LAKES DBT CENTER NEW PATIENT PACKET FOR ADULTS

THANK YOU FOR CONTACTING LAKES DBT CENTER!

We look forward to partnering with you on your mental health goals.

The first step in our journey together is for you to complete the attached forms. They will help us better understand your needs and to see if our DBT program is a good option for you:

- LC Adult History Questionnaire
- LDBTC DBT Questionnaire
- LDBTC Personality Inventory (DSM-5 Brief Form)
- LC Primary Care Physician (PCP) Notification
- LC Practice and Financial Agreement

Included, but optional:

- LC Credit / Debit Card / HSA Authorization (COF)
- LC Consent for Release of Information (ROI)

Also be sure to include:

- Scans of your Insurance Card(s) (front and back)
- Scan of your Picture ID

Please email all the documents to forms@lakescenter.com, upload on www.lakescenter.com/forms, or leave a printed copy at the office with any LC staff member.

After we have received all the completed and signed paperwork, we will evaluate the appropriateness of DBT for you. If it is suitable, we will schedule a consultation appointment with one of our clinicians.

Thank you for your cooperation, and we look forward to seeing you at our office soon!

- The Team at Lakes DBT Center
  2300 Haggerty Road, Suite 1170, West Bloomfield, MI 48323
  phone (248) 859-2457 • fax (248) 859-2473

LAKES CENTER
mental health network

ADULT HISTORY QUESTIONNAIRE

Please answer as completely as you can, then return this form before your scheduled appointment along with a copy of your **insurance card(s) and picture ID**. Please email to forms@lakescenter.com or upload on our website at www.lakescenter.com/forms

Are you interested in: ☐ Therapy (LPC) ☐ Medication Management (LPC) ☐ SPRAVATO® (LDC) ☐ DBT (LDBTC)		
Today's Date:	Appt. Date:	Appt. With:
How did you hear about Lakes Center?		Interested in: ☐ Online ☐ In Person ☐ Either

PERSONAL INFORMATION

Patient's Name	Age	Date of Birth
Gender Assigned at Birth	Gender Identity	Pronouns
Sexual Preference ☐ Straight ☐ Gay ☐ Bi-sexual ☐ Asexual ☐ Other: ☐ Prefer Not to Answer		
Address City, State, Zip	Social Security Number (Needed for insurance)	
May we send discrete reminders via email? ☐ YES ☐ NO (Check boxes below and right where we can leave messages)	☐ Primary Email Address	
☐ Home Phone | ☐ Cell Phone | ☐ Work Phone	☐ Secondary Email Address	
Emergency Contact Name	Address	
Relationship | Phone	City, State, Zip	
Marital Status: ☐ Single ☐ Married ☐ Other:		
☐ Employed ☐ Full-time Student ☐ Part-time Student ☐ Unemployed ☐ Other:		
Children: ☐ YES ☐ NO If YES, Please List Ages:		
Religion	Ethnicity	

INSURANCE (☐ Check here if None)

Primary Insurance Company	Contract Number	Group Number
Name of Subscriber	Subscriber's Date of Birth	Relationship to Subscriber
Employer	Subscriber's Address (☐ Same as Patient)	
Effective Date	Mental Health Insurance (if different)	Prescription Coverage ☐ YES ☐ NO
Secondary Insurance Company	Contract Number	Group Number
Name of Subscriber	Subscriber's Date of Birth	Relationship to Subscriber
Employer	Subscriber's Address (☐ Same as Patient)	
Effective Date	Mental Health Insurance (if different)	Prescription Coverage ☐ YES ☐ NO

PRESENTING PROBLEM

What problem brought you to Lakes Center?				
When did it begin?	Is there a prior history of these episodes? ☐ YES ☐ NO If YES, how many?			
Does it Effect:	Relationships	☐ YES ☐ NO	Work	☐ YES ☐ NO
	School	☐ YES ☐ NO	Leisure	☐ YES ☐ NO
Name three (3) things you would like changed in your current situation: 1.				
2.				
3.				

