**NEW PATIENT INFORMATION PACKET FOR COUNSELING SERVICES WITH LIFE’S WORK CLINIC, PLLC**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AUTHORIZE TO TREAT I affirm that I am the patient or legal guardian and responsible party of the above patient and, I hereby acknowledge that I authorize and give permission to the staff of Life’s Work Clinic, PLLC, (LWC) to render treatment and/or services to myself/above named minor child, and I hereby acknowledge that staff is responsible for treatment and/or services rendered in the course of treatment (therapeutic time in facility) and cannot be held responsible for my behavior/behavior of minor child outside of the context of the therapeutic treatment session at Life’s Work Clinic, PLLC.

**EMERGENCY CONTACT:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Relationship:** [ ] Spouse [ ]Mom [ ]Dad [ ]Step-[ ] Daughter/Son [ ]Step-Mom [ ]Step-Dad [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were You Referred to Us? If so, by Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is Your Primary Doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) I don’t have a primary doctor

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last Name First Middle)

**Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Street Name City State Zip Code)

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Only provide us contact numbers where we can contact you and/or we can leave a message regarding appointments, inquiries and office/medical related issues.)*

**Preferred Method of Appointment Reminder** [ ]None [ ] Call [ ]Text [ ]E-mail

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 Digits of SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

**INSURANCE ASSIGNMENT AND SELF PAY AGREEMENT**

Primary Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral Health Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Policy Holder: □Self □ Other: **Full Name/Relationship/Date of Birth**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral Health Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have insurance coverage with the primary insurance company and the second insurance payer, if applicable, listed above. I assign directly to Life’s Work Clinic, PLLC all insurance payments, if any otherwise payable to me for services rendered. I understand I am financially responsible for any deductible, co-insurance, copayment, non-covered charges, and any balances not covered under a signature for all insurance submissions. I understand that it is my responsibility to pay for any services rendered at the time of visit.

**FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT**

Payment for services rendered is the responsibility of the patient, parent, or guardian. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage on your behalf. *However, you are ultimately responsible for the payment of your bill, regardless of insurance coverage.* Once insurance claims have processed, any remaining balance(s) will be billed to the patient. If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the patient. If insurance issues arise, it is the responsibility of the patient to contact the insurance company, group plan, administrator, or employer representative for resolution. A patient's insurance policy is a contract between the patient and the insurance carrier. Life’s Work Clinic, PLLC, is not parties to that contract and cannot act as a mediator with the carrier or employer. The patient will become responsible for complete payment to the provider if coverage has terminated due to lack of premium payment. As required by insurance mandates, it is the responsibility of the patient to obtain any necessary authorization for medical treatments. If the patient is treated without the proper referral or authorization as required by the insurance carrier, the patient assumes responsibility for payment of all fees at the time of service.

**BY SIGNING BELOW, I AGREE TO LWC’s FINANCIAL RESPONSIBILITY POLICIES:**

Signature of Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

**HIPAA PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change as new information becomes available. If, in the course of overseeing your care, we change our Notice, we will inform you ahead of any proposed changes being implemented, and you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. While we are not required by law to agree with any extra restrictions, we shall always do our best to honor any additional restrictions you wish to impose in the due course of our operations.

By signing this form, you consent to our use and disclosure of protected health information about you for the purpose of treatment, payment and usual and anticipated healthcare operations. You have the right to revoke this consent with a signed document. However, such a revocation shall not affect any disclosures that we have already made in reliance on your prior consent.

Life’s Work Clinic, PLLC, provides this form in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You, the patient, understands that:

* Protected health information may be disclosed or used for treatment, payment or health care operations.
* Life’s Work Clinic, PLLC, has a Notice of Privacy Practices and that you, the patient, have the opportunity to review this Notice.
* Life’s Work Clinic, PLLC, reserves the right to change the Notice of Privacy Practices as new standards or information becomes available.
* You, the patient, has the right to restrict the uses of their information.
* You, the patient, may revoke this Consent in writing at any time and all future disclosures will then cease.
* Life’s Work Clinic, PLLC, may condition receipt of treatment upon signing of this Consent.

**INSURANCE INFORMATION:**

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any and necessary reports and forms to assist me in making collections from the insurance company and that any amount to be paid directly to this office will be credited to my account upon receipt. However, I understand and agree that all services rendered to me are charged directly to me and that, ultimately, I am personally responsible for payment for all services received at the clinic.

