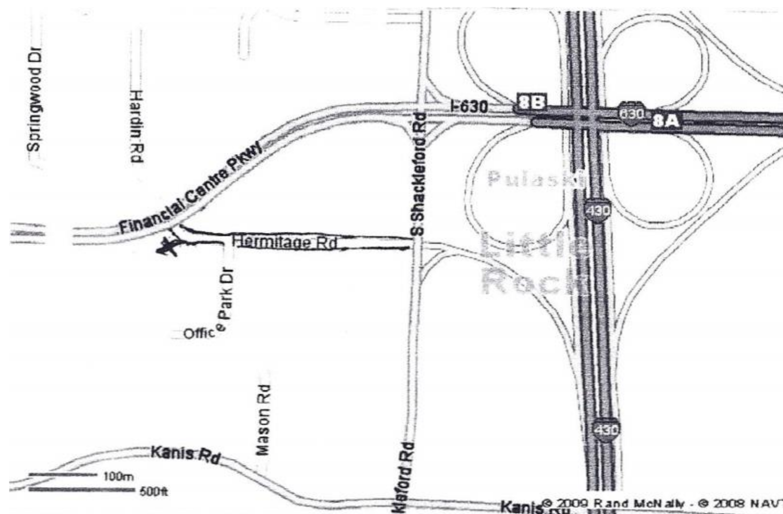
LESA LACKEY DOAN, LCSW
The Family Center
11215 Hermitage Road,
Suite 200 Little Rock, Arkansas 72211
(501) 221-2811
FAX# (501) 221-2812

Your appointment is scheduled for:

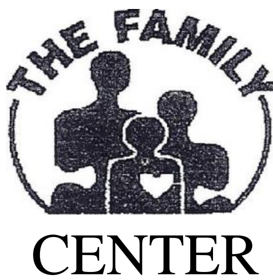
____at________________

Our office is in the Park West building located at:

11215 Hermitage Rd., Suite 200
Little Rock, AR 72211



Please bring your insurance card with you.



CENTER

LESA LACKEY DOAN, LCSW
FINANCIAL POLICY

Thank you for choosing me as your health care provider. The following is my Financial Policy. My main concern is that you receive the proper and optimal treatments needed to assist your difficulty. Therefore, if you have any questions or concerns about my payment policies, please do not hesitate to ask me. I ask that all patients read and sign this Financial Policy before being seen by me. Payment for services is due at the time services are rendered. In special instances, we may accept insurance assignment of insurance benefits. However, you must understand that:

l) Your insurance policy is a contract between you, your employer and the insurance company. I am NOT a party to that contract. I am NOT party to a court order. My relationship is with you, not your insurance company or the court.

2) All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services and providers of what they will or will not cover. I.E.: LCSW's ARE NOT COVERED with Medicaid ARKids 1 st PLAN B 3) Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

4) If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help expedite payment. For all unpaid balances, there will be a $2.50 monthly service charge,

5) It is your responsibility to check with your insurance & if applicable, your employer, to see if your insurance plan covers the professional services you are receiving here, Also, it is your responsibility to check with your employer about who their carrier is for behavior and mental health. If this carrier requires precertification before the first visit and you do not get this pre-certification, you will be responsible for the entire charge for the first visit.

6) Delinquent accounts will be subject to a Collection fee of 40%. Monthly statements will be issued for accounts with an unpaid balance and charged a $2,50 service fee up to 90 days. Checks returned for insuffcient funds will be charged $40.00 returned check fee.

*** By signing this agreement I hereby waive any time constraints in the collection of past due accounts.

***All accounts past 90 days past due will be turned over to an outside collection agency, and charged an additional 40% on balance due. The account may also be charged with additional attorney's fees and/or interest fees that may occur, unless the account is brought current. Also, if the patient is a child and you and your spouse are ordered by the court to divide the cost of this therapy, you as the custodial parent will be held responsible for the account. I do not list two responsible parties for the account. You may have your spouse or ex-spouse sign the intake form and this financial policy as co-responsible party, but you will be responsible for paying me for the services rendered. I am not a party to your divorce.

***** Please note that, unless cancelled 24 hours in advance, you will be charged for missed appointments at the established office cancellation rate of $75.00. Please call if you have to reschedule. My phone is answered 24 hours a day, 7 days a week.**

*** If you require my clinical consultation by telephone or e-mail, either during or after office hours, you will be charged for that time. If your treatment involves consultation with other professionals, you will also be charged for those services.

