LIFENET PSYCHIATRY
500 Mariners Plaza Dr., Suite 504
Mandeville, LA 70448
(985) 246-1250
Fax (985) 246-1251
admin@lifenetpsych.com

CONSENT TO EVALUATE AND TREAT

Patient: ______________________________ Age: _____ Date of Birth: __________

Sex: _____ Race: Black____ Hispanic____ White____ Other __________ Marital Status: ________

Address: _________________________ City: ______________ Zip Code: __________

Home #: ___________________ Cell #: __________________ Work #: ______________

SSN: ______________ Education Level: _____________________ Do you smoke? Y N

School/Employer Name: __________________________ Phone #: ______________

Email Address: ____

Emergency Contact: Name: __________ Relationship: _______ Phone #: ______________

Primary Care Physician: ___________________________ Phone #: ______________

Referral Source: ________________________________ Phone #: ______________

Pharmacy Name: __________________________ Location: ______________
Any Medication Allergies: ____
Approximate occurrence date: _____________ Type of Reaction: ______________

Insurance Carrier: ____
Policy or Member ID #: ________________________ Group#: ______________

Policy Holder/Guarantor:
Name: _______________________________ Relationship to Patient: ____________
DOB: _____________ SS#: _______________ Phone #: ______________
If Address is different than above:

____

I authorize LifeNet Psychiatry to evaluate and treat:(please complete here if 18 or older)

Patient Name: ____

Patient Signature: ______________________________ Date: ______________

Parent/Legal Guardian, having the authority to authorize treatment of minor: (please complete here if patient is under the age of 18)

Name: _____________________________ Relationship to Patient: ______________

Signature: ____________________________________ Date: ______________

Witness: ____ Date: ______________

LIFENET PSYCHIATRY
PATIENT RIGHTS/RESPONSIBILITIES

PATIENT RIGHTS:
Privacy and Confidentiality: All records and communications about me will be treated confidentially in compliance with applicable state and federal laws.
Complete and Current information: All information regarding your diagnosis, treatment and prognosis, the nature and purpose of tests, prescribed therapy and/or medications, and potential adverse effects associated with the treatment plan.
Clear Instructions: Clear and precise information concerning the need for follow-up visits, referral to other healthcare professionals, or additional measures necessary to achieve the desired outcome for your diagnosis.
Accept or Refuse Treatment: You as a patient have the right to accept any or all of the treatment plan after receiving a complete explanation.
A Copy of Medical Records: You may receive a copy of your records after a payment of reasonable copying fees and account balances, if any.
Information about your account: You have the right to receive the amount and purpose of charges and policies regarding payment of charges as well as procedures for resolving conflicts in the settlement of the patient's account.

PATIENT RESPONSIBILITIES:
Patient Information: Provide correct and complete information about your health.
Follow the Treatment Plan: Follow instructions by your Psychiatric Practitioner unless you notify him of concerns.
Take Responsibility for Your Actions: If you refuse treatment or do not follow your treatment provider's instructions.
Meet the financial obligations for your care as soon as possible.
Call the office if unable to keep scheduled appointments and arrive on time for scheduled appointment.

INFORMED CONSENT:
By signing below I acknowledge reading, understanding, and agreeing with the above policies and information. I understand that if I do not understand or have any questions about these policies, I may discuss them with my provider.

PATIENT NAME :________________________________ DOB: _______________

SIGNATURE:____________________________________ DATE:__________

IF PATIENT IS A MINOR, PARENT/GUARDIAN: ________________________________

LIFENET PSYCHIATRY
FINANCIAL POLICY AGREEMENT

We believe that everyone benefits when there is a clear and definite understanding of our financial policy prior to treatment.

1. PATIENTS WITHOUT INSURANCE: All patients without insurance are required to pay in full for the service rendered at the time of the appointment.
2. ALL PATIENTS WITH MANAGED CARE PLANS: It is your responsibility to know and understand your managed care plan. Generally, these plans require payment of deductibles and/or copayments. Patients are required to pay for services according to their insurance contract at time of service.
3. ALL PATIENTS WITH INSURANCE: If our office is contracted with your insurance company, we will file your insurance claims if you provide us with the proper information along with a copy of your current insurance card. In the event your insurance overpays, we will refund the overpayments to you promptly upon written request. Otherwise, overpayments will be credited to your account for future services. If your insurance company does not pay within 60 days, you are responsible for the remaining balance and you will be billed accordingly.
4. CANCELLATION POLICY: **There is a charge for failed appointments/late cancellations of appointments when less than a 24-hour notice is given by the patient.** You will be charged the full fee for the service which would have been rendered. We cannot bill insurance companies for these appointments. Reminder calls/text messages/emails to our patients are offered as a courtesy. It is the patients responsibility to keep up with their appointments.
5. DELINQUENT ACCOUNTS: In the event LifeNet Psychiatry is forced to pursue the balance of your account through a collection process, patient will be responsible for any and all costs and fees associated with this process.
6. Payment for services rendered may be made by check, cash or credit card (Master Card, Visa, Discover, or American Express). There is a $35 fee for all NSF checks.

