LACY THERAPY
Clinical Social Worker • Marriage & Family Therapist

Stephanie Lacy, LCSW LMFT, LLC

PSYCHOTHERAPY

Welcome!

This questionnaire is to assist me in better understanding your situation/problem. I recognize that there are a lot of questions, so if you do not understand a particular question or feel uncomfortable answering a question, feel free to leave it blank. I will review this questionnaire and discuss it thoroughly together with you in our first appointment.

Treatment with my office is voluntary and can be terminated at any time without penalty. My goal is to be as helpful to you as possible and to assist you in most effectively dealing with your current problems. If at any time you have any questions, concerns or ways I might improve my services, I would appreciate your input.

I understand that in all cases, strict standards of confidentiality and professional ethics will be maintained. I strive to protect and preserve the confidentiality of the patient's personal health information. I have a detailed document called the "Notice of Privacy Practices." It contains more information about policies and practices protecting the patient's privacy and is available upon request. I understand that I have the right to read the "Notice" before signing.

HIPAA ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct. plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly:
- Obtain payment from third-party payers: and
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understood the Notice or Privacy Practices. I understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy.

I authorize Stephanie Lacy, LCSW LMFT,LLC to release and/or obtain my records to/from other physicians for the purpose of continuity of care.

Signature of Patient. Parent or Guardian | Relationship to Patient | Date

AUTHORIZATION FOR TREATMENT & PAYMENT

I hereby consent to treatment bythe health care provider Stephanie Lacy, LCSW LMFT.

Signature of Patient. Parent or Guardian | Relationship to Patient | Date

Print Full Name

404-345-7062
770-531-7062 (FAX)

2335 LIMESTONE OVERLOOK
SUITE B
GAINESVILLE, GEORGIA 30501

Stephanie Lacy, LCSW LMFT, LLC

PSYCHOTHERAPY

Financial Policy and Assignment of Benefits

It is the policy of my office to request payment for services at the time the service is rendered. If it would be more helpful for you to pay the deductible and co-pay, I will be glad as a service to file your insurance for you. However, I cannot guarantee payment in part or in full by any insurance company or other third party, and therefore, you are ultimately responsible for any charges you incur. Co-payments are requested at the time of service. Your insurance requires that I collect a co-pay according to my contract with them. If you do not have your co-pay at the time of your visit, you will be charged a $6.00 billing fee. I accept payments by credit card, debit card, cash or check.

Missed Appointments and Cancellations:

I require a 24-hour notice of cancellation if you are unable to keep your scheduled appointment. There will be a charge of $60.00 for any appointment which is not cancelled with a 24-hour notice. Please be aware that your insurance company will not reimburse for missed appointments. If you incur a balance and it is not paid within two months from the date of service, a $6.00 billing fee will be added to your balance for each monthly statement mailed.

Insurance Information:

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Phone No.: _____ Insured's SS#: _____

Insured's Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance:

Insurance Company: _____ Policy #: _____

Employer: _____ Group #: _____

Secondary Insurance:

Insurance Company: _____ Policy #: _____

Employer: _____ Group #: _____

Note: In cases of divorce and/or separation, the parent who originally brought the child in for services is responsible for paying the office, regardless of which parent is legally responsible for insurance coverage and medical bills, as established by a divorce or any other agreement. Assignment from the non-custodial parents insurance carrier will be accepted only after this office has his/her signature on file.

I HAVE READ ANO UNDERSTOOD THE ABOVE BILLING POLICY, I AGREE TO PAY FOR SERVICES UNDER THE CONDITIONS AND SPECIFICATIONSSET FORTH IN THE BILLING POLICY AND ACKNOWLEDGE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES PROVIDED, REGARDLESS OF INSURANCE COVERAGE.

Assignment of Benefits: I authorize the release of any information necessary to process claims and direct payment to myself as the provider who accepts assignment.