**Requests for copies of a clinical record will be charged $.50cents per page; $15.00 service charge; electronic record transfer $100.00 service fee.*

I understand that temporary financial problems may affect timely payments of your balance. I encourage you to communicate any such problems so that I can assist you in the management of your account. I will work with you to make a payment arrangement on the account, but you must keep the account current.

Patient's Name: ______________________________ Date: ______________

Responsible Party:Date: ______________________________ ______________

If the patient is a child, both parents are jointly and severally liable for the financial responsibility on the patient's account, Co- Signature;

____

This information may be protected by Federal Law relating to confidentiality (42CFR Part2) prohibiting any further disclosure

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200 Little Rock, Arkansas
72211 (501) 221-2811
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HIPAA CONFIDENTIALITY INFORMATION

Dear Patient:

Physicians have always protected the confidentiality of health information by scaling medical records away in file cabinet and refusing to reveal your information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health plans. This Federal Law called HIP AA, (Health Information Portability and Accountability Act) goes into effect nationwide for all providers April 14, 2003. To comply with the privacy rule's standards protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physicians, the hospital or other mental health care providers will need to consider the privacy rule. A ll health information including paper records, oral communications, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions: these rights are not absolute. We also take precautions in our office to safeguard your health information such as training employees and employing computer security measures. Please feel free to ask your physician or our privacy officer about exercising your rights or how your health information is protected in our office.

The Notice of Private Practices posted in our waiting area explains our privacy practices, It contains very important information about how your confidential health information is handled by our office. It also describes how you can exercise your rights with rega rds to your protected health information. Please let us know if you have any questions about Notice of Private Practices. You may discuss any Notice of Privacy questions with Lesa L. Doan, LCS W.

Please sign and date the Acknowledgment of Privacy Practices on the back of this page. Thank you!

This information may be protected by Federal Law relating to confidentiality (42CFR Part2) prohibiting any further disclosure. It is understood that other uses of protected mental health care information are prohibited without the authorization from the patient.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,____ do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

____

Signature of Individual

____

Date

In the event this request is made by the individual's personal representative:

____

Signature of Personal Representative Date

____

Legal Authority of Personal Representative

CENTER

LACKEY LCSW
11215 Hermitage Road, Suite 200
Little Rock, AR 72211
(501) 221-2811

THIS FORM MUST BE COMPLETED IN FULL

PATIENT INFORMATION:

Patient's Name: ______________________________

First M.I. Last Nickname

Home Address: ______________________________

Street City State Zip

Home Phone: Work Phone: Cell Phone:

Birth Date: ____________ Age: ________ Sex: ________ SS#: ____________

Martial Status: Married Single Widowed Divorced Employer: Employer

Address: ______________ ______________

Referred By: Primary Care Physician:

Person Responsible for Payment: ______________________________

*Please note that, unless cancelled 24 hours in advance, you will be charged for missed appointments at the established omce cancellation rate of $75.00. Please call if you have to reschedule. My phone is answered 24 hours a day, 7 days a week.

In case of an emergency, who should be notified: ______________ Phone: ____________

Nearest relative: ______________ Phone: ____________ Relationship: ____________

SPOUSE INFORMATION:

Name: ______________ Date of Birth: ____________ SS#: ____________

Home Address: ______________________________ Phone: ____________

Employer: ______________________ Work Phone: ______________________

PRIM4RY INSURANCE INFORMATION:

Policy Holder's Name: ______________________ SS#: ______________________

Policy Holder's Date of Birth: ______________________

Name of Insurance Company: ______________________ Policy#: ______________________

Group#: ______________________ **Group Name:** Group Name: ______________________ **ID#:** ______________________

Phone # of Insurance Company: ______________________ Authorization #: ______________________

SECONDARY INSURANCE INFORMA TION:

Policy Holder's Name: ______________________ **SS#:** ______________________

Policy Holder's Date of Birth: ______________________

Name of Insurance Company: ______________________ Policy#: ______________________

Group#: ______________________ **Group Name:** ______________________ **ID#:** ______________________

Phone # of Insurance Company: ______________________ **Authorization #:** ______________________

DOES YOUR INSURANCE COVER OUT-PATIENT COUNSELmG WITH SOCIAL WORKERS? ______

ASSIGNMENTAND RELEASE:

1,authorize treatment by LESA LACKEY DOAN, LCSW.

____

Name of Patient

I, the undersigned, have insurance withand assign

____

Directly to Lesa Lackey Doan, LCSW, all mental health benefits. I consent to the release of information as required by my insurance carrier(s).