MENTAL HEALTH HISTORY

Have you ever had a significant period of time in which you have experienced:		
Serious Depression?	☐ YES ☐ NO	If YES, explain:
Serious Anxiety?	☐ YES ☐ NO	If YES, explain:
See or Hear Things others can't?	☐ YES ☐ NO	If YES, explain:
Trouble Understanding, Concentrating or Remembering?	☐ YES ☐ NO	If YES, explain:
Mood Swings? Irritability? Racing thoughts?	☐ YES ☐ NO	If YES, explain:
Serious thoughts of Suicide?	☐ YES ☐ NO	If YES, explain:
Self-harm (without intent to die)?	☐ YES ☐ NO	If YES, what behaviors?
Have you experienced trauma or abuse? ☐ Physical ☐ Emotional ☐ Sexual ☐ Other Please Explain:		
What treatment(s) have you had in the past for these issues? (Provide medication information on page 3)		
☐ Talk Therapy Please Explain:		
☐ DBT Please Explain:		
☐ Hospitalization / Day Treatment Approx. Year and Reason:		
☐ ECT ☐ TMS ☐ SPRAVATO® Please Explain:		
Would you like us to obtain copies of your old records? ☐ YES ☐ NO If YES, please bring the provider's contact information to your appointment and ask to complete a “Release of Information” form.		

MEDICAL HISTORY

Present state of general physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Current Weight?
Describe your present sleeping pattern (Hours per night, restful or not, problems getting to sleep, or waking early, etc.):
Did you have any medical problems during childhood or adolescence? ☐ YES ☐ NO If YES, please explain:
Do you have any current medical problems? ☐ YES ☐ NO If YES, please explain:
List any significant hospitalizations or surgeries:
Allergies: (☐ Check here if NONE)

MEDICATIONS

☐ Check here if attaching a separate list

LIST ALL *CURRENT* MEDICATIONS OR OVER THE COUNTER MEDICATIONS					Prescribed by:	
Medication	Dose	Frequency	How Long?	For	PCP	Psychiatrist
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

LIST ANY *PREVIOUS* PSYCHIATRIC MEDICATIONS				Prescribed by:	
Medication	Highest Dose	Was it Effective?	Side Effects	PCP	Psychiatrist
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SUBSTANCE USE HISTORY (☐ Check here if None)

Indicate the amount and frequency of use of the following:				
	Currently using?	Amounts	Frequency	How Long?
Alcohol	☐ YES ☐ NO			
Nicotine	☐ YES ☐ NO			
Caffeine	☐ YES ☐ NO			
Marijuana	☐ YES ☐ NO			
Illicit Drugs	☐ YES ☐ NO			
Prescription Med. Abuse	☐ YES ☐ NO			
Indicate substance(s) of preference:				
Substance abuse treatment type & dates:				
Was this treatment prompted / ordered by criminal justice system? ☐ YES ☐ NO If YES, please explain:				

CURRENT RELATIONSHIPS

Name of Spouse, Children, Others living with you	Relationship	Age	Quality of Relationship	Mental Disorder?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
If YES, which mental disorders?				
Any significant issues with your children as they were growing up?				
Currently?				
Who is your support system / provides guidance?				
With whom do you spend most of your leisure time with? ☐ Family ☐ Friends ☐ Alone ☐ Other:				
Favorite activity or hobby?				
☐ Never Married ☐ Married If so, how long? _______________ ☐ Separated ☐ Widowed ☐ Divorced ☐ Living Together If so, how long? _______________ Long-term relationship (not living together?) ☐ YES ☐ NO				
Date of present marriage or date you began living with your present partner:				
What are your feelings about the above relationship in general?				
How is the sexual relationship?				
Describe your partner's characteristics as a person:				
Previously Married? ☐ YES ☐ NO If YES, please list length of marriage				
If YES, any Conflicts with Ex-spouse? ☐ YES ☐ NO	Children? ☐ YES ☐ NO			
If YES to either, please explain:				

