

The LifeWorks Group, Inc.

Client Registration

Client Name _____
(Last) (First) (Middle) (Nickname)

Address: _____
City: _____ State: _____ Zip Code _____

Home Phone: () _____ Work Phone: () _____ Ext# _____

Cell Phone: () _____ E-Mail Address: _____

Birth Date: _____ Age: _____

Sex: M F Marital Status: Single Married Divorced Widowed

Employer: _____

If student, school attending: _____

If dependent child, are custodial parents: Married Separated Divorced Other

IN CASE OF AN EMERGENCY NOTIFY: Name: _____

Relationship: _____

Phone: () _____

Referred here by: _____ May we acknowledge your referral? Yes No

(Note: Your name will be kept confidential.)

How did you hear about LifeWorks? If online, please specify where (Website, YouTube, Facebook, etc.)

Would you like to receive our free E-Newsletter, which contains helpful information and resources?
(Your privacy is protected; we will not share your email with anyone) Yes

Financially Responsible Party (Guarantor) Information
(If the same as client please complete only #1 and #6 of this section)

1. Guarantor Name: _____
(Last) (First) (Middle)

2. Guarantor Address: _____

3. Guarantor Relationship to Client: Spouse Mother Father Sibling
 Relative Friend Other _____

4. Home or Cell Phone: () _____

5. Work Phone: () _____

6. Occupation: _____

7. SPECIAL ARRANGEMENTS: _____

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by The LifeWorks Group, Inc.

Guarantor Signature (Client signature if client is guarantor)

Date

Client Information & Consent for Treatment

Thank you for choosing The LifeWorks Group, Inc. for your counseling needs. We are committed to giving you the best care possible. To acquaint you further with the procedures and policies of our agency, we are providing the following information:

Appointments:

If you need to cancel an appointment, a minimum of 24 hours notice is required. **There will be a \$75.00 charge** if appointment is cancelled less than 24 hours before appointment time. If you do not call and do not show up for your appointment, the **full charge** will apply. In the evenings and on weekends, you may leave a message to re-schedule on our voice mail, which will accurately record the date and time of your call.

The courtesy call that you receive to remind you of your visit is usually made within 24 hours of your appointment. It is your responsibility to know when your appointment is scheduled. Less than 24 hours' notice does not allow LifeWorks sufficient time to offer that session to another client in need.

We also ask that you be punctual. If you are late for any reason, you will receive the remainder of your scheduled time. This is necessary so that we can see the remaining clients at their scheduled times.

Emergencies:

In the case of a life-threatening emergency, please call 911. To leave a message for your counselor, please call our office at (407)647-7005, so they can return your call as soon as possible.

Financial Responsibility:

You are financially responsible for all services rendered. Full payment is expected at the time of service, unless other contractual arrangements apply. **Please make checks payable to The LifeWorks Group, Inc.** We also accept credit card payments with VISA, MasterCard, Discover and American Express. You hereby authorize the assignment of insurance benefits, **if applicable**, to The LifeWorks Group, Inc. **if applicable**, you also authorize The LifeWorks Group, Inc. to release any information necessary for the processing of claims.

There will be a **\$25.00 fee** for checks that are returned as non-sufficient funds or non-payable. You will receive an invoice from our office letting you know the total amount due. If you have questions regarding your account, please contact our Office Manager at (407)647-7005. All correspondence will be sent to the address on your LifeWorks Registration Form. If this presents a problem for you, please contact our Office Manager for another address to keep on file.

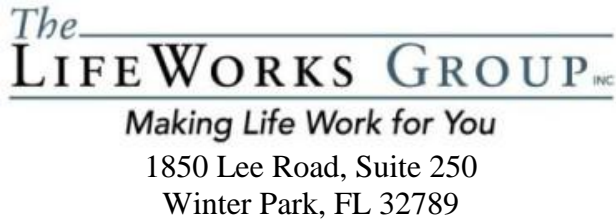
Confidentiality:

Your client records are the property of The LifeWorks Group, Inc. and shall be treated as confidential. To ensure quality record maintenance and client confidentiality, LifeWorks will conduct routine client record audits. To comply with state and federal laws regarding client confidentiality, your records will not be released without proper written consent from you.

