THE LAKEWOOD GROUP, LLC

Mental Health Services

2237 Ridge Road • Suite 101 • Rockwall, Texas 75087-5161
(972) 771-3969 • Fax: (972) 771-8258
www.lakewoodgroup.net

Robert F. Mehl, III, Ph.D. & Associates, LLC
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H. Michael Cunningham, Ph.D.
Johnathan L. Fowler, Ph.D.
Joni L. Caldwell, Ph.D.
Jeffrey M. Vance, Ph.D.
Jessica L. Abraham, LCSW
Mary K. You, Psy.D.

REGISTRATION INFORMATION

(Please Print)

Patient Name:_____Date:_____-_____-_____
Last First Middle Initial
Birthdate: _____-_____-_____; Age:_____; Gender:_____; Race (optional):_____
Marital Status: Single___; Married___; Widowed___; Separated___; Divorced___
Home Address:_____ City:_____ State:___ Zip:_____
Cell Phone: (____)_____-_____, Work Phone: (____)_____-_____,
email: _____, Home Phone: (____)_____-_____,
Patient Social Security #:_____ Driver's License #:_____
Employer:_____ Occupation:_____
Work Address:_____ City:_____ State:___ Zip:_____
Referred by:_____ Family Physician:_____

Responsible Party:_____Relationship to Patient:_____
Home Address:_____ City:_____ State:___ Zip:_____
Cell Phone: (____)_____-_____, Work Phone: (____)_____-_____,
email: _____, Home Phone: (____)_____-_____,
Responsible Party Social Security#:_____ Driver's License #:_____
Employer:_____ Occupation:_____
Work Address:_____ City:_____ State:___ Zip:_____

Primary Insurance: _____ Phone: (____)_____-_____
Name of Insured:_____ Policy #: _____ Group #:_____
Secondary Insurance:_____ Phone: (____)_____-_____
Name of Insured:_____ Policy #:_____ Group #:_____

Emergency Contact:_____, Relationship to Patient_____
Address:_____ City:_____ State:___ Zip:_____
I agree that any of the numbers listed below may be called in case of emergency, Initials_____
Home Phone: (____)_____-_____, Cell Phone: (____)_____-_____
Work Phone: (____)_____-_____

For Office Use Only: Prov:_____ Psy Dx: _____ GAF: _____

Modality:_____ Med Dx: _____ Refer By: _____

Date 1st Symptoms:_____ Date previous same or similar symptoms:_____

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AUTHORIZATION FOR CONFIDENTIAL HANDLING OF HEALTH INFORMATION

This form instructs and authorizes The Lakewood Group about how to communicate confidential information, including information about appointments.

Name of Patient:_____, □ Information about appointments, billing and care to patient only.
or
□ Information about appointments, billing and care to parent, guardian, or personal representative only; Name:_____
Note: Both parents of a minor child have equal rights to full information unless otherwise stated in a divorce decree. If you are a divorced parent, a copy of the relevant pages and signature pages of a divorce decree must be provided to this office.

I, undersigned Patient, Parent, Guardian or Personal Representative authorize The Lakewood Group to contact me in the following ways: (Please check all that apply.)
Cell:_____, □ may leave a message regarding: □ appointments, □ billing, □ care.
Other phone: _____, □ may leave a message regarding: □ appointments, □ billing, □ care.
Email: _____, □ may leave a message regarding: □ appointments, □ billing, □ care.
*__Note:__ Email and phone communications are potentially not secure with regard to confidentiality

Other persons we may contact, including step-parents if relevant:
Name:_____, Relationship to patient:_____
Cell:_____, □ may leave a message regarding: □ appointments, □ billing, □ care.
Other phone: _____, □ may leave a message regarding: □ appointments, □ billing, □ care.
Email: _____, □ may leave a message regarding: □ appointments, □ billing, □ care.

Name:_____, Relationship to patient:_____
Cell:_____, □ may leave a message regarding: □ appointments, □ billing, □ care.
Other phone: _____, □ may leave a message regarding: □ appointments, □ billing, □ care.
Email: _____, □ may leave a message regarding: □ appointments, □ billing, □ care.

I further authorize the Lakewood Group to contact the Emergency Contact listed on the first Registration page in case of emergency.
I understand there are potential limits to confidentiality with email and phone communications.

