LIFESTREAM BEHAVIORAL CENTER

CONSUMER INFORMATION UPDATE

DO NOT WRITE IN SHADED AREAS – FOR OFFICE USE ONLY

Consumer Type: ☐**ESTABLISHED** ☐**NEW** ☐**NON-ADMIT**	**Date:**	**Preferred Language**:

NAME: Last, First Middle

ALIAS:

DATE OF BIRTH	SOCIAL SECURITY #	**Client ID #**

SEX	RACE	ETHNICITY	MARITAL STATUS
☐M ☐F	☐ American Indian/Alaskan ☐ Asian ☐ Black ☐ Hawaiian/Pacific Islander ☐ Multi-Racial/Other ☐ Unk ☐ White	☐ Cuban ☐ Haitian ☐ Mexican ☐ Mexican American ☐ None of the Above ☐ Other Hispanic ☐ Puerto Rican ☐Spanish/Latino	☐ Divorced ☐ Legally Separated ☐ Married ☐ Registered Domestic Partner ☐ Separated ☐ Single ☐ Unreported ☐ Widowed

EMPLOYMENT STATUS			
☐Active military, overseas ☐ Active military, USA ☐ Disabled ☐ Employed in family run business	☐ Full time ☐ Full time student ☐ Homemaker ☐ Inmate, criminal	☐ Inmate, other ☐ Leave of absence ☐ Not authorized to work ☐ Part time	☐ Part time student ☐ Retired ☐ Self employed ☐ Terminated/unemployed ☐ Unknown

ADMISSION TYPE	**AGENCY ADMISSION DATE**	**ASSIGNED CLIENT ID#**
☐**Voluntary competent** ☐**Voluntary incompetent** ☐**Involuntary competent** ☐**Involuntary incompetent**		

HOMELESS	CURRENT ADDRESS ZIP CODE CITY STATE COUNTY
☐Yes ☐No	

HOME TELEPHONE #	WORK TELEPHONE #	CELL TELEPHONE #	EMAIL ADDRESS*

PERMANENT ADDRESS ☐Same as Current ☐None ☐ Other as noted below

Permanent Address City State Zip Code

MAILING ADDRESS ☐Same as Current ☐None ☐ Other as noted below

Mailing Address City State Zip Code

PRIMARY CARE PROVIDER (Who do you go to when you have a cold or the flu?)

Name: Address: Phone:

DISCLOSURES OF INFORMATION	**CONSENTS SIGNED:**	REFERRED BY: (provide name, agency, &/or circumstance of referral)
☐ **Family Members, inc Emergency Contact** ☐ **PCP Notification** ☐ **Referral Source (s)** ☐**Other _____**	☐**Agreement for Treatment** ☐**Consumer Guarantor** ☐***Electronic Correspondence** ☐ **Rights & Responsibilities**	

INCOME (check & supply amount – **Must be Filed in Completely**)

INDIVIDUAL: $_____ SPOUSE: $_____ ☐Food Stamps $_____ ☐SSI $_____ Other $_____

☐SSDI $_____ ☐TANF $_____ ☐Child Support $_____ OSS $_____ ☐ Soc Sec $_____

TOTAL HOUSEHOLD INCOME	☐ Monthly $	☐ Annual $	# in HOUSEHOLD

- Please Continue on Back -

CONFIDENTIAL AND PRIVILEGED
For Professional Use Only

LifeStream Behavioral Center

DO NOT WRITE IN SHADED AREAS – FOR OFFICE USE ONLY

Name	Last	First	Middle

If name is changed, please complete information below:

Did you provide opportunity to update voter registration:? ☐YES ☐NO ☐Provided ☐Declined (Not Interested) ☐Already a registered voter

OCCUPATION	If minor, FATHER NAME EMPLOYER ADDRESS	HOW LONG	TELEPHONE #

SPOUSE OCCUPATION	If minor, MOTHER NAME EMPLOYER ADDRESS	HOW LONG	TELEPHONE #

RESPONSIBLE PARTY	MEDICARE #	MEDICAID #	POLICY #

INSURANCE COVERAGE: Company Name Group or Individual Name of Policy Holder Date Of Birth

PHARMACY BENEFIT: Company Name Plan Name Account Number

CONTACTS:

NAME	RELATION	RESPONSIBLE PARTY	GUARANTOR	EMERGENCY CONTACT	GUARDIAN

****** Proof of Income **MUST BE VERIFIED ANNUALLY** in order to qualify for financial assistance.

Please sign and date to attest that all the information provided is true and accurate.

_____ Consumer's Name (Please **PRINT**)

_____ _____

Signature of Consumer or Consumer Representative Date

_____ _____

Witness Signature Date

LifeStream
Where Hope Comes to Life

STATEMENT ON PRESCRIPTION PRACTICES

In order for us to assist you with your ongoing prescription needs, it has become necessary for us to ask that you comply with the following practice concerning your refills.

At the time of each appointment with us, please bring either all medication bottles or a complete list (including dosage and quantity information) of all medications you take. We especially need to know about all over-the-counter medications you are taking (vitamins, herbal supplements, etc.). We will use this information to make sure our records reflect your current medication information, which will help us in monitoring your health care. You will be asked to sign a release for us to contact your PCP.

Please try to anticipate when you will need a new prescription in order to refill your medications and ask for those prescriptions at the time of your next visit. This should help prevent you from running out of your medication. However, if you do run out, please follow these instructions:

Call your pharmacy to see if you have any remaining refills of the medications in question. Prescription refills will not be authorized if you are not compliant with the required follow-up appointments with your doctor. In such cases, you will be required to see your doctor on the next available opening that the doctor has.