_____

Signature of Client, Parent or Guardian | Relationship to Client | Date

404-345-7062
770-531-7062 (FAX)

2335 LIMESTONE OVERLOOK
SUITE B
GAINESVILLE, GEORGIA 30501

PATIENT INFORMATION

Patient Name: _____

Age_____ Date of Birth_____ Sex M / F SS#_____

Marital Status: Single_____ Married_____ Widowed _____ Divorced _____ Separated ____

Address_____

City: _____ State: _____ Zip: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____Occupation:_____

Race & Ethnicity (*Per the Federal government, we are asked to gather the following information*)

Race: American Indian / Alaskan ___ Asia ___ Black / African American ___ Hawaiian / Pacific Islander ___ White ___
Ethnicity: Hispanic or Latino ___ Not Hispanic or Latino ___ Declined ___

Email Address_____ (*For Couple's Therapy*) **Partner Email Address:** _____

Preferred Method of Communication (Choose One): Home Phone: ____ Cell Phone: _____ **Email:** _____

Preferred Contact (if other than patient): _____Contact Phone_____

For Couple's Therapy

Partner Name_____ Date of Birth_____ Partner Phone No.: _____

SS#_____Employer:_____Occupation: _____

REFERRING PHYSICIAN or Other Source:

Referral Source: _____

EMERGENCY NOTIFICATION

Name_____Relationship: _____ Phone: _____

AUTHORIZATION FOR COMMUNICATION

Please identify if there is anyone, other than yourself, who you give permission for our office to discuss your bill on your behalf:

Name: _____Relationship: _____ Phone: _____

_____ _____

Signature Date

I. Presenting Problem

Describe in one sentence what prompted you to schedule an appointment:

_____

_____

What Problems are you currently experiencing?	How Long?	Worsening/Improving/Unchanged?
1.		
2.		
3.		

Please circle symptoms that apply:

Decreased appetite	Explosive temper	Decreased sleep	Auditory hallucinations
Increased appetite	Self-criticism	Trouble waking too early	Intrusive thoughts
Low energy	Tearfulness	Violence	Bothersome thoughts
High energy	Impulsivity	Aggression	Inability to hold a job
Withdrawal from others	Distractibility	Nightmares	Relationship problems
Decreased ability to enjoy things	Decreased concentration	Sexual problems	Alcohol / Drug problems
Excessive worrying	Sleeping too much	Visual hallucinations	Legal problems

As a child, please circle any symptoms that applied:

History of ADD/ADHD	School failure	Stealing	Sexual problems
Decline in grades	Unusual fears	Explosive behavior	Problems with the law
Developmental disability	Tics	Fire setting	Problems with friends
Learning disability	Bed wetting	Runaway	Cruelty to animals
Skipping school	Lack of respect for authority	Alcohol/drug use	
Avoidance of school	Lying	Tobacco use	

Please check significant stressors experienced in the past year:

	Major Losses:	
	Moves:	
	Work:	
	Family:	
	Other:	

II. Past Psychiatric History

Previous Outpatient Treatment	Treatment Date	Treatment Provider	Reason for Treatment	Results
Psych Hospitalization				

**** Check medications previously taken for depression, anxiety, etc...(On Back Page)***

III. Past Substance Abuse History

Substance Used Alcohol/Drugs	Age Started	Time Period Of Use	Amount Used	Date of Last Use	Effects/ Consequences	Treatment

IV. Family History

Please identify any of the following family members who have experienced problems with:

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Aunt	Uncle
Depression										
Anxiety										
Bipolar										
Schizophrenia										
Suicide										
Drug/Alcohol Problems										
Abuse										

V. Medical

If you have or have ever had a problem, please circle:

Diabetes	Breathing Problems	Arthritis	Meningitis
Thyroid Problems	Asthma	Head Injury	Dizziness
High Blood Pressure	Seizures	Anemia	
Heart Problems	Stroke	Kidney Problems	
Rapid Heart Rate	Back Problems	Migraine Headaches	

Other: _____

Primary Care Physician: _____

Surgeries / Major Illnesses	Time Period	Physician

Are you seeing any other physicians or therapists? If so, please list current medications and treating providers:

Medication	Dosage	Start Date	Reason	Prescribing Physician

Medication Allergies: _____Yes _____No If yes, medication allergy: _____

V. Social

Who currently lives in your household?