Special instructions:
Please list any special instructions for contacting you or for sharing your private health information _____

_____

_____

SIGNATURE: Patient: _____ Date: _____-_____-_____

Print patient name:_____

OR

Parent or Guardian or Personal Representative: _____ Date: _____-_____-_____

Print name: _____

If the patient is either under age or has a guardian appointed by the court, this request must be signed by the patient's legal guardian. If the request is signed by a personal representative of the patient, a legal description of such representative's authority to act for the patient must be provided.

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PATIENT SERVICES AGREEMENT

Patient Name:_____

This Agreement contains information about privacy and patient rights. As required by law, your Notice of Privacy Practices for use and disclosure of Private Health Information (PHI) is posted at www.lakewoodgroup.net and is available from our office at 972-771-3969. The law requires that we obtain your signature acknowledging that you were provided this information. Your signature represents a revocable agreement between us. A written revocation will be binding on us unless The Lakewood Group has taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOTHERAPY SERVICES: The nature of Psychotherapy varies depending on the personalities of the therapist and patient. In order for the therapy to be successful, you will have to work on things talked about both during sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. However, benefits of psychotherapy include better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Your therapist will evaluate your needs and offer treatment recommendations. You can discuss any questions you may have. If you have persistent doubts, your therapist will help you get a second opinion.

MEDICAL SERVICES: If you are seeing a psychiatrist, medication may be prescribed. Your psychiatrist will discuss the medication effects and possible side effects. You have the right to know about alternative medications and about non-medical alternatives. Your psychiatrist will discuss the advantages and disadvantages of each approach.

MEETINGS: Psychotherapy sessions consist of one 38 to 52 minute session, or one 53 to 60 minute session depending on your wishes and insurance company reimbursement. Medication Management sessions last 20 or 30 minutes. **Once an appointment is scheduled, you will be expected to give 24 hours advance notice of cancellation or pay a missed appointment fee. Please note that insurance companies do not pay for cancelled sessions.**

PROFESSIONAL FEES: The fee schedule is attached. **There is a fee for returned checks.**

GIFTS: It is the policy of The Lakewood Group not to accept gifts.

COURTROOM TESTIMONY: Courtroom testimony is not offered by providers at The Lakewood Group. If subpoenaed for appearance at a deposition or for courtroom testimony, signator agrees to pay $1500.00 for a personal lawyer for the provider. Also, in case of subpoena, the testimony fees on the Patient Services Agreement: Standard Fee Schedule (attached) apply.

CONTACTING YOUR DOCTOR: The automated phone system allows you to leave a voice message for your doctor, the appointments secretary or other staff. You may also speak directly to the office. We try to return your call within 24 hours, with the exception of weekends and holidays. For urgent calls please follow the instructions on the phone system for paging your doctor. If you have an emergency, please call 911, or go to the nearest hospital emergency room.

LIMITS ON CONFIDENTIALITY: The law protects communications between a patient and a mental health provider. Typically, information about your treatment is only released to others if you sign a written Authorization form. This signed Agreement provides consent for the following:

- Your doctor or therapist may need to consult other professionals about a case. Every effort is made to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. If you don't object, you will not be told about these consultations unless your doctor or therapist feels that it is important to your work together.
- Your doctor or therapist practices with other mental health professionals and The Lakewood Group employs administrative staff. In most cases, your doctor or therapist needs to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect fees.
- If a patient seriously threatens to harm himself/herself, your doctor or therapist may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- If your treatment involves couple, marital or family therapy, notes on each person are comingled in the record. In the case where one party requests records, it may not be possible to exclude notes involving other parties involved in treatment sessions.

There are some situations where your doctor or therapist may disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, such information is protected by law. Your doctor or therapist cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency requests information for health oversight activities, we may be required to provide it.

INITIALS _____

Patient Name:_____

- If a patient files a complaint or lawsuit against a doctor or therapist of The Lakewood Group, your doctor or therapist may disclose relevant information regarding that patient for the purpose of legal defense
- If a patient files a worker's compensation claim, your doctor or therapist must, upon request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some unusual situations in which your doctor or therapist is legally obligated to take actions necessary to protect others from harm and may have to reveal some information about a patient's treatment.

- If your doctor or therapist believes that a child has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, a report must be made to the appropriate governmental agency. Your doctor or therapist may then be required to provide additional information.

- If a doctor or therapist believes that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others, the doctor or therapist may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient.

