



LIFE MANAGEMENT ASSOCIATES

With you every step of the way.

A division of LMA Systems Group Inc.

INSTRUCTIONS FOR COMPLETING PAPERWORK

You must have Adobe Reader installed on your computer. Go to www.adobe.com to download the FREE software.

Print out all pages and fill out as completely and accurately as possible. (There should be 8 pages including this first instruction page.)

You must bring all paperwork to your first session along with all necessary insurance information and photo ID.

Please Note: If you do not bring your completed paperwork to your appointment you will be required to complete paperwork during your allotted session time.

If you have questions about your paperwork, please call Life Management Associates at 717.394.6688.

CLIENT # _____ EAP _____ DSM# _____ TPP# _____
 Open Date _____ Closed Date _____ Reopen Date _____ Reclose Date _____
 Therapist _____ LMA Facility Greenfield Ephrata Silver Springs Willow Valley

PLEASE PRINT. FILL OUT INFORMATION COMPLETELY.
All information is confidential.

PRIMARY CLIENT (person being seen by therapist) _____ **Child** _____ **Adult** _____
Name _____ Social Security No. _____
 Address _____ Birth date ____ / ____ / ____ Sex Male Female
 City _____ State ____ Zip _____ Employer/School _____
 Home Phone () _____ - _____ Work/School Phone () _____ - _____ Cell () _____ - _____
 Relationship Status: Single _____ Married _____ Divorced _____ Co-Habiting _____ Other _____
Emergency Contact Person: _____ Relationship _____
 Address _____ Phone () _____ - _____

Please contact me by: Call home/message Call work/message Call cell phone
 Do NOT call home Do NOT call work Mail

If Primary Client is CHILD complete below:

PARENT/GUARDIAN INFORMATION

MOTHER _____
 Address _____
 Phone: home () _____ work () _____
 Date of birth: _____
 Social Security No. _____
 Employer _____
FATHER _____
 Address _____
 Phone: home () _____ work () _____
 Date of birth: _____
 Social Security No. _____
 Employer _____
 Brothers/sisters (Name, birth date, school)

If Primary Client is ADULT, complete

SPOUSE/PARTNER INFORMATION

NAME _____
 Address _____
 Phone: home () _____ work () _____
 Date of birth: _____
 Social Security No. _____
 Employer _____
 Children of primary client – (Name, birth date school)

 Stepchildren of primary client (Name, birth date, sch)

Have you or family member used LMA services in the past? _____ If yes, when were you last in? _____

Primary Care Physician _____ Address _____
 Phone: () _____ Fax () _____

PAYMENT/INSURANCE INFORMATION

Person/Organization Responsible for Payment _____

Primary Insurance Co. _____ Secondary Insurance Co. _____
 Insured Person _____ Insured Person _____
 Policy # _____ Policy # _____
 Relationship to client _____ Relationship to client _____

PRIMARY CLIENT PLEASE SIGN HERE (if Primary Client is a minor, parent/guardian sign)

"My signature certifies that I received a service or item on the date listed below. I understand that payment for this service or item may be from third party payors such as health insurance companies and/or Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws."

I hereby give consent to LMA or its affiliates to provide assessment and/or treatment to me or my minor child.

SIGNATURE _____ **Date** _____

COMPLETE THIS SIDE ONLY IF YOU ARE USING THE LMA EAP

PRIMARY PRESENTING PROBLEM – reason for using services

- | | | | |
|------------------------------------|-----------------------------|-----------------------------|-------------------|
| 1 Anxiety | 8 Eating Disorder | 16 School Problems | 24 Pre-Retirement |
| 2 Depression | 9 Medical Condition | 17 Anger Management | 25 Eldercare |
| 3 Stress | 10 Weight Management | 18 Grief/Loss | 26 Childcare |
| 4 Alcohol Abuse | 11 Financial | 19 Marital/Couples Conflict | 27 Other: _____ |
| 5 Rx Drug Abuse | 12 Legal | 20 Relationship Issues | |
| 6 Illicit Drug Abuse | 13 Career/Vocational | 21 Abusive Relationship | |
| 7 Addiction/
Addictive Behavior | 14 Personal Growth/Wellness | 22 Adjustment Disorder | |
| | 15 Job Performance/Conflict | 23 Evaluation | |

