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 by the 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

Couple Intake

I. Presenting Problem

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

_____

_____

What Problems are you Currently Experiencing?	How Long?	Is this worsening, improving, or 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 problem
Excessive worrying	Sleeping too much	Visual hallucinations	Legal problems

Partner **- 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 problem
Excessive worrying	Sleeping too much	Visual hallucinations	Legal problems

Please check significant stressors experienced in the past year:

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	Major Losses:	
	Moves:	
	Work:	
	Family:	
	Other:	

II. Past Therapy / Treatment History

Previous Therapy	Therapy Date	Therapist	Reason for Therapy	Results

Partner:

Previous Therapy	Therapy Date	Therapist	Reason for Therapy	Results

III. Past Substance Abuse History

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

Partner:

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

Please list current medications and treating providers:

Medication	Dosage	Start Date	Reason	Prescribing Physician

***Partner*, please list current medications and treating providers:**

Medication	Dosage	Start Date	Reason	Prescribing Physician

IV. Family History

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

	Mother	Father	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Brother	Sister	Aunt	Uncle
Depression										
Excessive Anxiety										
Bipolar										
Schizophrenia										
Suicide										
Drug/Alcohol Problems										
Abuse										

Partner:	Mother	Father	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Brother	Sister	Aunt	Uncle
Depression										
Excessive Anxiety										
Bipolar										
Schizophrenia										
Suicide										
Drug/Alcohol Problems										
Abuse										

V. Medical History

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

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

Partner:

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

Surgeries / Major Illnesses	Time Period	Physician

Partner:

Surgeries / Major Illnesses	Time Period	Physician

V. Social History

Who currently lives in your household?

Name	Age	Relation

Number of marriages: ____Length of present marriage: _____Dates of previous marriages: _____

Partner:

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: _____

Partner: ____ Employed _____ Unemployed _____ Disabled _____ Retired

Current job: _____ Length of Employment: _____

Work Related Concerns: _____

Educational Background:

Last Completed Grade: _____ ***Partner:*** - Last Completed Grade:_____

Legal Background:

Past or present legal problems: _____

Custody Information: _____

Partner - Past or present legal problems: _____

Custody Information: _____

Support System:

Number of close friends/ family members: _____

Hobbies / Interests: _____

Religious preference / Beliefs: _____

VI. Previous Medication taken for Depression, Anxiety, Etc.

Anti—Depressants	Any Side Effects

Partner:

Mood Stabilizers	Any Side Effects

ADD / ADHD Medication	Any Side Effects

Sleep Medication	Any Side Effects

Anti—Anxiety Medications	Any Side Effects

Anti—Psychotic Medication	Any Side Effects

Alzheimers / Dementia Medication	Any Side Effects

Medication Allergies: _____ **Yes** _____ **No**

If yes, medication allergy: _____

Partner:

Medication Allergies: _____ **Yes** _____ **No**

If yes, medication allergy: _____