If such a situation arises, your doctor or therapist will make every effort to discuss it with you before taking any action.

RECORDINGS: Audio and/or Video recordings during appointments are not permitted.

PROFESSIONAL RECORDS: Protected Health Information about you is kept in two sets of records:

Your Clinical Record includes information about your reasons for seeking therapy, your diagnosis, treatment goals, medications, your progress, your medical and social history, your treatment history, any past treatment records received from other providers, reports of professional consultations, billing records, and reports that have been sent to anyone, including reports to insurance carriers. Typically, you may examine and/or receive a copy of your Clinical Record. If your doctor or therapist refuses your request for access to your Clinical Record, you have a right of review.

Psychotherapy Notes assist your doctor or therapist in providing treatment. They contain the sensitive information that you may reveal. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. You may examine and/or receive a copy of your Psychotherapy Notes unless your doctor or therapist determines that release would be harmful to your physical, mental or emotional health.

PATIENT RIGHTS: You have some rights regarding your protected health information including requesting that your doctor or therapist amend your record; requesting restrictions on what is disclosed to others; requesting an accounting of most disclosures of protected health information that you have not authorized; determining the location to which protected information disclosures are sent; having complaints about your doctor's or therapist's policies and procedures recorded in your records; and a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures.

MINORS & PARENTS: The law allows parents to examine a minor child's treatment records unless the treatment is for suicide prevention, chemical addiction, or sexual, physical or emotional abuse. Because privacy is often crucial to success, your doctor or therapist will typically provide parents only with general information the child's treatment. Before giving parents any additional information, the doctor or therapist will discuss the matter with the child.

BILLING AND PAYMENTS: **Payment is due at each session, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment.** Use of a collection agency or small claims court will require us to disclose otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT: If your health insurance provides coverage for mental health treatment, your doctor or therapist will fill out forms and help you receive the benefits to which you are entitled; however, **you (not your insurance company) are responsible for full payment of our fees**. Please find out exactly what mental health services your insurance policy covers.

In the event The Lakewood Group or any of its professional affiliates files claims for insurance reimbursement, your signature below authorizes payment of benefits to be issued directly to The Lakewood Group or the professional affiliate. If your insurance company mistakenly remits payment to you, you agree to send that check along with any paperwork to The Lakewood Group.

If your insurance company does not pay or denies claims for services provided to you within 45 days after submitting the claim, your signature below authorizes The Lakewood Group and/or your individual provider to file a formal complaint on your behalf with the Insurance Commissioner of Texas. Your contract with your health insurance company might require that your doctor or therapist provides information such as a clinical diagnosis, treatment plans or summaries, or copies of your entire Clinical Record. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, The Lakewood Group has no control over what they do with it once it is in their hands. By signing this Agreement, you agree that The Lakewood Group can provide requested information to your carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE HAD THE OPPORTUNITY TO READ AND RECEIVE A COPY OF THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE.

A copy of this document is available upon your request.

SIGNATURE: Patient: _____ Date: _____-_____-_____

OR Parent or Guardian or Personal Representative: _____

If the patient is under age or has a guardian appointed by the court, this agreement must be signed by the patient's legal guardian. If the agreement is signed by a personal representative of the patient, a legal description of such representative's authority to act for the patient must be provided.

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PATIENT SERVICES AGREEMENT
STANDARD FEE SCHEDULE

This is our standard fee schedule. These are the fees you will be expected to pay unless your managed care company has a lower negotiated rate. Our office will verify your insurance before the first appointment and inform you of your expected payments or copayments.

SERVICE	FEE
Initial Psychodiagnostic Interview	250
Psychotherapy, 53+ min.	230
Psychotherapy, 38-52 min.	180
Interactive Complexity	30
Psychological or Neuropsychological Testing, per hour	230
Family Therapy, 53+ min.	230
Family Therapy, 45-50 min.	180
Group Therapy	85
Preparation of material for an attorney, per hour	230
Court Appearance by Subpoena	1500
Testimony by Deposition, per hour including travel time, Minimum four hour retainer required	360
Courtroom testimony, per hour including travel time, Minimum four hour retainer required	600
Returned Check Fee	50
Disability Paperwork, per occurrence, per hour	230
Diagnostic Letter, per hour	230
Consultation with School Personnel, per hour	230
Formal Recommendations for school (excluding testing), per hour	230
Missed Appointment without 24 hour notice	180

The above table represents our standard fees. This schedule covers the vast majority of our services. There may be a different fee for specific specialty services. Please check with your doctor or the office staff in those special cases.