I have read and agree with the terms of this agreement.

Patient Name:______________________________ DOB: ____________________

Responsible Party Signature:________________________ Date:____________________

ASSIGNMENT OF BENEFITS

I authorize payment of insurance benefits to LifeNet Psychiatry for services rendered.

Responsible Party Signature:________________________ Date:____________________

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Patient Name: ______________________

DOB: ______________

CREDIT CARD CONSENT POLICY FORM

I, the undersigned, authorize LifeNet Psychiatry to keep my signature on file and to charge my credit/debit card account as indicated below:

A charge to the credit/debit card will ONLY be made under the following circumstances:

1. Missed appointments
2. Cancellations made less than 24 hours from time of scheduled appointment and the appointment deemed unexcused
3. Any claim that is denied secondary to insurance not being in effect at the time of service
4. Any claim that is denied secondary to failure on the part of the patient's responsible party to obtain prior authorization or referral and/or complete forms required by insurance company needed to process the claim
5. Any claim that is applied toward a deductible
6. Any claim that becomes more than 120 days past due after proper filing and at least 1 re-filling by this office

Charges are as follows **unless** you are using insurance that is active at each date of service:

1. Medication management initial evaluation $250
2. Medication management follow-ups vary by time spent
3. Psychotherapy evaluation $130.00
4. Psychotherapy follow-ups $110.00 **except** for duel patients

Prior to the first visit, LifeNet Psychiatry will perform an "Authorization Only" transaction in the amount of $1.00 as part of our Credit Card Validation Process. The Cardholder may see this transaction on the account for up to five days.

I the undersigned understand that this form will be valid for the duration of my treatment with this office UNLESS I cancel through written notice to LifeNet Psychiatry, 500 Mariners Plaza Dr., Ste. 504, Mandeville, LA 70448.

Visa__________ MasterCard__________ Discover__________ Amex__________

______________________________ ______________________________
Patient Name Cardholder Name

____
Cardholder billing address

______________________________ CVV__________ Mo________Yr__________
Credit Card Number Expiration Date

______________________________ ______________________________
Cardholder Signature Date

LifeNet Psychiatry Service, LLC
500 Mariners Plaza Dr., Suite 504
Mandeville, LA 70448
985-246-1250 Office 985-246-1251 Fax

Patient Name: ______________________

Date of Birth: ______________________

Controlled Substance Agreement

Narcotics, amphetamines, and benzodiazepines may be useful in treating some medical conditions. However, because of their high potential for abuse, the above drugs are strictly controlled by state and federal governments and it is a FELONY to violate these guidelines. This is a contract between ______________________________ and LifeNet Psychiatry.
(patient/guardian)

As a patient, I agree that:

1. I will not fill prescriptions for similar controlled substances from more than one provider.
2. I will fill all maintenance medications as well as my controlled medications and understand that if I fill my controlled medications without my maintenance medications I will be in violation of this agreement.
3. Only I will pick these prescriptions up and only I will request refills of these medications. I understand that I can only pick up prescriptions on the day they are due and not prior to that date.
4. I will keep my regularly scheduled appointments.
5. By signing this agreement, I am giving informed consent for the treatment with controlled medications and understand clearly that:
   a. I am responsible for keeping my medications in a secure location so they will not be stolen, lost, etc. These types of drugs may not be replaced. If they are misplaced or stolen a police report needs to be filed immediately and a face to face appointment scheduled.
   b. There is a risk of becoming dependent on controlled substances.
   c. My judgment and actions may be impaired by using controlled substances.
   d. The prescribing practitioner has my permission to share information regarding this contract with the pharmacy, my insurance company, and any doctor I am currently seeing and any doctor I may see in the future.
   e. I agree to random drug screens to determine drug levels as practitioner deems necessary.

If I fail to abide by this contract I may be terminated as a patient from this practice.

______________________________ ______________________

Patient's/Guardian's Signature Date

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Patient Name: ______________________________

Patient Date of Birth: ________________________

I, __________________________________ authorize the following people to have access to my mental health record and insurance/billing information.