This HIPAA Consent Form is Signed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X Signature of Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

**BRIEF MEDICATION and TREATMENT HISTORY FORM**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am a client of Life’s Work Clinic, PLLC (LWC). The following is a list of all my prescribed and non-prescribed medications from all my other healthcare providers. I understand that my treatment at LWC will rely on this information to make appropriate treatment decisions and that it is my responsibility to ensure that this information is accurate. I will also make sure that I regularly update this information if there are any future changes in these medications. I also understand that I may opt to simply go to my patient portal available through my other providers and print a list of medications and that this will likely provide a more accurate and complete medication list that will include current strengths and prescribed dosages of all drugs currently prescribed to me.

PRESCRIBED MEDICATION(S): PRESCRIBER(S):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OVER THE COUNTER MEDICATIONS: PRIOR PSYCHIATRIC IN-PATIENTS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BY SIGNING BELOW, I CONFIRM THE INFORMATION ABOVE IS CORRECT:**

Signature of Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR OFFICE POLICIES AND PROCEDURES**

Life’s Work Clinic, PLLC is dedicated to providing excellent behavioral health services and treating patients with dignity and respect. Below are our office policies and conditions of care:

**Please initial below where indicated as acknowledgement and consent of all office policies and procedures:**

\_\_\_\_\_**Emergency Calls**: For after hour emergencies, please call 911 or go to the nearest emergency room. If calling after hours, patients can call 1-231-620-7977 and leave a message for non-emergencies. All calls will be handled by the clinical director and/or their staff. Any agreement that you may have with your individual counselor regarding after hours contact will remain in effect.

**\_\_\_\_\_Billing Policy**: LWC will bill your insurance, on your behalf; provided we are contracted with your insurance company and you are not a private pay patient. The responsible party agrees to provide all insurance information, at or prior to the first appointment. The responsible party also agrees to notify LWC of any changes in insurance coverage within 10 days and is responsible for all charges not covered or not paid by the insurance for any reason. Co-payments, deductible & any fees not paid by the insurance are due at the time of service.

\_\_\_\_\_**Returned Checks**: are subject to a $30.00 processing fee.

\_\_\_\_\_**Appointment Cancellation** Please be aware of our 24-hour cancellation policy for all appointments. If you cancel late or miss a counseling appointment without notice, a $75.00 fee will be automatically charged to the card on file. This fee is not covered by insurance and is the responsibility of the client. For clients with state-funded insurance plans, three no-shows or late cancellations will result in the termination of their contract.

\_\_\_\_\_**Active Patient**: You will automatically be considered inactive after three missed appointments without notice or passage of two months without an appointment, with no reply to office contact attempts.

\_\_\_\_\_**Termination of Treatment**: Treatment can be terminated for the following reasons and shall include but not be limited to: Multiple delinquent payments; Failure to keep the scheduled appointments as per office policies; Any disruptive or threatening behavior at the clinic or over the phone.

\_\_\_\_\_**Privacy Policy Notice**: I acknowledge that I have reviewed a copy of the Notice of Privacy Practices. Office Policies and Procedures Notice: I acknowledge that I have reviewed a copy of the Office Policies and Procedures Policies. I hereby authorize LWC to conduct an evaluation and perform treatment for myself and/or my dependents with regards to behavioral health.

**BY SIGNING BELOW, I AM AGREEING TO THE POLICIES OUTLINED ABOVE:**

Signature of Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

**TEXT MESSAGING AND TELEMEDICINE CONSENT FORM**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telemedicine Consent:**

I understand that Life’s Work Clinic, PLLC, utilizes state of the art technology in an effort to increase ease of patient access to practitioners. One of these technologies is based on teleconferencing which is often called “telemedicine”.

The Michigan Public Health Code Section 500.3476(b) defines Telemedicine as:

"Telemedicine" means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided.

By signing this consent form, I am agreeing to see my practitioner at Life’s Work Clinic, PLLC, either in-person or by telemedicine.

**Text Messaging Program Consent:**

At Life’s Work Clinic, PLLC, we are happy to provide our patients with the option to participate in our text-based patient communication system. Some of the features include the ability to:

1. Receive text message appointment reminders and
2. Communicate about important medical issues related to you care via text messages

You may choose to discontinue your participation in our text communication system at any time simply by replying “Stop” to any text you receive. We will consider this your intent to stop getting information by text.

Please provide us with the following contact information:

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction.

Please sign at the bottom of this page to indicate that you agree to allow us to use this information in providing your services.

**BY SIGNING BELOW, I AM AGREEING TO PARTICIPATE IN THE PROGRAMS OUTLINED ABOVE:**

Signature of Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_