Your signature below signifies that you have read this fee schedule and understand it as a part of the Patient Services Agreement.

SIGNATURE: Patient:_____ Date: _____-_____-_____

OR Parent or Guardian or Personal Representative: _____

If the patient is either under age or has a guardian appointed by the court, this agreement must be signed by the patient's legal guardian. If the agreement is signed by a personal representative of the patient, a legal description of such representative's authority to act for the patient must be provided.

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INSTRUCTIONS: Many insurance companies request that a release of information be obtained so that your therapist or doctor may communicate with your Primary Care Physician regarding your care. It is your right to agree or refuse to agree to such a release. If you agree to release this information, it can be very helpful to us and to your Primary Care Physician in coordinating your total health care. If you do not wish communication with your Primary Care Physician, sign at the right and return. _____

AUTHORIZATION TO RELEASE INFORMATION / PROTECTED HEALTH INFORMATION

I, _____ authorize _____
(your name) (your Lakewood Group doctor's name)
The Lakewood Group, LLC to release to and/or obtain from:

Name of individual: _____

Organization: _____

Address: _____

_____

Phone: (_____)_____-_____ Fax: (_____)_____-_____

the information regarding _____ , Date of Birth _____-_____-_____.

I, the undersigned, understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance upon it or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. In any event this consent shall expire six (6) months after the date of patient discharge from treatment, unless another date, event or condition is specified.

Optional: Specified date_____-_____-_____, or event _____ or condition_____.

I further understand that services may not be made contingent upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I further understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of your information and may no longer be protected by the HIPAA Privacy Rule.

By my signature below, I am authorizing the purpose of the release to be at the request of the individual unless otherwise stated below. I am also authorizing release of any and all protected health information unless otherwise stated below.

Optional: Purpose of release of information _____.

Optional: Released information will be limited to: _____

_____

SIGNATURE: Patient: _____ Date: _____-_____-_____

OR Parent or Guardian or Personal Representative: _____

If the patient is either under age or has a guardian appointed by the court, this authorization must be signed by the patient's legal guardian. If the authorization is signed by a personal representative of the patient, a legal description of such representative's authority to act for the patient must be provided.

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Functioning and Symptom Scale

Robert F. Mehl III, Ph.D.

Name: _____ Date:_____/_____/_____

Person completing form: ___Self ___Parent/Guardian

Please mark the extent to which each item has applied to you during the past seven (7) days.

If you are a parent or guardian completing the form on behalf of your minor child, please mark the extent to which you believe each item has applied to your child during the past seven (7) days.

Please mark only one response per item. Please answer every item. Forms with unanswered items or multiple responses per item may invalidate the entire questionnaire.

Work quickly but carefully without spending too much time on each item.

	None	A Little Bit	Moderate	Quite a Bit	Extreme	
Feeling overwhelmed with too much to do to get things done.....	||	||	||	||	||	[1]
Loss of interest in normal activities.....	||	||	||	||	||	[2]
Feeling unappreciated.....	||	||	||	||	||	[3]
Feeling tired.....	||	||	||	||	||	[4]
Problems attending work or school	||	||	||	||	||	[5]
Loss of appetite.....	||	||	||	||	||	[6]
Feeling blamed by family members.....	||	||	||	||	||	[7]
Difficulties with memory or concentration.....	||	||	||	||	||	[8]
Wanting to avoid being around people.....	||	||	||	||	||	[9]
Loss of interest in sex or romance.....	||	||	||	||	||	[10]
Feeling that no matter what I do, I still seem to get into trouble.....	||	||	||	||	||	[11]
Feeling nervous or agitated inside.....	||	||	||	||	||	[12]
Problems in completing normal household chores.....	||	||	||	||	||	[13]
Sudden or general feelings of fear or panic..	||	||	||	||	||	[14]
Feeling others complain too much about drinking, drugs, or prescription use.....	||	||	||	||	||	[15]
Shortness of breath.....	||	||	||	||	||	[16]
Feeling unhappy.....	||	||	||	||	||	[17]
Trouble sleeping.....	||	||	||	||	||	[18]
Physical health has interfered with ongoing activity.....	||	||	||	||	||	[19]
Feeling tense.....	||	||	||	||	||	[20]