CHILDHOOD / FAMILY HISTORY

Names of your Parents and Siblings	Relationship	Age	Quality of Relationship	Mental Disorder?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
If YES, what type of mental health issues?				
List any other relatives with a history of emotional or mental disorder or suicide (include diagnosis and treatment if known):				
Have any of your relatives ever had a serious problem with drugs or alcohol? ☐ YES ☐ NO ☐ Unknown				
If YES, which relative:			Substance(s):	
If YES, which relative:			Substance(s):	
How was your relationship with your mother / female caregiver growing up?				
Currently?				
How was your relationship with your father / male caregiver growing up?				
Currently?				
How did your parents / caregivers get along with each other while you were growing up?				
Currently?				
How was your relationship with your siblings / other children growing up?				
Currently?				

BIRTH / DEVELOPMENTAL HISTORY

Question	Response
Did your mother use alcohol or drugs during pregnancy?	☐ YES ☐ NO ☐ Unknown
Did your mother have any problems during pregnancy?	☐ YES ☐ NO ☐ Unknown
Did your mother have any problems during labor or delivery?	☐ YES ☐ NO ☐ Unknown
Did you have any problems immediately after birth?	☐ YES ☐ NO ☐ Unknown
Did you have any developmental delays?	☐ YES ☐ NO ☐ Unknown
If YES to any, explain:	

EDUCATION

Did you have any specific learning issues in school? ☐ YES ☐ NO ☐ Unknown	
Were You: ☐ Frequently Absent ☐ Suspended ☐ Expelled ☐ Bullied	
If YES to any, explain:	
Highest level of Education:	Degree:

MILITARY HISTORY (☐ Check here if None)

Have you served in the military? ☐ YES ☐ NO If YES, how long?	
Type of Discharge:	☐ Combat Exposure ☐ Traumatic Experiences ☐ Service-connected Disabilities
Explain:	

EMPLOYMENT

What has been your usual employment pattern in the past 5 years? ☐ Full-time (35+hrs per week) ☐ Part-time ☐ Military Service ☐ Student ☐ Retired ☐ Disability ☐ Unemployment ☐ Other:	
Current Occupation:	Employer:
How long have you worked at your present job?	Is it ☐ Full-time ☐ Part-time
How satisfied are you with your present job?	
Any significant problems in past or present job situations?	
How are your work relationships: With fellow Employees?	
With Supervisors?	With Subordinates?
Are you or have you been on: ☐ Social Security Disability (SSD) ☐ Supplemental Security Income (SSI) ☐ Workers Comp	
How many people depend on your income?	

LEGAL HISTORY (☐ Check here if None)

Any past or present litigation or legal problems? ☐ YES ☐ NO If YES, please explain:				
How many times have you been arrested and / or charged with any of the following?				
	Major Driving Violation		Burglary or Robbery	Other:
	Driving While Intoxicated		Weapons Offense	
	Public Intoxication		Assault	
	Disorderly Conduct		Parole / Probation Violation	
	Drug Charges		Contempt of Court	
	Shoplifting		Domestic Violence	
Have you ever been ordered by the court for treatment? ☐ YES ☐ NO If YES, please explain:				
Have you ever been? ☐ Incarcerated ☐ Arrested ☐ Community Service ☐ Treatment Programs ☐ Probation ☐ Other, please explain:				
Dates of Incarceration	Reason			

MARK AVAILABILITY FOR INDIVIDUAL / GROUP THERAPY:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

Thank you for completing this detailed form. It will be saved in your clinic record and is kept confidential.

Please return via email to forms@lakescenter.com or upload on our website at www.lakescenter.com/forms along with scans of your Insurance Card(s) (front and back) and your picture ID.

