

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: _____

Soc. Sec. #: _____ Birth Date: _____ Age: _____

Sex: ___ M ___ F Martial 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?

How did you hear about LifeWorks? _____ (Note: Your name will be kept confidential.)

Would you like to receive our free e-News and articles designed to save time and solve stress?

(Note: Your email address is kept confidential and is never shared with third-parties. Please provide the best email address to send this complimentary resource if different from the email address above _____)

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 (Circle one): Spouse Mother Father Sibling
Relative Friend Other

4. Home Phone: () _____

5. Soc. Sec. #: _____

Birth Date: _____

6. Drivers License #: _____

7. Guarantor's Employer:

8. Occupation:

9. Work Phone: () _____

10. 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 clinic, 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 within 24 hours of 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 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 true emergency, please call 911. For prayer and encouragement, please call our friends at the Central Florida Helpline (407)333-9028. To leave a message for your counselor, please call our office at (407)647-3900, and he/she will return your call as soon as possible.

Financial Responsibility:

You are fully 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.

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.

Confidentiality:

Your client records are the property of The LifeWorks Group, Inc. and shall be treated as confidential. To insure 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 the proper written consent.

Everything about your care will be held in strictest confidence (with the exception of those situations which we are required by law to report, such as suspected or reported child abuse, etc.) 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 "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 _____

Client Consent Form
The LifeWorks Group, Inc.
Dwight Bain, LMHC
1850 Lee Road, Suit 250
Winter Park, FL 32789

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

MARRIAGE and FAMILY:

Marital Status: Single _____ Engaged _____ Married _____ Separated _____ Divorced _____

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

Spouse Name _____ Spouse Age _____ Spouse 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

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? _____

Alcohol use: Never _____ occasionally _____ Often _____ Habitually _____

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:

Do you attend church? _____ How frequently? ____ Occasionally ____ Weekly ____ More than once a week

Are there any recent changes in your faith or church attendance? _____ Please explain _____

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

How long have these problems existed? _____

Thank you for sharing your insights so that we may better serve you!