	None	A Little Bit	Moderate	Quite a Bit	Extreme	
Problems concentrating on work or school.....	||	||	||	||	[21]
Feelings of weakness.....	||	||	||	||	[22]
Wanting to break, smash, or destroy things.....	||	||	||	||	[23]
Suicidal feelings or actions.....	||	||	||	||	[24]
Not feeling close to family members.....	||	||	||	||	[25]
Feelings are frequently or easily hurt.....	||	||	||	||	[26]
Lack of exercise.....	||	||	||	||	[27]
Feeling that something is wrong with my mind.....	||	||	||	||	[28]
Feeling angry at others.....	||	||	||	||	[29]
Feeling unliked by others.....	||	||	||	||	[30]
Feeling that authorities are to blame for some of my problems.....	||	||	||	||	[31]
Feeling inadequate.....	||	||	||	||	[32]
Neglecting hygiene, cleanliness, or neatness.....	||	||	||	||	[33]
Feeling hopeless about the future.....	||	||	||	||	[34]
Using prescription medications for pain, tranquilizing, or sleeping (whether prescribed or not)	||	||	||	||	[35]
Feeling lonely.....	||	||	||	||	[36]
Feeling distressed.....	||	||	||	||	[37]
Specific fears (such as spiders, snakes, closed spaces, heights, etc.)...	||	||	||	||	[38]
Getting sick quite easily.....	||	||	||	||	[39]
Feeling unsafe outside of home.....	||	||	||	||	[40]
Problems working as carefully as usual.....	||	||	||	||	[41]
Guilty feeling..... [42]		||	||	||	||
Feeling out of control of my temper.....	||	||	||	||	[43]
Not feeling worthwhile.....	||	||	||	||	[44]
Feeling angry or irritated at family members.....	||	||	||	||	[45]
Preoccupied with sex.....	||	||	||	||	[46]
Not taking time to relax.....	||	||	||	||	[47]
Feeling unable to control thoughts or activities.....	||	||	||	||	[48]
Not as able to participate in regular social activities.....	||	||	||	||	[49]

	None	A Little Bit	Moderate	Quite a Bit	Extreme	
Having to take orders from those who know less than I do.....	||	||	||	||	||	[51]
Concerned with weight.....	||	||	||	||	||	[52]
Spending more money than is available.....	||	||	||	||	||	[53]
Problems with thoughts going too fast.....	||	||	||	||	||	[54]
Using illegal drugs.....	||	||	||	||	||	[55]
Feeling dissatisfied with things.....	||	||	||	||	||	[56]
Having disturbing thoughts.....	||	||	||	||	||	[57]
Having difficulty with ongoing pain.....	||	||	||	||	||	[58]
Seeing or hearing things others do not.....	||	||	||	||	||	[59]
Problems finishing work or schoolwork.....	||	||	||	||	||	[60]
Feeling that others are out to get me.....	||	||	||	||	||	[61]
Feeling like injuring or hurting myself.....	||	||	||	||	||	[62]
Unable to complete tasks.....	||	||	||	||	||	[63]
Feeling family members are just out for themselves.....	||	||	||	||	||	[64]
Feeling depressed.....	||	||	||	||	||	[65]
Difficulty allowing leisure time for myself.....	||	||	||	||	||	[66]
Feeling anger.....	||	||	||	||	||	[67]
Sensing increasing conflict with others.....	||	||	||	||	||	[68]
Feeling others get in the way of my happiness.....	||	||	||	||	||	[69]
Getting into trouble with authorities.....	||	||	||	||	||	[70]
Feeling others are in control of my mind.....	||	||	||	||	||	[71]
Not eating regular meals.....	||	||	||	||	||	[72]
Having frequent aches and pains.....	||	||	||	||	||	[73]
Drinking alcohol.....	||	||	||	||	||	[74]
Having difficulty making decisions.....	||	||	||	||	||	[75]
Fears of abusing children.....	||	||	||	||	||	[76]
Feeling physically unhealthy.....	||	||	||	||	||	[77]
Avoiding open spaces.....	||	||	||	||	||	[78]
Feeling like injuring, beating, or hurting someone else.....	||	||	||	||	||	[79]
Avoiding crowds.....	||	||	||	||	||	[80]