NAME	RELATIONSHIP TO PATIENT
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

I will notify LifeNet Psychiatry in writing if people should be added or removed from this list

SIGNATURE: ______________________________________ DATE: ______________

LifeNet Psychiatry now offers a secure, easy-to-use online patient portal for patients to access their health information. This free self-service health management tool is a convenient way to manage your personal healthcare.

________ Yes, please send me an online invitation to access my health records

________ No, I decline this invitation

Patient EMAIL ADDRESS: ____

If patient is a minor, please list email address for authorized user

LifeNet Psychiatry

Adult Patient Intake Form

NAME: ______________________________ DOB: ____________

REFERRED BY: ______________________________ OCCUPATION ______________________

PRESENTING PROBLEMS

Briefly describe your current difficulties:

____

____

____

____

How long has this been of concern to you? ____________ When was this problem first noticed? ________

What seems to help the problem? ______________________________

What seems to make the problem worse? ______________________________

Have any other family members had similar problems? Yes No If yes, whom? ________________

Have you received evaluation or treatment for the current problem or similar problems? Yes No

If yes, when and with whom? ______________________________

If currently, list address: ______________________________

Are you on any medication at this time for the current problem? Yes No Please list :

____

Describe any major event(s) that might be related to the problem (e.g. death, divorce, abuse, etc.): ________

____

____

DEVELOPMENTAL HISTORY

As far as you know, were there any problems with your mother's pregnancy or delivery of you?

Yes_____ No _______ If yes. Details: ______________________________

As far as you know, did you walk, talk, and sit up on time?

Yes _____ No_____ If no, details: ______________________________

Did you have any childhood illnesses?

Yes _______ No ______ If yes, details: ______________________________

Did you have normal relationships with your peers when you were a child?

Yes_______ No _______ If no, details: ______________________________

EDUCATIONAL HISTORY

Schools Attended: Dates Degrees

Universities: ______________________________

High School: ______________________________

Special Education (yes / no) If yes, type of class ______________________________

MEDICAL HISTORY

Please list medications below:

MEDICATION	AGE	REASON PRESCRIBED

Please list any Medication Allergies: ______________________________

Have you ever suffered from a head injury which caused confusion or loss of consciousness? Yes No

LifeNet Psychiatry

Adult Patient Intake Form

Patient Name: ____________________

DOB: ______________

Place a check next to any illness or condition that you have had. When you check an item, also note the approximate date or age at the time of the illness.

ILLNESS/ CONDITION	AGE OR DATES	ILLNESS/CONDITION	AGE OR DATES
__AIDS or HIV positive	________	___Fainting Spells	________
__Allergies	________	___Fetal Alcohol Syndrome	________
__Anemia	________	___Fever	________
__Aneurysm	________	___Guillain-Barre Syndrome	________
__Anoxia	________	___Head Injury	________
__Arteriovenous Malformation	________	___Headaches	________
__Arthritis	________	___Heart Disease or Problems	________
__Asthma	________	___Lead Poisoning	________
__Ataxia	________	___Hepatitis	________
__Automobile Accident	________	___Herpes	________
__Back Pains or Problems	________	___High Blood Pressure	________
__Bleeding Problems	________	___Jaundice	________
__Blood Disorders	________	___Leukemia	________
__Bone or Joint Disease	________	___Malnutrition	________
__Broken Bones	________	___ Meningitis	________
__Cancer	________	___Muscular Disease	________
__ Chorea	________	___Pain Problems	________
__Coma	________	___Paralysis	________
__Cystic Fibrosis	________	___Pituitary Disorder	________
__Dazed or Unconscious	________	___Pneumonia	________
__Dementia	________	___Poisoning	________
__Diabetes	________	___Poliomyelitis	________
__Dysarthria	________	___Rheumatic Fever	________
__Dyspraxia (or Apraxia)	________	___Scarlet Fever	________
__Ear Infections (PE Tubes)	________	___Sensory Loss	________
__Other Ear Problems	________	___Sexual Molestation	________
__Eczema or Hives	________	___Sexually Trans. Disease	________
__Electrical or Chemical Shock	________	___Speech or Language Prob.	________
__Encephalitis	________	___Epilepsy, Seizures, Fits	________
__Stroke	________	___Suicide Attempts or Thoughts	________
__Sunstroke or Heat Exhaustion	________	___Thyroid Disorder or Problem	________

Tests (please check and give age):

__Electroencephalogram (EEG)	________	___Tuberculosis	________
__Skull X-rays	________	___Tumor	________
__CT Scan	________	___Visual Problems	________
__MRI Scan	________	___Whooping Cough	________
__BRAM Study	________	___Evoked Potentials	________
__Ophthalmologic (Vision)	________	___Audiological Evaluation	________