Form Completed by: (Print Name) Date

DBT QUESTIONNAIRE

Is Dialectical Behavioral Therapy (DBT) For You?

Does This Sound Like You? Ask yourself these questions… Below is a list of symptoms and traits that are common to people with a diagnosis of Borderline Personality Disorder.

Please note affirmative answers to the questions do not indicate a fixed conclusion. They may, however, provide you with the realization that there's a possibility you or a loved one may have BPD or its traits. A definitive diagnosis can only be made through an evaluation by a psychiatrist or mental health clinician.

Name: ____ Date: __________________

	Please check Yes or No
Have you found it hard to have close friends for very long?	☐ YES ☐ NO
Do you feel like you have fewer friends than those around you?	☐ YES ☐ NO
Have you ever been accused of behaving in ways that are all or nothing with nothing in between?	☐ YES ☐ NO
Have you taken on the values or beliefs of other people, religions, or philosophies, only to regret it later?	☐ YES ☐ NO
Have you experienced intense episodes of sadness, irritability, anxiety, or panic attacks?	☐ YES ☐ NO
Do you have trouble sleeping?	☐ YES ☐ NO
Do you have chronic feelings of emptiness?	☐ YES ☐ NO
Do you have trouble being alone?	☐ YES ☐ NO
Have you experienced intense relationships?	☐ YES ☐ NO
Do you often feel lonely even when you are in a relationship?	☐ YES ☐ NO
Do you consciously or unconsciously fear being abandoned?	☐ YES ☐ NO
Do you seem to require more time with your partner than those you observe around you?	☐ YES ☐ NO
Do social engagements and vacations often end up in turmoil?	☐ YES ☐ NO
Do you feel a strong need for control?	☐ YES ☐ NO
Have you had emotional outbursts that seemed appropriate at the time, but you regretted later?	☐ YES ☐ NO
Have you suffered from intense bouts of anger that last for hours, maybe even a few days?	☐ YES ☐ NO
Are your expressions of anger sometimes followed by shame and guilt?	☐ YES ☐ NO
Have you ever cut someone off and refused to speak to them?	☐ YES ☐ NO
Do you use alcohol or drugs to soothe your emotional pain?	☐ YES ☐ NO
Have you been known to spend too much, eat too much, be sexually promiscuous, or drive too fast?	☐ YES ☐ NO
Has anyone ever accused you of being paranoid?	☐ YES ☐ NO
Have you ever deliberately cut or injured yourself in other ways?	☐ YES ☐ NO
Have you ever experienced so much emotional pain that you felt like you wanted to die?	☐ YES ☐ NO
Have you ever attempted suicide?	☐ YES ☐ NO
Have you previously been diagnosed with borderline personality disorder?	☐ YES ☐ NO
Please note that DBT is a commitment-based therapy and will require weekly 1-hour individual and 2-hour skills group therapy. **At this time, are you willing and or able to make this commitment?**	☐ YES ☐ NO

PERSONALITY INVENTORY

DSM-5-BRIEF FORM (PID-5-BF) ADULT

Name: ____ Date: ________________

Instructions: This is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no right or wrong answers, so you can describe yourself as honestly as possible. We will keep your responses confidential. We'd like you to take your time and read each statement carefully, selecting the response that best describes you.