Everything about your care will be held in strictest confidence (with the exception of situations which we are required by law to report, such as suspected or reported child abuse, elder abuse, homicidal or suicidal threat). If you choose to have your LifeWorks provider keep a third party informed of your progress in counseling, it will be necessary to complete a separate "Release of Information" form that will be kept on file.

Please sign below to indicate you have read and understand the above and are consenting to receive treatment by a LifeWorks provider:

Client or Guardian _____ Date _____



Confidential Client Consent Form

I understand that, under the health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payments from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature of Patient/Client

Date

Signature of Parent, Guardian, or Personal Representative

Date

Relationship to Patient/Client: _____

Date

MARRIAGE and FAMILY:

Marital Status: Single Engaged Married Separated Divorced

How long divorced _____ Number of divorces _____ Length of current relationship _____

Partner/Spouse Name _____ Age _____ Occupation _____

Please list children by age: (Place a check by name if from previous marriage or adoption)					
NAME	AGE	SEX	EDUCATION	LIVING AT HOME	SPECIAL CONCERNS

Please list any other person (s) living in your home:

NAME	AGE	SEX	RELATIONSHIP	SPECIAL CONCERNS

HEALTH RATING: Excellent Good Average Poor Very Poor

Are you currently under a doctor's care? ___ If yes, please explain. _____

Physician's Name: _____ Phone () _____

Are you currently taking medication? _____ What? _____

Have you ever used drugs recreationally? _____ What and when? _____

Have you, your spouse or children ever had any major medical or emotional problems? If yes, please explain. _____

Have you seen a counselor before today? _____ Who?: _____

RELIGION/FAITH:

How important is spirituality in your counseling? Very important Somewhat important Not important

Would you be comfortable with your counselor praying with you? Yes No

SPECIFIC PROBLEM AREAS: Please check any of the following that are currently troubling you:

<input type="checkbox"/> Abortion/Adoption	<input type="checkbox"/> Depression	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Addictions	<input type="checkbox"/> Divorce	<input type="checkbox"/> Loss of control	<input type="checkbox"/> Sexual Addiction
<input type="checkbox"/> Adolescent issues	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Loss of energy	<input type="checkbox"/> Sexual issues
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Envy /Jealousy	<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Shame
<input type="checkbox"/> Anger	<input type="checkbox"/> Family issues	<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Single parent
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Father issues	<input type="checkbox"/> Loss of trust	<input type="checkbox"/> Singleness
<input type="checkbox"/> Apathy	<input type="checkbox"/> Fear	<input type="checkbox"/> Marriage	<input type="checkbox"/> Spouse abuse
<input type="checkbox"/> Bitterness/Resentment	<input type="checkbox"/> Finances/Debt	<input type="checkbox"/> Medication/Drug Issues	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Burnout/Stress	<input type="checkbox"/> Forgiveness	<input type="checkbox"/> Men's issues	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Change of lifestyle	<input type="checkbox"/> Frustration	<input type="checkbox"/> Mid-life	<input type="checkbox"/> Self-esteem
<input type="checkbox"/> Child abuse	<input type="checkbox"/> Grief	<input type="checkbox"/> Mother issues	<input type="checkbox"/> Rejection
<input type="checkbox"/> Children/discipline	<input type="checkbox"/> Guilt	<input type="checkbox"/> OCD	<input type="checkbox"/> Unemployment
<input type="checkbox"/> Children/school	<input type="checkbox"/> Homosexuality	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Verbal abuse
<input type="checkbox"/> Children/rebellion	<input type="checkbox"/> Honesty	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Violence/Rage
<input type="checkbox"/> Communication	<input type="checkbox"/> Infidelity	<input type="checkbox"/> PMS/Hormones	<input type="checkbox"/> Withdrawal
<input type="checkbox"/> Conflict	<input type="checkbox"/> In-Laws	<input type="checkbox"/> Pornography	<input type="checkbox"/> Worry
<input type="checkbox"/> Confusion	<input type="checkbox"/> Job problems	<input type="checkbox"/> Rape	
<input type="checkbox"/> Crisis	<input type="checkbox"/> Legal issues	<input type="checkbox"/> Religion/Faith Issues	
<input type="checkbox"/> Death of loved one	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Separation	

How long have these problems existed? _____