OTHER MEDICAL PROBLEMS: ____

____

Are there any medical illnesses that run in your family? Yes _____ No_____
If yes, details: ____

Is there any one in your family who has had problems with anxiety or depression? Yes ______ No_____
If yes, details: ____

Is there anyone in your family who has abused alcohol or other drugs? Yes______ No______
If yes, details: ____

Is there anyone in your family who has had psychiatric illness? Yes______ No____
If yes, details: ____

Is there anyone in your family who has been in trouble with the law? Yes____ No____
If yes, details: ____

LifeNet Psychiatry

Patient Name: ______________________________

Adult Patient Intake Form

DOB: ____________________

Is there anyone in your family who has had seizures or other neurological problems? Yes_____ No_____
If yes, details:______________________________

Is there anyone in your family who has had Tourette's syndrome or vocal tics? Yes______ No______
If yes, details:______________________________

Is there anyone in your family who has movement disorder or any unusual movements? Yes______ No______
If yes, details:______________________________

Is there anyone in your family who has heart problems? Yes______ No______
If yes details:______________________________

Is there anyone in your family who has high blood pressure? Yes______ No______
If yes details:______________________________

Is there anyone in your family who has had attention problems? Yes______ No______
If yes details:______________________________

Is there anyone in your family who has had learning disabilities? Yes______ No______
If yes details:______________________________

SOCIAL HISTORY

Do you smoke? Yes___ No_____ If yes, how much?______________________________
How much caffeine do you drink, including caffeinated tea and soda? ______________________________
Any current or past substance abuse problems including alcohol? Yes___ No___
If yes, details:______________________________
Briefly describe your work history:______________________________
____
Have you ever been in trouble with the law? Yes____ No____
Describe:______________________________
What is your current marital status? ______________________________
List names and ages of children:______________________________
Are you currently in an intimate relationship?
Yes ____ No____ If yes, for how long?______________________________
Do you have trouble in your relationship with others? Yes ____ No____
If yes, details:______________________________
How many intimate relationships with others?______________________________
Are there any cultural beliefs that would effect the treatment of any mental or behavioral disorder? Yes No
If yes, please describe:______________________________
Are there any transportation issues for patient visits? Yes No If Yes, then please describe: ______________
____

You have been asked a lot of questions. Can you think for a minute and describe any other problems you have that might be related to what you came here for?

____
____
____
____
____
____
____

I certify that all statements made and all questions answered are true and accurate to the best of my knowledge.

SIGNATURE______________________________DATE______________________

Patient Name: ____________________

DOB: ______________

MOOD DISORDER QUESTIONNAIRE (MDQ)

INSTRUCTIONS:

Please answer each question as best you can.

	Yes	No
1 Has there ever been a period of time when you were not your usual self and ...		
– you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
– you were so irritable that you shouted at people or started fights or arguments?	☐	☐
– you felt much more self-confident than usual?	☐	☐
– you got much less sleep than usual and found that you didn't really miss it?	☐	☐
– you were more talkative or spoke much faster than usual?	☐	☐
– thoughts raced through your head or you couldn't slow your mind down?	☐	☐
– you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
– you had much more energy than usual?	☐	☐
– you were much more active or did many more things than usual?	☐	☐
– you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
– you were much more interested in sex than usual?	☐	☐
– you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
– spending money got you or your family in trouble?	☐	☐
2 If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3 How much of a problem did any of these cause you–like being unable to work; having family, money or legal trouble; getting into arguments or fights?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

Patient Name: ____________________

DOB: ______________

Zung Self-Rating Depression Scale (SDS)

For each item below, please place a check mark (✓) in the column which best describes how often you felt or behaved this way during the past several days

Place check mark (✓) in correct column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue.				
2. Morning is when I feel the best.				
3. I have crying spells or feel like it.				
4. I have trouble sleeping at night.				
5. I eat as much as I used to.				
6. I still enjoy sex.				
7. I notice that I am losing weight.				
8. I have trouble with constipation.				
9. My heart beats faster than usual.				
10. I get tired for no reason.				
11. My mind is as clear as it used to be.				
12. I find it easy to do the things I used to.				
13. I am restless and can't keep still.				
14. I feel hopeful about the future.				
15. I am more irritable than usual.				
16. I find it easy to make decisions.				
17. I feel that I am useful and needed.				
18. My life is pretty full.				
19. I feel that others would be better off if I were dead.				
20. I still enjoy the things I used to do.				

Zung WW. (1965). A self-rating depression scale. *Archives of General Psychiatry* 12: 63-70.