		0 Very False or Often False	**1** Sometimes or Somewhat False	**2** Sometimes or Somewhat True	**3** Very True or Often True	**Item Score** (Clinician)
1	People would describe me as reckless.					
2	I feel like I act totally on impulse.					
3	Even though I know better, I can't stop making rash decisions.					
4	I often feel like nothing I do really matters.					
5	Others see me as irresponsible.					
6	I'm not good at planning ahead.					
7	My thoughts often don't make sense to others.					
8	I worry about almost everything.					
9	I get emotional easily, often for very little reason.					
10	I fear being alone in life more than anything else.					
11	I get stuck on one way of doing things, even when it's clear it won't work.					
12	I have seen things that weren't really there.					
13	I steer clear of romantic relationships.					
14	I'm not interested in making friends.					
15	I get irritated easily by all sorts of things.					
16	I don't like to get too close to people.					
17	It's no big deal if I hurt other peoples' feelings.					
18	I rarely get enthusiastic about anything.					
19	I crave attention.					
20	I often have to deal with people who are less important than me.					
21	I often have thoughts that make sense to me but that other people say are strange.					
22	I use people to get what I want.					
	I often "zone out" and then suddenly come to and realize that a lot of time has passed.					
24	Things around me often feel unreal, or more real than usual.					
25	It is easy for me to take advantage of others.					
	Sub-Total					
	Total/Partial Raw Score:					
	Prorated Total Score: (if 1-6 items left unanswered)					
	Average Total Score:					

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PRIMARY CARE PHYSICIAN (PCP) NOTIFICATION

THIS IS NOT A REQUEST FOR MEDICAL RECORDS

OFFICE USE ONLY

Attention Primary Care Provider:

Your patient is being seen at: Lakes Center, 2300 Haggerty Road, Suite 2160, West Bloomfield, MI 48323, Phone 248-859-2457, Fax 248-859-2473. With patient authorization, we herein provide diagnoses and medications, including medication changes. **Please retain for your records.**

Patient Name: ___________________________ DSM Diagnoses (including codes): ___________

____

Treatment Information, including Medications: _____________________________________

____

____

Therapist/Psychiatrist Signature Print Name and Credentials

Attention Patient:

If you would like us to notify your primary care doctor that you are receiving services here, please provide the complete name, phone number and fax number of your Primary Care Physician.

Primary Care Physician or Clinic Name: ____

Phone: ____________________________________ Fax: ______________________________

Please read and complete the following:

I (name) ____ DOB: _____________ authorize Lakes Center to exchange information regarding my mental health, substance abuse, or medical health for the purposes of continuity of care, as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on my mental health or substance abuse treatment as protected under 42 CFR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care provider, and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for 1 year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to Lake Center. I also understand that it is my responsibility to notify my behavioral health care provider if I chose to change my primary care physician.

If you **do not** want to authorize us to notify your primary care physician, please complete the section below:

_____ I don't have a primary care/family doctor.
_____ I don't want my primary care/family doctor to know I'm receiving services.
_____ I just don't want to.

____

Patient/Legal Guardian Signature Date

PRACTICE AND FINANCIAL AGREEMENT

The following pages provide important information about our practice. Please review and then remove the last two pages from the packet and keep for your future reference.

By initialing below, you acknowledge that you:

______ Have been made aware of your rights and responsibilities as a client.

______ Have been informed of practice specific information and given an orientation to services.

______ Are aware of Lakes Center Mental Health Network (Lakes Center or LC-MHN) privacy practices and know you can ask for a detailed description.

______ Understand confidentiality and the limits of it as it pertains to adults and minors.

______ Have reviewed and understand the Lakes Center financial agreement and how to contact the billing department with questions or issues.

______ Give permission to bill your insurance and agree to pay out of pocket costs (toward deductibles, copays, coinsurance fees, previous missed appointment fees, or additional service fees as listed in the agreement) at the time of the appointment.

My signature below indicates my understanding of the above policies and I consent to treatment at Lakes Center. I understand I can ask for further information and retain the ability to terminate my consent at any time.

____

Print Patient Name

____

Patient/Legal Guardian Signature   Date

PRACTICE ORIENTATION AND AGREEMENT

Your Rights and Responsibilities as a Client:

- You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.
- You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.
- You have the right to privacy and confidentiality regarding the services you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act. Information may be disclosed for various reasons including: to provide treatment, for payment purposes, health care operations, appointments, as required by law, public health, descendants, health and safety, and workmans' compensation. (Detailed description provided upon request)
- You have the responsibility to provide informed consent to services offered to you.
- You have the responsibility to follow our Financial Agreement. (Detailed on the following page)

Services Offered:

Lakes Center offers an array of mental health and substance abuse services. These services include: individual psychotherapy, DBT, family therapy, marital therapy, psychiatric evaluations, and medication therapy. We also provide an esketamine-based treatment. Appointments may be in-office or online. Your clinician will provide you with a detailed description of the nature of services, expected benefits, and potential risks.

