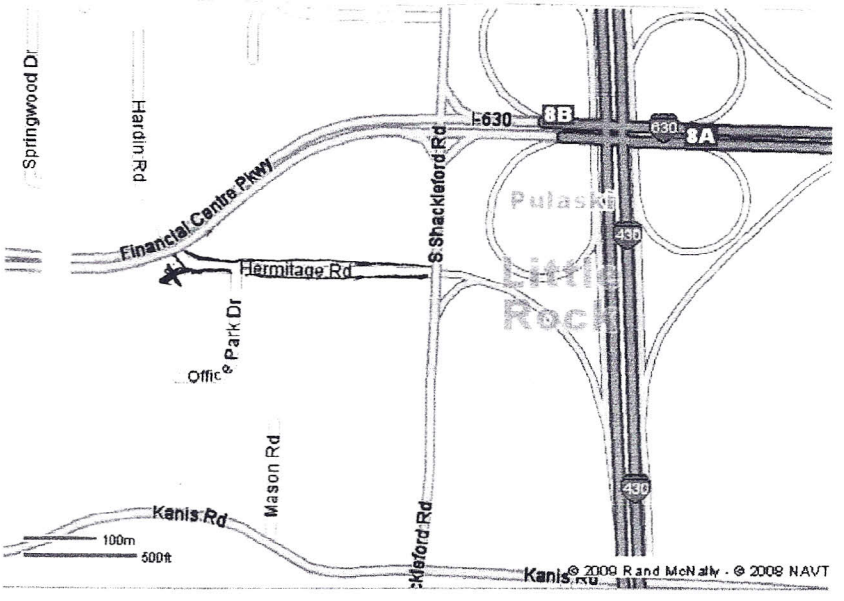
LESA LACKEY DOAN, LCSW
The Family Center
11215 Hermitage Road, Suite 200
Little Rock, Arkansas 72211
(501) 221-2811
FAX# (501) 221-2812

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, AR 72211*(501) 221-2811

YOUNG PERSON'S QUESTIONAIRE

NAME: _____

AGE: _____ DOB: _____

ADDRESS: _____

MOTHER'S NAME: _____

ADDRESS: _____

FATHER'S NAME: _____

ADDRESS: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

1. ARE YOU PRESENTLY EXPERIENCING PROBLEMS OF ANY KIND? IF SO, EXPLAIN

_____

_____

_____

_____

2. WHAT KIND OF RELATIONSHIP DO YOU HAVE WITH YOUR PARENTS?

_____

_____

_____

_____

3. BROTHER(S) AND/OR SISTER(S)

_____

_____

_____

_____

Questions 4 through 7 Continued over on next page.....

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4. DO YOU HAVE FRIENDS? IF SO, WHAT DO YOU LIKE ABOUT THEM?

5. DO YOU LIKE SCHOOL? IF NOT , WHY NOT?

6. WHAT DO YOU DO IN YOUR FREE TIME?

7. DO YOU WANT TO COME TO THERAPY? IF SO, WHAT CHANGES WOULD YOU LIKE TO SEE?

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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.

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