Violence ☐Physical Abuse ☐Sexual Abuse ☐Emotional Abuse ☐Rape/Sexual Assault ☐Death of a Loved One ☐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____

____

As far as you know, has your child ever experimented with alcohol, tobacco, or drugs? ☐Yes ☐No

If yes, please explain____

____

Is your child having a problem with any specific member or members of the family? ☐Yes ☐No

If yes, please explain____

____

Are you/your child's parents having problems at this time? ☐Yes ☐No

If so, is your child aware of them? ☐Yes ☐No ☐Don't Know