Operations:

Appointments may be individually arranged from 8:00 am and 10:00 pm, 7 days a week. Not all clinicians are available during all hours. Office staff hours depend on the day and volume of patients. Please call the office to verify hours for that day. Appointment dates, times, and after-hours contact will be arranged between you and your treating clinician. **In case of an emergency, call 911 for help, call the 988 suicide hotline, or you may visit your local emergency room. You can also contact the nearest crisis center (Oakland County Crisis Line at 800-231-1127)**. We practice in a non-smoking environment. Illicit drugs and weapons are not allowed on the premises. Persons in possession of either will be asked to leave immediately.

Minors and Parents:

If you are under 18 years of age (and are not emancipated), or a parent, you should be aware that the law may allow parents to examine their child's treatment records. You should also be aware that clients over age 14 can consent to (and control access to information about) their own mental health treatment (although that treatment cannot extend beyond 12 sessions or 4 months). Lakes Center's policy is to request (but not require) an agreement from any client between ages 14 and 18 and their parents ("Adolescent Informed Consent" form), allowing clinicians to share general information with parents about attendance at scheduled sessions and progress in treatment.

FINANCIAL AGREEMENT

Standard fees for services are available upon request. By signing the Practice and Financial Agreement Form (the first page of this packet), you indicate that you understand that these are the charges established for services by Lakes Center and these charges will be submitted to your insurance company. You also agree that you understand that if you fail to sign the Practice and Financial Agreement Form your insurance company will not be billed for your services, and you will have to pay direct out of pocket fees set by Lakes Center. Lakes Center will check your insurance coverage as a courtesy. When we call, we are always told that the information given by the insurance company is not a guarantee of benefits or payment, and the information provided may not be current. **Ultimately, it is your responsibility to understand your individual coverage. Therefore, we strongly encourage you to check with your insurance company prior to any services.**

The billing staff will charge you according to the information quoted to us by your insurance company on the date of service. When we receive payment, if your insurance company has determined you owe additional charges, as required by law, you will be billed. If we determine you have overpaid, we will offer different options for a refund.

Please keep in mind all payments are due at the time of service. **Balances must be kept below $200 to continue treatment or receive refills on medications**. Any paperwork, samples, or medication pick up from our office require balances to be paid when receiving them. For prior authorizations, refills, or the provision of medical records there may be a fee charged to your account for $10-$50 depending on complexity. For any requested letters, form completions, and phone consultations which require your prescriber or therapist to spend additional time outside of your appointment you may be charged up to $150 an hour. You may pay over the phone with a credit card, with a check to LPCC or with cash.

In order to continue services, please make sure your account is below our office policy standard of $200 or you have an active payment plan set up with the billing department. Lakes Center does not mail statements out regularly. When we do delinquent account mailings, roughly every three months, we will send a bill to your house/email. If you need a bill before that time for any reason, you must contact the billing department and request a bill to be sent to you. If you need to set up a payment plan, **please contact our Billing Department at (248) 313-9550**.

If you are doing online appointments, a credit card must be kept on file for online appointments and phone appointments. You must fill out a Credit/Debit/HSA/Authorization Form so that the payment may be made at the time of service. It is your responsibility to inform the staff member or clinician to charge your card on each visit.

Keep in mind that all appointments need to be cancelled with a 24-hour business day notice in order to not be subjected to a missed appointment fee, which can be up to $150. Please contact your individual provider for more information about missed appointment fees as each have their own rates and decide if cancellation fees are charged or waived. Payment of missed or late cancelled appointments are to be paid before your next service with Lakes Center or treatment and medication refills may be suspended.

