Lotus Wellness Center

This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-7.

ADOLESCENT INTAKE FORM (ages 12-17)

CLIENT INFORMATION

Name:_____

Date of Birth: _____ Age: _____ ❒ Male ❒ Female

Physical Address: _____

Mailing Address: _____

Phone (Cell): _____ Messages okay?_____

Phone (Home): _____ Messages okay?_____

School: _____ Grade: _____

Race/Ethnic Origin: _____

Religious Preference: _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

_____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking counseling?

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒Yes ❒No

If yes, what did you find **most helpful** in therapy? _____

_____

If yes, what did you find **least helpful** in therapy? _____

_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes _____No

If yes, how often do you drink? _____Daily _____Weekly _____Occasionally _____Rarely

If yes, how much do you drink? _____(#) per time.

Do you currently use Tobacco? _____Yes _____No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____Yes _____No

If yes, what drugs do you use? _____

If yes, how often do you use? _____Daily _____Weekly _____Occasionally _____Rarely

Have you received any previous treatment for chemical use? Y/N _____

If so, where did you go?_____

____Inpatient ____Outpatient

ADOLESCENTS *(please answer the following with* Y/N)

Have you ever used more than 1 chemical at the same time to get high? _____

Do you avoid family activities so you can use? _____

Do you have a group of friends who also use? _____

Do you use to improve your emotions such as when you feel sad or depressed?? _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past. _____

FAMILY HISTORY

Are your parents married or divorced? _____

Do you think their relationship is good? (Y/N/Unsure)_____

If your parents are divorced, whom do you primarily live with? _____

How often do you see each parent? Mom_____% Dad _____%.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

FAMILY CONCERNS *(Please check any family concerns that your family is currently experiencing)*

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol or Drug use
	Lack of honesty		Trauma
	Medical Concerns		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a child
	Inadequate health insurance		Job change or job dissatisfaction
	Inadequate housing/feeling unsafe		Other

Other concerns not listed above _____

PEER RELATIONS

How do you consider yourself socially: ___outgoing ____shy ____depends on the situation.

Are you happy with the amount of friends you have? (Y/N)_____

Have you ever been bullied? (Y/N) _____

Are your parents happy with your friends? (Y/N)_____

Are involved in any organized social activities (e.g. sports, scouts, music)?

_____

SCHOOL HISTORY

Do you like school? (Y/N)_____

Do you attend regularly? (Y/N)_____

What are your current grades? _____

Do you feel you are doing the best you can at school? (Y/N) _____

Is there anything else you would like me to know: _____

_____

_____

Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: _____ Date of Birth: _____

Mother's/Guardian's Name: _____ Phone Contact: _____

Mother's/Guardian's Physical Address: _____

Mother's/Guardian's Mailing Address: _____

Father's/Guardian's Name: _____ Phone Contact: _____

Father's/Guardian's Physical Address: _____

Father's/Guardian's Mailing Address: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

(If additional space is need please list on the back of page)

Current Reason For Seeking Counseling For Your Adolescent

Briefly describe the problem for which your adolescent is seeking to have counseling for?

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

What is most concerning right now?

_____

_____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? ☐Yes ☐No

If Yes, where: _____

Approximate Dates of Counseling: _____

For what reason did your son or daughter go to counseling?

_____

_____

Does your son or daughter have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy?

_____

_____

What did you find **least helpful** in therapy?

_____

_____

Has your son or daughter used psychiatric services? Yes____ No____ If yes, who did they see?

_____

If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes_____ No _____

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe: _____

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child?

Yes ___ No ___ If yes, describe:

_____

_____

Did your child have health problems at birth? Yes _____ No _____ If yes, describe:

_____

_____

Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

Yes ___ No ___ Not sure_____ If yes, describe:

_____

_____

Did your child have any unusual behaviors or problems prior to age 3?

Yes ___ No ___ Not sure_____ If yes, describe:

_____

_____

Has your child experienced emotional, physical, or sexual abuse?

Yes ____ No ____ Not sure _____ If yes, describe:

_____

_____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____

If yes, please explain your concern:

_____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____

If yes, please explain your concern:

_____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

_____

_____

FAMILY HISTORY

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Father's Name: _____ **Birth Date:**_____ **Age:** _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Mother's Name: _____ **Birth Date:**_____ **Age:** _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

PARENT'S MARITAL STATUS

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated

❒Widowed ❒Other _____

Length of marriage/relationship:_____

If divorced, how old was your child at time of divorce? _____

If divorced, How much time does your child spend with each parent?

