

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 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?

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

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 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 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 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 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, 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 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 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
The LifeWorks Group, Inc.
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 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 Client/Client

Date

Signature of Parent, Guardian, or Personal Representative

Date

Relationship to Client: _____

Date

STRESS WARNING CHECKLIST

INSTRUCTIONS: Below is a list of physiological and psychological problems which may be related to stress. Indicate the frequency with which you have been bothered by each of these problems in the last ninety (90) days by placing the appropriate number from the scale below in the space provided to the left of each item.

- 0 = None or none at all
- 1 = Seldom
- 2 = Once in a while
- 3 = Often
- 4 = Constantly or very frequently

	Confusing or forgetting details		Angry feelings
	Missing appointments		Fatigue
	Feelings of nervousness		Nightmares
	Aching neck and muscles		Menstrual distress
	Difficulty in making decisions		Hives
	Alcohol/ nonprescription drugs		Inappropriate anger
	Early morning awakening		Tension headaches
	Excessive daydreaming		Low-grade infections
	Irrational mistrust of friends		Worrisome thoughts
	Prescription drug use		Asthma attacks
	Feeling worthless and insecure		Dermatitis
	Prolonged periods of brooding		Hyperventilation
	Difficulty with other people		Constipation
	Excessive worrying over trivia		Diarrhea
	Working harder and later		Irritability
	Disconnected speech or writing		Sexual problems
	Stomach indigestion		Insomnia
	Lower back pain		Colitis attack
	Common flu or cold		Arthritis
	Periods of depression		Overeating
	Minor accidents		Allergy problems
	Migraine headaches		Loss of appetite
	High blood pressure		Peptic Ulcer
	Nausea or vomiting		Cold hands or feet
	Heart Palpitations		Total
	Total		

___ Enter second Column total

___ Grand Total

MARRIAGE and FAMILY:

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

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

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? _____

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:

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

How long have these problems existed? _____