Please remove these last 2 pages and keep for future reference.

OPTIONAL FORMS

The following forms are not mandatory. You can complete them now, or you can do so at a later date if they are needed.

CREDIT/DEBIT/HSA AUTHORIZATION

FOR USE AS A CARD ON FILE (COF)

I authorize Lakes Center Mental Health Network to keep my card information on file and to use it automatically to keep my balance current. This includes paying for deductibles, copays, and missed appointments fees. The amounts owed are based on my insurance plan. I will refer to my EOB's (Explanation of Benefits) from my insurance to verify what I owe. A receipt/notification will not be provided unless requested.

____

Patient Name

____

Name on Card (if different)

____

Card Number

____

Expiration Zip Code CVV Code (3-digit or 4-digit for Amex)

____

Signature of Authorized User COF Agreement Signing Date

This is the easiest and most efficient way to maintain your balance in order to continue treatment at the office. Treatment will be suspended if your balance is over $200, and an approved payment plan is not in place. You can also pay by credit card over the phone, by check made out to LPCC, cash at the office, or on our website at www.lakescenter.com/payments.

If this form is not filled out online, please email scanned or filled out pdf to forms@lakescenter.com, upload on www.lakescenter.com/forms, or leave a printed copy at the office with any LC staff member.

LAKES CENTER
mental health network

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: ____ Birth Date: ______________________

Other Names Used in Treatment: ____

I authorize the disclosure of records about me (or my minor child) between:

Lakes Center	AND	Physician / Organization:
Attention:		Attention:
2300 Haggerty Rd, Suite 2160		Address:
West Bloomfield, MI 48323		City, State, Zip:
Phone: 248-859-2457		Phone:
Fax: 248-859-2473		Fax:

Information may include any of the following:

Alcohol or drug abuse, or mental health treatment as defined by the Michigan Department of Public Health Code 1989, No. 174. This includes venereal disease, tuberculosis, HIV, AIDS, and hepatitis.

Specific type of information to be disclosed: (Check all that apply to person/organization listed above)

☐ Identifying Information
☐ Appointment Information
☐ Assessment
☐ Dates and/or Completion of Tx
☐ Discharge Summary
☐ Emergency Contact
☐ Financial/Insurance Information
☐ Lab Results
☐ Physical Examination
☐ Progress Notes
☐ Progress Report
☐ Psychiatric Evaluation
☐ Psychiatric Med. Reviews
☐ Psychological Testing
☐ Thank You Letter
☐ Treatment Plans
☐ Urine Drug Screens
☐ Other: __________ ___________________

Purpose and need for such disclosure: (Check all that apply to person/organization listed above)

☐ After Care Planning
☐ Assessment of Patient
☐ Continuity Care
☐ Disability Benefits
☐ Driver's License Appeal
☐ Educational Planning/Placement
☐ Employer Request/Job Stability
☐ Family Involvement
☐ Insurance Benefits
☐ Legal Services/Compliance
☐ Payment
☐ Pre-Employment Screening
☐ Referral for Services
☐ Social Security Benefits
☐ Treatment Planning
☐ Workers' Comp. Benefits
☐ Other: _____________ _______________________

Revocation of Authorization

This Authorization may be revoked by me at any time by my written notice to the named individual or organization (listed above), except to the extent that the person or organization which is to make the disclosure has already taken action in reliance upon it.

Without expressed revocation, this consent expires for the following reason(s), whichever is later (Check one box):

☐ Date: (One year from discharge unless otherwise specified) ______________________________________

☐ Event: ____

☐ Condition: Once information is disclosed, no further information can be disclosed pursuant to this consent.

Redisclosure: While Lakes Center does not condone the redisclosure of information to another party, there is the possibility that information released to another could be redisclosed without further consent.

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Patient Signature Date

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Parent / Legal Guardian Signature Date