About the EMPLOYEE who has the EAP Benefit

Age _____ Sex (M/F) _____ Years Employed by Organization _____

Check one in each category:

Referral Source

- Self
- Management (Mandatory)
- Management (Suggested)
- Union
- Medical
- Human Resources
- Family
- Co-Worker
- Community Resource
- Managed Care Program
- Other/Unknown

Education Completed

(check highest level completed)

- Grade School
- Some High School
- High School Graduate
- Some College
- College Degree
- Some Graduate School
- Graduate Degree
- Trade/Technical School
- Associates Degree
- GED
- Other/Unknown

Marital/Relationship Status

- Single
- Married
- Divorced
- Separated
- Widow/Widower
- Co-Habiting

Job Category:

School Employee:

- School Administration
- School Middle Mgmt/Dept Head
- School Teacher
- School Salaried (other than teacher)
- School Hourly
- Other/Unknown

Other Employee:

- Executive
- Management
- Supervisor/Line Leader
- Professional
- Technical
- Administrative
- Outside Sales
- Skilled Labor/Craftsperson
- Service
- General Labor
- Other/Unknown

About the Employee DEPENDENT

*(complete only if the Primary Client is **NOT** the employee or the Primary Client is a minor)*

Relationship to Employee: Spouse Child Stepchild Parent Other

Age: _____ **Sex:** Male Female

Education Completed by Dependent *(Check current or highest level completed):*

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Young child (not yet in school) | <input type="checkbox"/> High school graduate | <input type="checkbox"/> Graduate degree | <input type="checkbox"/> Other/Unknown |
| <input type="checkbox"/> Preschool/Kindergarten | <input type="checkbox"/> Some college | <input type="checkbox"/> Trade/Technical school | |
| <input type="checkbox"/> Grade School | <input type="checkbox"/> College degree | <input type="checkbox"/> Associates degree | |
| <input type="checkbox"/> Some high school | <input type="checkbox"/> Some graduate school | <input type="checkbox"/> GED | |

Medical History Form

To best serve you and provide effective treatment, we ask that you complete this form which will provide important information about your physical health.

Name: _____ DOB: _____ Date: _____

May your Primary Care Physician (PCP) be contacted for coordination of care? ___ Yes ___ No

If no, reason: _____

Name of PCP: _____ Date of Last Physical Exam: _____

Current Medical Problems:

Current Medications:

Past Medical Problems:

ALLERGIES AND/OR SENSITIVITIES: _____

Over-the-Counter Medications or Herbal Supplements:

Side Effects from Current or Past Medications:

Serious Illnesses, Diseases, or Surgeries treated or that required Hospitalization:

Habits:

Do You:	Consumption:	(Please circle timeframe)
Smoke	_____ Packs	per day / week / month
Drink Coffee/Caffeine	_____ Cups/oz.	per day / week / month
Drink Alcohol	_____ oz.	per day / week / month
Drink Beer	_____ oz.	per day / week / month
Other Drugs/Substances	_____	per day / week / month

Name: _____

Client # or DOB: _____

Life Management Associates Financial Policy

The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND MAC-CARD. A SIGNED CONSENT IS NECESSARY IF USING ANOTHER PERSON'S VISA, MASTERCARD, DISCOVER OR MAC-CARD. YOU WILL BE CHARGED A PROCESSING CHARGE FOR ALL RETURNED CHECKS.

Regarding Insurance: You are responsible for payment of all professional services you receive at Life Management Associates. Life Management Associates (LMA) bills your insurance company as a courtesy to you, however, we cannot bill your insurance company unless you give us accurate and complete insurance information. **It is your responsibility to obtain precertification for treatment, if necessary.** Please inform Life Management Associates of any changes in your insurance information.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company assigns payment to Life Management Associates, we will reimburse you. If Life Management Associates has a contract with your managed care plan, you are responsible for all copayments and deductibles at the time of service.

