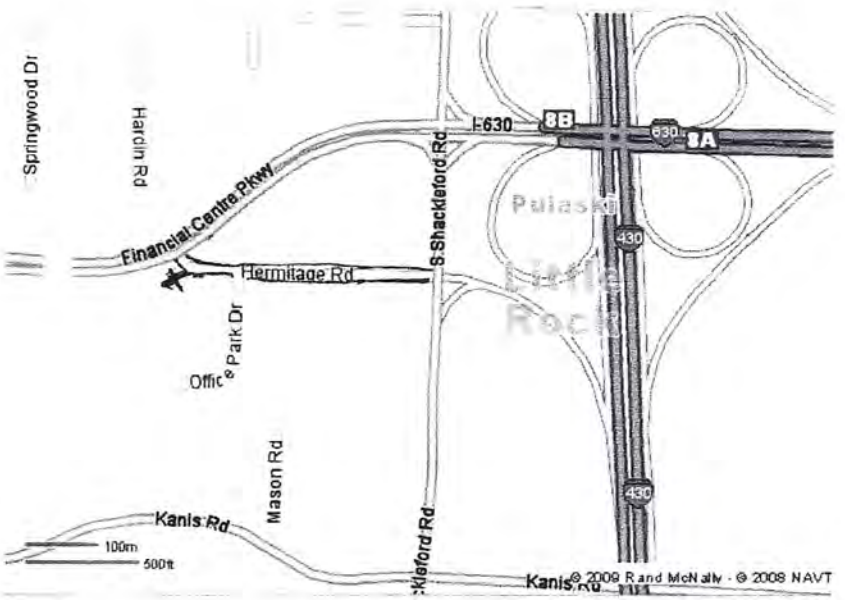
**LESA LACKEY DOAN, LCSW**
**The Family Center**
**11215 Hermitage Road, Suite 200**
**Little Rock, Arkansas 72211**
**(501) 221-2811**
**FAX# (501) 221-2812**

**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.**

# 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:

1) 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 1st 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 pre-certification 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 insufficient funds will be charged $40.00 returned check fee.

***** By signing this agreement I hereby wave 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

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:** _____

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# HIPPA 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 HIPAA, (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. All 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 regards 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, LCSW.

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 written 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


LESA LACKEY DOAN, LCSW*11215 Hermitage Road, Suite 200*Little Rock, Arkansas 72211*(501) 221-2811

# CHILD REGISTRATION

**DATE:** _____ **PATIENT'S NAME:** _____ **HOME PHONE:** _____

**SEX: M / F BIRTHDATE:** _____ **PARENT'S MARITAL STATUS: MARRIED DIVORCED WIDOWED**

**SOC. SEC#:** _____ **WHO HAS CUSTODY, IF PARENTS DIVORCED:** _____

**ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

**MOTHER'S NAME:** _____ **MOTHER EMP BY:** _____ **W/C PHONE:** _____

**MOTHER'S SOC.SEC#:** _____ **MOTHER'S DATE OF BIRTH:** _____

**FATHER'S NAME:** _____ **FATHER EMP BY:** _____ **W/C PHONE:** _____

**FATHER'S SOC.SEC#:** _____ **FATHER'S DATE OF BIRTH:** _____
**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**PERSON RESPONSIBLE FOR PAYMENT:** _____ RELATION: _____
IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED: _____ PHONE: _____
NEAREST RELATIVE: _____ RELATION: _____ PHONE: _____
PLEASE BE ADVISED THAT BOTH PARENTS WILL BE HELD JOINTLY AND SEVERALLY RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT.
ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE. ****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.**

**DO YOU HAVE ANY MEDICAL INSURANCE?** YES NO IF YES,
NAME OF PRIMARY INSURANCE: _____ NAME OF INSURED: _____
I.D. NUMBER: _____ GROUP NUMBER: _____ EMPLOYER: _____

NAME OF SECONDARY INSURANCE (IF ANY) YES NO IF YES,
I.D. NUMBER: _____ GROUP NUMBER: _____ EMPLOYER: _____

SCHOOL CHILD ATTENDS: _____ TEACHER'S NAME: _____
ADDRESS OF SCHOOL: _____ PHONE: _____
WHAT GRADE IS CHILD IN: _____ HOW LONG ATTENDED THIS SCHOOL: _____
OTHER SCHOOLS IF LESS THAN ONE YEAR - AT PRESENT ONE: _____