1,also consent to the notification of the physician

____

Name of Patient or Legal Guardian

who referred me, regarding this treatment. Yes ______________ No ______________

______________________________ ______________________________

Patient's Signature Date

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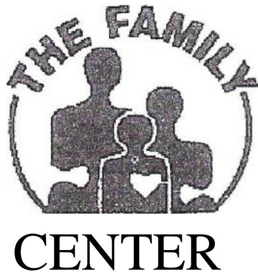

CENTER

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11215 Hermitage Road, Suite
200 Little Rock, Arkansas 72211
(501) 221-2811

ADULT EVALUATION DATABASE

Date ______________________________

Instructions: Please fill this out as fully as you can comfortably. Don't labor over it; don't worry if you don't understand part of it. I will go over and complete it with you.

Name:Date of Birth: Age: Male ________ Female

________ Single__________Married Widow/er

Please briefly describe what problems you are having, and how you think I can help.

____

____

____

____

____

____

Have you had any thoughts of suicide? Yes No If yes,
please explain: ____

Please place a check mark by any of the following your have been having problems with:

____Difficulty sleeping Decreased appetite Increased appetite Tearfulness
Loss of sense of humor Less ability to enjoy regular activities Loss of energy

____Lowered self-esteem Lack of concentration Anger/irritability
Less interest in doing daily grooming (bath, shave, wash hair)____Withdrawal from others

Evaluation Database — Page 2

What is better now, since you made the phone call to set up this appointment? Please explain:

Are any of the following areas of your life particularly stressful to you? (Circle all that apply):

Marriage/relationship Health Legal Problems Employment Financial problems

Extended family problems Other

Please explain : ____

What areas of your life are you satisfied with and don't want to change?

This information may be protected by Federal Law relating to confidentiality (42CFR Part2) prohibiting any further disclosure

Have you ever seen a psychiatrist for your problems before? Yes No If yes, please list the doctor's name, hospitals and dates of treatments:

Have you ever taken medicines for depression, anxiety, or any other mental illness? Yes If No yes, please list the medicines:

Have you ever seen a therapist? If so, please list the dates of treatment and outcome:

Please circle any of the following you have had problems with:

Generalized anxiety Anxiety/panic attacks Eating Disorder (anorexia, bulimia)

Mania Hearing voices Compulsive behavior Obsessive thoughts List the names of physicians you have seen recently, what you saw them for and when:

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List previous hospitalizations:

Year Hospital City & State Reason

____

____

____

What medicines do you take regularly, what dose and who prescribes them?

____

____

____

____

____

Have you had any serious illnesses? (Circle all that apply):

Cancer Thyroid problems Migraine headaches Asthma Diabetes HIV

Bowel problems Stomach ulcers Hepatitis Heart Disease High blood pressure

Other: ____

____

Do you smoke cigarettes? Yes No If yes, how much per day? Do you drink ______________ alcoholic beverage? Yes No If yes how often do you drink?

____

How much do you drink?

____

Have you used other drugs? (Crystal methamphetamine, cocaine, marijuana, etc.) Yes No If yes, what drugs, how often, how much?

____

____

____

____

This information may be protected by Federal Law relating to confidentiality (42CFR Part2) prohibiting any further disclosure

Have you ever been in treatment for alcohol and/or drug abuse? Yes No If yes, where and when did you receive treatment?

____

____

____

Have you ever had any legal charges against you, or do you have current legal charges? Yes No If yes, please explain:

____

____

____

Names and ages of children:

____

____

Names and ages of siblings:

____

Is there any family history of mental illness? (Please include children, siblings and parents)

Is there any family history of alcohol/drug abuse? (Please include children, siblings and parents)

This information may bc protcctcd by rcdcral Law rclating to confidcntiality (42CFR Part2) prohibiting any funhcr disclosure

How would you describe your childhood? Happy? Not Happy? What happened?

Were you ever physically abused while growing up? Yes No If yes, by whom?

Were you ever sexually abused while growing up? Yes No If yes, by whom?

How far did you go in school?

Did you ever serve in the military? Yes No What branch? How long?

How many times have you been married? ______________________________

Where are you currently employed? ______________________________

How long have you worked there? ______________________________

If less than one year, where else have you worked and how long? ______________

____

Did you ever serve in the military? Yes No What branch? ______________

How long? ____

Are you currently on work disability? Yes No

If yes, how long have you been off work? Please give specific dates: ______________

____

What do you consider your strengths? ______________________________

____

____

Identify your support system. Have you had someone in your life who has been very influential or who looked up to you? Please explain: ______________________________

____

____

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