Overdue Accounts: if your balance to us is in arrears, we will exercise the right to utilize the services of a collection agency after reasonable attempts have been made to collect the overdue balance. As a final measure, if your account balance remains unpaid, these non-payment amounts will become part of your permanent credit history. When your account is submitted for collection, certain privileged health information will be released to the collection agency, specifically, name, amount and dates of service. Your signature below indicates your agreement with this policy should any collection proceedings be necessary.

Minor Patients:

The adult accompanying a minor is responsible for full payment unless other arrangements have been made in advanced and approved by the Office Manager.

Missed appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at \$70.00 per office visit. Payment is due before the next scheduled appointment. As a reminder, insurance will not pay for missed sessions. Remember, you will be personally responsible for these charges.

I have read and agree to this Financial Policy.

Please sign below to indicate that you have read and will comply with the above Financial Policy.

X _____ Date _____
Signature of Client or Responsible Party

X _____ Date _____
Signature of Co-Responsible Party

IF YOU HAVE LMA'S EAP, PLEASE COMPLETE REVERSE SIDE

Client Name: _____

Client # or DOB: _____

Notice of Life Management Associates Policies and Practices to Protect the Privacy of Your Health Information

(PA. Form – March 31, 2003)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We (Life Management Associates) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes **with your consent**. (signed form necessary) To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
 - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another provider.
 - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within LMA’s office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of LMA’s office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when

your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reasonable cause, on the basis of our professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity, we are required by law to report this to the Pennsylvania Department of Public Welfare.
- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), we may report such to the local agency which provides protective services.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and we determine that you are likely to carry out the threat, we must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

- **Worker's Compensation:** If you file a worker's compensation claim, we will be required to file periodic reports with your employer, which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing one of our providers. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Provider's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide notice to you of those revisions prior to your next meeting.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision a provider has made about access to your records, you may contact June Robinson, Privacy Officer at 717-394-6688

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice upon your next clinical appointment with Life Management Associates.

Acknowledgement for Receipt of: Notice of Life Management Associates Policies and Practices to Protect the Privacy of Your Health Information.

I have received this privacy notice about how my PHI may be used by Life Management Associates.

_____ (client)

_____ (date)

_____ I would like a copy of my privacy rights.

(March 31, 2003 – HIPAA)

Client's Informed Consent

I have chosen to receive assessment and treatment services through Life Management Associates. My choice has been voluntary, and I understand that I may terminate my involvement at any time.

I understand that treatment is a cooperative effort between my therapist and me, and that there is no guarantee that I will feel better.

I understand that records collected about me will be held or released in accordance with state laws regarding confidentiality of such records.

I understand that state and local laws require that my therapist report suspected abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist break confidentiality, if necessary, and report all cases in which there exists a danger to self or others. To ensure my protection, my therapist may contact appropriate parties which may include family members, law enforcement or other parties.

I understand that I am ultimately responsible for payment of fees for professional services. It is my responsibility to receive any necessary pre-certification for services. Any unpaid balance to my bill will be forwarded to a collection agency and / or small claims court and ultimately to the Credit Bureau to secure payment for such services.

I understand that managed care or other insurance plans require certain demographic and / or clinical information in order to authorize and review services. I give my permission to release such information for the purposes of obtaining insurance coverage and having my service assessed for utilization review.

I understand that my therapist is required by insurance carriers and other parties to maintain a record and complete any required insurance forms. Records related to my case will be completed during my sessions with the therapist.

I understand that treatment sessions are typically 45 to 50 minutes in length.

I understand that my therapist may consult with colleagues at Life Management Associates, including the Clinical Director, about my treatment to ensure that I am receiving the highest quality care.

I understand that weapons are not permitted to be brought onsite unless approval is first gained from my therapist.

I have read, understood and agreed to the above.

Signature of Client/Parent/Guardian

Signature of Witness

Date