**ASSIGNMENT AND RELEASE:**
**I, the undersigned, have insurance coverage with** _____
and assign directly to THE FAMILY CENTER, Lesa Lackey Doan, all medical benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize THE FAMILY CENTER to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured / Guardian Date

**SIGNATURE OF PERSON RESPONIBLE FOR BILL:** _____
OTHER THERAPISTS OR DOCTOR SEEN: _____
REFERRED BY: _____

***This information may be protected by Federal Law relating to confidentiality (42CFR Part2) prohibiting any further disclosure also the Privacy act of 1976 aside from uses and disclosures for treatment, payment, and mental health care operations required by law, it is understood that other uses of protected mental health care information are prohibited without the written authorization from the patient.***

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# EVALUATION DATABASE (CHILD/MINOR)

Date _____

Instructions to Parent/Guardian: Please fill this out as fully as you can comfortably. If you feel your child can understand some of the questions, please ask them yourself or have them fill in what they are comfortable with. If you can't complete the entire form, don't worry, as I will go over the database with you.

Child's full name _____
Male _____ Female _____ Date of Birth _____ Age____

Child's School _____

Biological mother's name _____ Phone_____

Biological Father's name _____ Phone _____

Stepmother's name _____ Phone _____

Stepfather's name _____ Phone _____

Custodial parents' name & phone number _____
(Please include home, work & cell phone numbers) _____

Please write briefly what problems your child is having and what you hope I can do to help.

_____

_____

_____

Has your child had any thoughts of suicide? YES NO
If yes, please explain

_____

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

___ Difficulty sleeping ___ Decreased appetite ___Increased appetite ___ Withdrawal

___Loss of sense of humor ___ Less ability to enjoy regular activities ___ Anger/irritability

___Tearfulness ___ Lack of concentration ___ Loss of energy

___ Other (Explain) _____

CHILD/MINOR DATABASE, PAGE TWO

Are any of the following areas particularly stressful for your child? (Circle all that apply).

Relationships Health Legal problems Employment

School Financial problems Extended family problems

Please explain:

_____

_____

_____

_____

_____

_____

## PSYCHIATRIC HISTORY

Has your child ever been treated for a psychiatric illness (depression, anxiety, ADHD, eating disorder, etc.)? YES NO

If yes, please list doctor's names, hospitals and dates of treatment:

_____

_____

_____

Has your child ever taken medicines for ADD, depression or anxiety, or other mental illness? YES NO

If yes, please list the medicines: _____

_____

_____

CHILD/MINOR ADMISSION DATABASE, PAGE THREE

Has your child had any of the following? Circle your answer.

| | | |
|---|---|---|
| Neurological exam | Yes | No |
| Psychiatric exam | Yes | No |
| Psychological exam (or testing) | Yes | No |
| Professional counseling/psychotherapy | Yes | No |

If you answered yes to any of the above, please list the names of the doctor or therapist:

_____

_____

Please circle if your child has had problems with:

| | | |
|---|---|---|
| Generalized anxiety | Panic attacks | Anorexia or bulimia |
| Mania | Hearing voices | Obsessive thoughts and/or compulsive behavior |

**Medical History**

List the names of physicians your child has seen recently, what he/she saw them for and when:

_____

_____

_____

What medicines does your child take regularly, what does, and who prescribes them?

_____

_____

_____

ADMISSION DATABASE - PAGE FOUR

Has your child had any allergic reactions to medicines? YES NO

If yes, please list _____

What is your child's height? _____ Weight? _____

Does your child have any serious illnesses? What? _____

**Habits**

Does your child smoke cigarettes? YES NO If yes, how much per day? _____

Does your child drink alcoholic beverages? YES NO

If yes, how often does your child drink? Please circle whatever most closely applies to him/her)

Daily 3-5 times per week 1-2 times per week 1-3 times per month

1-3 times per six months 1-3 times per year

How much does your child drink at each event? _____

Has your child used drugs? (Crystal meth, cocaine, marijuana, etc.) YES NO
If yes, what drugs, how often, how much?