Name	Age	Relation

Marital status for self: _____ Number of marriages: _____ Length of present marriage: _____

Dates of previous marriages: _____

Work History:

_____ Employed _____ Unemployed _____ Disabled _____ Retired

Current Job: _____ Length of Employment: _____

Work Related Concerns: _____

Educational Background:

Adults - Last Completed Grade: _____ Child - Current Grade:School:

School Changes: _____

School Concerns: _____

Legal Background:

Adults - Past or present legal problems: _____

Child - Legal problems: _____

Custody Information: _____

Support System:

Number of close friends/ family members: _____

Changes with relationship to friends: _____

Hobbies / Interests: _____

Religious preference / Beliefs: _____

LIST OF MEDICATIONS

TRADE NAME	GENERIC NAME

Antipsychotic Medications

	Abilify	aripiprazole
	Clozaril	clozapine
	Compazine	prochlorperazine
	Fanapt	iloperidone
	Geodon	ziprasidone
	Haldol	haloperidol
	Invega	paliperidone
	Latuda	
	Lidone	molindone
	Loxitane	loxapine
	Mellaril	thioridazine
	Moban	molindone
	Navane	thiothixene
	Orap (for Tourette's syndrome)	pimozide
	Permitil	fluphenazine
	Prolixin	fluphenazine
	Risperdal	risperidone
	Saphris	asenapine
	Serentil	mesoridazine
	Seroquel	quetiapine
	Stelazine	trifluoperazine
	Taractan	chlorprothixene
	Thorazine	chlorpromazine
	Trilafon	perphenazine
	Vesprin	trifluopromazine
	Zyprexa	olanzapine

Mood Stabilizer Medications

	Cibalith-S	lithium citrate
	Depakote, Depakene	valproic acid
	Eskalith	lithium carbonate
	Lamictal	lamotrigine
	Lithane	lithium carbonate
	Lithobid	lithium carbonate
	Neurontin	gabapentin
	Tegretol	carbamazepine
	Topamax	topiramate
	Trileptal	oxcarbazepine

Anti-Anxiety Medications

	Ativan	lorazepam
	Klonopin	clonazepam
	Valium	diazepam
	Xanax	alprazolam
	Vistaril	
	Buspar	
	Tranzene	clorazepate
	Librium	chloriazepoxide
	Centrax	prazepam
	Serax	oxazepam

Antidepressant Medications

	Adapin	doxepin
	Anafranil	clomipramine
	Asendin	amoxapine
	Aventyl	nortriptyline
	Celexa (SSRI)	citalopram
	Cymbalta	duloxetine
	Desyrel	trazodone
	Effexor	venlafaxine
	Elavil	amitriptyline
	Lexapro (SSRI)	escitalopram
	Ludiomil	maprotiline
	Luvox (SSRI)	fluvoxamine
	Marplan (MAOI)	isocarboxazid
	Nardil (MAOI)	phenelzine
	Norpramin	desipramine
	Pamelor	nortriptyline
	Parnate (MAOI)	tranylcypromine
	Paxil (SSRI)	paroxetine
	Pertofrane	desipramine
	Pristiq	desvenlafaxine
	Prozac (SSRI)	fluoxetine
	Remeron	mirtazapine
	Serzone	nefazodone
	Sinequan	doxepin
	Surmontil	trimipramine
	Tofranil	imipramine
	Vivactil	protriptyline
	Wellbutrin	bupropion
	Zoloft (SSRI)	sertraline

Sleep Medications

	Ambien / Ambien CR	zolpidem
	Restoril	temazepam
	Sonata	zaleplom
	Rozerem	
	Vistaril	
	Desyrel	trazodone
	Lunesta	eszopiclone
	Halcion	trazaim
	Dalmane	flurazepam/

Alzheimer/Dementia Medications

	Aricept	
	Excelon	
	Luvox	Fluvoxamine

ADD/ADHD Medications

	Adderall	amphetamine
	Adderall XR	amphetamine (extended release)
	Concerta	methylphenidate (long acting)
	Cylert	pemoline
	Dexedrine	dextroamphetamine
	Dextrostat	dextroamphetamine
	Focalin	dexmethylphenidate
	Intuniv	guanfacine
	Metadate ER	methylphenidate (extended release)
	Ritalin	methylphenidate
	Vyvanse	lisdexamfetamine