Mother_____%, Father _____%

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol or Drug use
	Lack of honesty		Trauma
	Medical Concerns		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a child
	Inadequate health insurance		Job change or job dissatisfaction
	Inadequate housing/feeling unsafe		Other

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

_____

_____

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

_____

_____

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

_____

_____

What personal qualities would you say your son or daughter has?

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe)

_____

_____

Is there anything else you would like me to know: _____

_____

_____

Parental Consent to Treat a Minor

I, _____ (Name of Parent or guardian of child), give my permission for my child, _____ (Full Name of Minor), _____ (Birth Date of Minor), to be treated at the Lotus Wellness Center in Palatine, IL. I also understand that in order for therapy to be successful with any individual, their confidentiality needs to be respected, even in the case of a minor child, with exceptions of if the minor is a danger to him/herself or to others.

I understand that this permission to treat with respect for my child's confidentiality is given with my full consent. This consent will be valid throughout the duration of therapy, or until the following date: _____ (Date consent expires).

_____

Parent or guardian's signature | Relationship to minor | Today's date

_____

Name and Address of Parent or guardian (Street, City, State and Zip)

_____

Other parent or guardian's signature | Relationship to minor | Today's date

_____

Name and Address of other parent or guardian (Street, City, State and Zip)

_____

Address of minor (Street, City, State and Zip)

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible unless otherwise specified in another written contract, for all services rendered to the patient. **I agree to pay for services rendered, in full at the time of service, unless other arrangements are made in advance.** Whether or not I have insurance, I as a patient/guarantor am responsible for the charges for services rendered to the patient. I further understand that I will be responsible for any additional charges for services, which may not be available at the time of leaving the office. We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for psychiatric care is a contract between you and the carrier. You should direct any questions and/or complaints regarding coverage to your insurance carrier. **If at any time, your health insurance coverage changes, please notify our office immediately or you will be held accountable for all charges at the time of services rendered.** Any account exceeding 90 days without a payment or arrangement shall be considered delinquent and can be subject to legal actions or assignment to a collection agency. **Co-payments and outstanding balances are due at the time of service. In case of no insurance, payment in full will be due at the time of service. For individual counseling services, initial evaluations are $150, and follow-ups are $100 for a self-pay client. Please inquire regarding self-pay rates for all other services.**

_____ *Initial*

NON-PAYMENT

If you are unable to make a payment on your bill, please contact our office for possible payment arrangements. If your bill is 90 days overdue without payment, you will not be able to schedule further appointments, and your bill may be subject to late fees or turned over to collections for non-payment.

_____ *Initial*

NOTICE OF PRIVACY PRACTICES

I hereby authorize Lotus Wellness Center, PC to release any and all information to insurance companies or associations, employee groups, government agencies or their third party payors and their agencies or employees, as may be necessary for the completion of all my claims. **By signing below, you agree that you received, read and understand our Privacy Practices. If you choose to keep information confidential from insurance, we can discuss self-pay rates.**

_____ *Initial*

*APPOINTMENTS

Expected length of services to be provided is often difficult to predict and this factor will be discussed with you prior to initiation of the services. Counseling sessions are **typically 45-50 minutes** in length and in order to see the most progress, clients are encouraged to begin with weekly or biweekly sessions.

_____ *Initial*

*APPOINTMENT CANCELLATION POLICY

Because my clinician holds your appointment slot open for me, I understand that the office requests more than 24 hours notice be given for cancellations. **I understand that failure to cancel with at least 24 hours notice will result in a $50 fee.** Charges for missed appointments are not covered by insurance. I understand that this charge will be directly billed to me, and must be paid prior to the next appointment. Recurrent no-shows may result in a discharge from care.

_____ *Initial*

*INITIAL CONSULTATION

The initial consultation, otherwise known as the intake interview is an important and mandatory procedure for all new clients, which provides you and your clinician the opportunity to get to know each other and determine if you are a good treatment match. During this time, the individual's background, therapeutic concerns and goals, schedule availability and financial resources are discussed and an initial treatment plan is agreed upon. Details of confidentiality and fees are also discussed. I understand the importance of this initial meeting.

_____ *Initial*

LETTERS/FORMS

Lotus Wellness Center PC does not provide disability letters, companion pet letters, or letters regarding your ability to work, or any letters that would inform providers of your mental health history. You must discuss these needs with your medical, psychiatric or primary care provider.