_____

_____

Has your child ever been in alcohol or drug treatment? YES NO
If yes, when and where? _____

_____

Has your child ever suffered the consequences of drug or alcohol abuse such as legal problems (DWI, DUI), public intoxication, possession of drugs, dealing drugs, etc.), medical problems (DT's, seizures, stomach problems, hepatitis, pancreatitis, AIDS, etc.), social (School problems, job problems, loss of friends or family?) YES NO

Please
explain: _____

## Family History

Was your child's pregnancy planned? YES NO

Were there any problems or complications during the pregnancy? YES NO
If yes, what problems? _____

Were any drugs or alcohol used during the pregnancy? YES NO
If yes, please explain _____

At what age did your child take their first steps _____, said their first words _____.

Has your child ever been pregnant? YES NO N/A
If yes, names & ages of children: _____

Names & ages of your child's brothers and sisters (including half & step siblings): _____
_____

Does your child's brothers or sisters have a problem with depression, anxiety or any other psychiatric illness? YES NO

If yes, who and what illness? _____

Does your child's brothers or sisters have a problem with drug or alcohol abuse? YES NO

Is your child's mother living? YES NO Is your child's father living? YES NO

Are they married to each other? YES NO

If divorced, how old was your child when they divorced? _____

Does your child's biological mother have a problem with any psychiatric illness? YES NO

Does your child's biological father have a problem with any psychiatric illness? YES NO

Does your child's biological mother have a problem with drug or alcohol abuse? YES NO

Does your child's biological father have a problem with drug or alcohol abuse? YES NO

If there are stepparents involved in the child's care, do they have a problem with either psychiatric illness or drug or alcohol abuse? YES NO

Does any of your child's biological relatives have a problem with psychiatric illness? YES NO

CHILD/MINOR ADMISSION DATABASE - PAGE SIX

Does any of your child's biological relatives have a problem with drug or alcohol abu e?
YES NO

Who lives in the child's home? _____

Who is the primary disciplinarian? _____

What are the usual methods of discipline? _____

Is your child adopted? _____

**Social History**

How would your child describe his/her childhood? Happy? Not happy? Why?

_____

_____

_____

Has your child suffered physical abuse? YES NO
If yes, by whom? _____
When did it occur? _____
Has it been reported? YES NO
If yes, by whom? _____

Has your child suffered sexual abuse? YES NO
If yes, by whom? _____
When did it occur? _____
Has it been reported? YES NO
If yes, by whom? _____

Is your child currently employed? YES NO N/A
If yes, where? _____
How long has he/she worked there? _____

What school does your child attend? _____

How are his/her grades? _____ Conduct? _____

CHILD/MINOR ADMISSION DATABASE – PAGE SEVEN

What kind of problems does he/she have in school?

_____

_____

_____

Does he/she have any learning disabilities? _____

Does he/she socialize well with peers? _____

Does he/she have any legal charges? _____

Is there any other information you would like me to know?

_____

_____

_____

THE FAMILY CENTER

# PARENT QUESTIONAIRE

**DATE:**_____

**CHILD'S NAME**_____**AGE**_____**DOB**_____

**PARENT'S NAME(S):**_____

**ADDRESS:**_____**PHONE:**_____

**ARE YOU THE LEGAL GUARDIAN:**_____**YES** _____**NO**

**SIBLINGS: (NAMES AND AGES)**_____

_____

**PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. IF YOU ANSWER YES TO SOME QUESTIONS, PLEASE PROVIDE EXPLANATION:**

**A. CHIEF REASON FOR YOUR CONCERN:**_____

_____

_____

**B. WHAT THERAPEUTIC OUTCOME (CHANGES) WOULD YOU LIKE TO SEE:**

_____

_____

_____

**C: FAMILY HISTORY:**

| PSYCHIATRIC | YES | NO |
|---|---|---|
| 1. NERVOUS BREAKDOWN | ___ | ___ |
| 2. ALCOHOLISM | ___ | ___ |
| 3. DRUG ADDICTIONS | ___ | ___ |
| 4. SEIZURES | ___ | ___ |
| 5. MENTAL RETARDATION | ___ | ___ |
| 6. SUICIDES | ___ | ___ |
| 7. TICS | ___ | ___ |
| 8. MEDICINES FOR CHILD | ___ | ___ |
| 9. MEDICINES USED BY OTHER FAMILY | ___ | ___ |
| 10. OTHER, SPECIFY | ___ | ___ |

