LAKES CENTER
mental health network

LAKES CENTER NEW PATIENT PACKET FOR ADULTS

THANK YOU FOR CONTACTING LAKES 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 develop a treatment plan that is tailored for you:

- LC Adult History Questionnaire
- LC Self-Rated Symptom Questionnaire (DSM-5)
- 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.

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

- The Team at Lakes Center Mental Health Network
  2300 Haggerty Road, Suite 2160, West Bloomfield, MI 48323
  phone (248) 859-2457 • fax (248) 859-2473

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

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

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SELF-RATED SYMPTOM QUESTIONNAIRE (DSM-5)

Name: _____ Age: _____ Sex: _____ Date: _____

	The questions below ask about things that might have bothered you. **For each question, mark the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.**		**0 None** Not at all	**1 Slight** Rare, less than a day or two	**2 Mild** Several days	**3 Moderate** More than half the days	**4 Severe** Nearly every day	**Highest Domain Score** (Clinician)
I	1.	Little interest or pleasure in doing things?						
	2.	Feeling down, depressed, or hopeless?						
II	3.	Feeling more irritated, grouchy, or angry than usual?						
III	4.	Sleeping less than usual, but still have a lot of energy?						
	5.	Starting lots more projects than usual or doing more risky things than usual?						
IV	6.	Feeling nervous, anxious, frightened, worried, or on edge?						
	7.	Feeling panic or being frightened?						
	8.	Avoiding situations that make you anxious?						
V	9.	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?						
	10.	Feeling that your illnesses are not being taken seriously enough?						
VI	11.	Thoughts of actually hurting yourself?						
VII	12.	Hearing things other people couldn't hear, such as voices even when no one was around?						
	13.	Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?						
VIII	14.	Problems with sleep that affected your sleep quality over all?						
IX	15.	Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?						
X	16.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?						
	17.	Feeling driven to perform certain behaviors or mental acts over and over again?						
XI	18.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?						
XII	19	Not knowing who you really are or what you want out of life?						
	20.	Not feeling close to other people or enjoying your relationships with them?						
XIII	21.	Drinking at least 4 drinks of any kind of alcohol in a single day?						
	22.	Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?						
	23.	Using any of the following medicines ON YOUR OWN, that is, without doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?						

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PRIMARY CARE PHYSICIAN (PCP) NOTIFICATION

THIS IS NOT A REQUEST FOR MEDICAL RECORDS

Attention Primary Care Provider:

OFFICE USE ONLY

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

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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.

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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.

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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.

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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
Attention:
2300 Haggerty Rd, Suite 2160
West Bloomfield, MI 48323
Phone: 248-859-2457
Fax: 248-859-2473

AND

Physician / Organization:
Attention:
Address:
City, State, Zip:
Phone:
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.

Rediscloure: 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.

_____

Patient Signature Date

_____

Parent / Legal Guardian Signature Date