_____ *Initial*

***INSURANCE POLICY**

This office accepts most major insurance providers. However, if we are out of network with your insurance company, we will provide you with all of the necessary paperwork to file your own insurance reimbursement. Generally speaking, most insurance companies will pay a percentage of each session after you meet your deductible. The majority of insurance companies reimburse clinicians at a 60/40 or 70/30 percentage split. If you choose to utilize your insurance, please note that to meet the requirements for in-network reimbursement, the counselor must submit an official client diagnosis and an ongoing progress report, treatment plan, etc. Such information requires that the therapist divulge a good deal of personal information about the client, which then becomes part of his/her permanent medical record which can be accessed by others. If you are concerned about your confidentiality with insurance claims, please ask us regarding self-pay and sliding fee rates.

_____ *Initial*

TELEPHONE CALLS

Calls prompted by the client that require clinician to call back **will be charged**. Giving medical advice and treatment is a service we provide. Any co-payment or deductible will be the patient's responsibility. You may prefer to make an appointment vs. discussing your healthcare needs over the phone. At times, your clinician may initiate a phone or telehealth session. If this is the case, it will be treated similarly to a face-to-face session and all co-payments and deductibles will be the client's responsibility.

_____ *Initial*

***SCHEDULE OF FEES**

All clients begin with a 50-minute initial consultation with a counselor. Thereafter, clients schedule standard, weekly/biweekly sessions with their counselor. You are responsible for all fees at the time of service; cash, credit card, and personal checks are accepted. Any unpaid balance may be turned over to a collection agency if you refuse to remain responsible for your account. You will be expected to pay for late cancelled or forgotten appointments with a **$50 charge**, unless there has been an emergency or at least notice of cancellation given within 24 hours. The fee must be paid at your next appointment. There will be a $35 charge for any checks that are returned for insufficient funds.

SELF-PAY RATES

Fees vary according to the type and length of services. Sliding fees are granted for a limited amount of sessions no more than 10 sessions in a 12 month period. Clients must meet income requirements. Please contact us to apply.

I certify that the information provided on the Patient Profile is correct to the best of my knowledge. I have read and understand the above and duly authorize Lotus Wellness Center, PC and/or it's appointees to execute the above and its terms.

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

MEDICAL HISTORY

- Drug allergies: _____

VIDEO RECORDING IN RECEPTION AND BACKROOM OF OFFICE

I understand that for my *safety and security*, the *reception area and back of the office* will be recorded. Rooms in which confidential care takes place are not recorded. These recordings will only be viewed by Lotus Wellness Center staff and will be held on a HIPPA compliant platform for 24 hours. They will be permanently deleted after 24 hours.

Name: _____ Date:_____

Signature: _____

IMPORTANT NOTICE:

EFFECTIVE FEBRUARY 12, 2018

Starting on February 12, 2018, Lotus Wellness Center will charge a non-refundable processing fee of **3% for any credit/debit card payments.**

Methods of payment that **do not** incur this charge are **cash, check and chase quickpay** (drleogerdov@gmail.com). These payment methods will not incur any additional fees. We appreciate your understanding.

Respectfully,

Lotus Wellness team

Date:_____

Name:_____ Signature:_____

CREDIT CARD AUTHORIZATION

The security of your personal information is extremely important. Lotus Wellness Center PC is committed to protecting the security and privacy of any personal information you provide, including any financial information. Please inquire of any questions concerning this authorization, the" information regarding services" and/or "Notice of Privacy Policy Practices" forms provided for your review and agreement.

This form is requested for all clients and required to be on file. Please inform us when there are any changes made to this credit card so that we can have updated information on file.

Client Name/s: _____

Please read all below:

Acceptable forms of payment are: cash, check, debit card or credit card.

My initials below:

_____ Without my debit/credit card, I authorize Lotus Wellness Center PC to use my credit/debit card number provided below to process charges/fees assigned to any named individual listed above.

_____ I authorize Lotus Wellness Center PC to be compensated for missed appointments of which the client/s named above did not show up for session or cancel session less than 24 hours before the time of the appointment. Missed and late cancelled appointments are billed at a rate of $50 per session.

Please complete all the following information:

Type of card: _____

Exact name on card: _____

Relationship to client: _____

Card number: _____

Expiration date: _____ CUV: _____

Billing address: _____

Signature: _____ Date:_____