Lifeway Couples 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:_____

LifeWay
COUNSELING CENTERS

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

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

LIFEWAY COUPLES QUESTIONAIRE

Name:_____ Age:_____

Partner's Name:_____ Age:_____

Relationship Status: ☐Single ☐Engaged ☐Married ☐Divorced ☐Separated ☐Remarried

For how many years: _____

Ethnicity: ☐Black/African American ☐Hispanic/Latino ☐Native American ☐White

☐Asian ☐Other:_____

Are religious or spiritual values important in your life? ☐Yes ☐No ☐Somewhat

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

Living Situation: ☐House ☐Apartment ☐Condo ☐Living with Family/Friend ☐Other:_____

Household Member Names:	Relationship to Client:	Age:

Siblings Names:	Relationship to Client:	Age:

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

_____

_____

_____

_____

Medical History

Personal and Family Medical History:	**You**	**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 _____	☐	☐	

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage For about how long?

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

_____

Mental Health Treatment History		
Type of Counseling	Current Past- How long ago (i.e. '10 years ago')	
Individual	☐ ☐ How long ago:_____	
Marriage	☐ ☐ How long ago:_____	
Family	☐ ☐ How long ago:_____	
Outpatient Services	☐ ☐ How long ago:_____	
Psychiatric Hospitalization Hospital name:	How long ago	Reason (suicidal, depressed, etc.)

Do you have any history of abuse or trauma? ☐Verbal ☐Physical ☐Emotional ☐Sexual ☐Other:_____

If yes, when did it occur: ☐Childhood ☐Past ☐Current

Have you/your partner struck physically restrained, used violence or injured the other person in this relationship?
☐Yes ☐No

While in this relationship, have you/your partner engaged in:
☐A physical affair ☐An emotional affair ☐Used pornography

Have you ever attempted suicide? ☐Yes ☐No

Are you currently struggling with unsafe thoughts towards yourself or others? ☐Yes ☐No

Do you or your partner have a military history? ☐Yes, I do ☐Yes, My spouse ☐No
If yes: ☐Active ☐Discharged

Are you having financial stresses? ☐Yes ☐No

How many hours do you sleep at night (on average):_____

Substance Use Assessment

Substance	Amount/Frequency	Age of First Use	Date of Last Use
Alcohol			
Marijuana			
Opioids/Opiates			
Other Drugs Used Recreationally: _____			