**IF ANSWER IS YES TO ANY OF THE ABOVE, PLEASE EXPLAIN ON BACK.**

| MEDICAL | | |
|---|---|---|
| 1. HEART DISEASE | ___ | ___ |
| 2. HIGH BLOOD PRESSURE | ___ | ___ |
| 3. DIABETES | ___ | ___ |
| 4. THYROID | ___ | ___ |
| 5. OTHER (i.e. asthma, etc.) | | |

_____

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D. DEVELOPMENTAL HISTORY

PREGNANCY (PRENATAL)

1. USE OF DRUGS (prescription/non-prescription)

2. MEDICAL COMPLICATIONS/ACCIDENTS

3. ATTITUDE TOWARD PREGNANCY

4. COMPLICATING LIFE EVENTS(ie death of family member, divorce, etc)

LABOR AND DELIVERY (PERINATAL)

1. MEDICAL COMPLICATIONS AT BIRTH

2. BIRTHWEIGHT OF CHILD

3. PARENT/CHILD EXPERIENCE DURING FIRST YEAR

INFANCY (0-18 MONTHS)

1. WALKING BEGAN
2. MEDICAL PROBLEMS

3. FEEDING DIFFICULTY

4. IRRITABILITY

5. SLEEPING PATTERN

6. SEPARATION ANXIETY

7. FEARFULNESS

8. SENSITIVITIES

9. LIFE PROBLEMS

TODDLER (18 - 36 MONTHS)

1. TALKING BEGAN

2. ONSET AND SUCCESS OF TOILET TRAINING

3. TEMPER TANTRUMS

4. NIGHT TERRORS OR FEARS

5. SOCIALIZATION/SEPARATION BEHAVIOR

6. SLEEPING PATTERN

7. LIFE PROBLEMS

PRESCHOOL (4-5 YEARS)

1. SOCIALIZATION

2. ADJUSTMENT TO PRESCHOOL

3. SEPARATION BEHAVIOR

4. IMPULSE CONTROL

5. TOILETING BEHAVIOR

6. MASTURBATION

7. LIFE PROBLEMS

LATENCY (6 - 11 YEARS)

1. PEER RELATIONS

2. INTERESTS, HOBBIES

3. IMPULSE CONTROL

4. COORDINATION/CLUMSINESS

5. EDUCATIONAL STATUS (ie learning disabilities, regressions, etc)

6. LIFE PROBLEMS

PUBERTY AND ADOLESCENCE (12 - 16+ YEARS)

1. MENARCHE

2. MASTURBATION

3. SEXUAL ACTIVITY

4. ALCOHOL AND DRUG USE

5. EDUCATION STATUS

6. PEER RELATIONSHIPS

7. MAJOR BEHAVIOR PROBLEMS

8. DEPRESSION/ANXIETY

9. LIFE PROBLEMS

MEDICAL HISTORY

1. SIGNIFICANT ILLNESSES

2. OPERATIONS

3. SIGNIFICANT INJURIES SINCE BIRTH

4. HISTORY OF ALLERGIES

5. CURRENT USE OF MEDICATION

6. HANDICAPS; SPECIAL PROBLEMS

E. CURRENT SITUATION

1. PLEASE DESCRIBE THE CURRENT MARITAL RELATIONSHIP

2. PLEASE DESCRIBE YOUR RELATIONSHIP WITH YOUR CHILD

3. PLEASE LIST YOUR CHILD'S STRENGTHS AND WEAKNESSES

4. IF A COURT OR LEGAL AGENCY IS INVOLVED WITH YOUR CHILD, PLEASE EXPLAIN

5. PLEASE LIST AGENCIES/INDIVIDUALS WHO HAVE PROVIDED THERAPY FOR YOUR CHILD OR OTHER FAMILY MEMBERS

6. IF YOUR CHILD HAS EXPERIENCED A DIVORCE WITH YOU OR BEFORE, PLEASE DESCRIBE BRIEFLY AND INDICATE THE AGE OF YOUR CHILD AT THE TIME

7. WHO ARE THE SIGNIFICANT PERSONS, FAMILY MEMBERS IN YOUR CHILD'S LIFE

8. PLEASE LIST METHOD(S) OF DISCIPLINE USED IN HOME

9. WHAT PERSONALITY TRAITS BEST DESCRIBE YOUR CHILD

10 HOW DOES YOUR CHILD HAVE FUN? HOW DO THE PARENTS HAVE FUN? HOW DOES THE FAMILY HAVE FUN?

THANK YOU FOR YOUR TIME AND INTEREST IN YOUR CHILD