Only under extenuating circumstances will your prescription be called in to a local pharmacy. Please allow 72 hours (2-3 working days–Monday-Friday) from the time you call for a new prescription to the time that your prescription (or override on prescription), to be called in. Prescriptions will not be called in to long distance or mail order pharmacies. Check with your pharmacy to verify if your prescription is ready – not the doctor.

Please contact this office if you feel there is a side effect from your medication, there has been a change in dosage or if you have questions regarding your medication.

We do not fax or mail prescriptions to out-of-state prescription plans, pharmacies, or to your home. We will be happy to provide written prescriptions for you to mail or fax. Allow 7 days for all written prescriptions.

Prescriptions requiring preauthorizations may require an office visit to document the continued necessity for that specific medication, or possibly change of medication that is on your prescription drug plan.

By signing this form, you are stating that you agree and understand the above.

_____ _____

Consumer Signature Date

_____

Witness

FISCAL

CONSUMER INSURANCE INFORMATION

THE FOLLOWING INFORMATION MUST BE PROVIDED IN ORDER TO FILE YOUR INSURANCE:

Name: _____
PRINT Last First MI

Consumer's Marital Status: ☐Single ☐Married ☐Other _____

☐Employed ☐Full Time Student ☐Part-time Student

Insurance Provider: _____

Name of Insured: _____

Insured's Date of Birth: _____ Sex: ☐Male ☐Female

Insured's Social Security #: _____

Insured's ID Number: _____

Policy Number: _____ Group Number: _____

Insured's Employer's Name: _____

Is there another health benefit plan: ☐YES ☐NO

If yes, Provider: _____

Other Insured's Name: _____

Date of Birth: _____ Sex: ☐Male ☐Female

Other Insured's Policy or Group Number: _____

Other Insured's ID Number: _____

Insurance Plan Name: _____

_____ _____
Witness Consumer's Signature

_____
Date

Original: Insurance Dept.
CC: Chart

JOINT NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003 – Revised: June 14, 2013

THIS DOCUMENT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Officer.

WHO WILL FOLLOW THIS NOTICE

LifeStream Behavioral Center, Inc. ("LifeStream") practices are followed by:

- Any Medical Staff members of LifeStream.
- Any health care professional authorized to enter information into your health record.
- Any member of a volunteer group we allow to help you while you receive services from LifeStream.
- All employees, staff, and other LifeStream personnel and consultants/contractors.

Our Responsibilities

LifeStream is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of the notice currently in effect.
- Notify you if we are unable to agree to a requested restriction/amendment
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain at the time. Should our information practices change, we will post our new notice in the reception areas of each of our facilities. We also maintain a website that provides information about our customer services or benefits and will post our new notice on that Web site located at www.lsbc.net.

We will not use or disclose your health information without your authorization, except as described in this notice.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. This record contains information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you. For example, this information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who are involved in your care
- Means by which you or a third-party payer can check that services billed were actually provided.

Your health record contains protected health information. State and Federal law protects this information. Understanding that we expect to use and share your health information helps you to:

- Make sure it is correct,
- Better understand who, what, when, where and why others may access your health information, and
- Make more informed decisions when authorizing sharing with others

Your Health information Rights

Under the Federal Privacy Rules, 45 CFR Part 164, you have the right to:

- Request a restriction on certain uses and sharing of your information but we are not required to agree to any such request. This means you may ask us not to use or share any part of your protected health information for purposes of treatment, payment or healthcare operation. You may also ask that this information not be disclosed to family members or friends who may be involved in your care. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- Request that we send you confidential communications by alternative means or at alternative locations but you must specify in writing how or where you wish to be contacted.
- Obtain a paper copy of the notice of information practices upon request. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may print out a copy of this notice from our website.
- Inspect and obtain a copy of your health record. You have the right to inspect and copy your mental health information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed mental health professional chosen by LifeStream. LifeStream will comply with the outcome of the review.
- Request that your health record containing protected health information be clarified. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. You may ask for a form for that purpose and the form will require certain specific information. LifeStream is not required to accept the information that you propose.
- An accounting of disclosures. You may request a list of the disclosures of your mental health information that have been made to persons or entities other than for treatment or health care operations in the last six (6) years, but not prior to April 14, 2003.
- Take back your authorization to use or share health information except to the extent that action has already been taken

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a physician, therapist or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. For example, if you are seeing both a physician (psychiatrist) and a psychotherapist, they may share information in the process of coordinating your care. Another example: our physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or with your consent to a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. You have the right to restrict certain disclosures of PHI to health plans/insurance companies if you pay out of pocket in full for the health care service.

We will use your health information for regular health operations.

For example: Staff may look at your record when reviewing the quality of services you were provided. Members of the risk management or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide. We may use and disclose medical information to contact you as a reminder that you have an appointment.

We may use and disclose protected health information to tell you about or recommend treatment alternatives or other health-related benefits and services that may be of interest to you.

Business Associates: There are some services provided in our organization through contracts with Business Associates. Examples include contracts for transcription services, training and other educational services, and collection services. Information shall be made available on a need-to-know basis for these activities associated with compliance with regulatory agencies. Whenever an arrangement between LifeStream and a business associate involves the use or sharing of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Qualified Service Organization (QSO): If you are receiving alcohol or drug abuse services from LifeStream, information that would identify you as a person seeking help for a substance abuse problem is protected under a separate set of federal regulations known as "Confidentiality of Alcohol and Drug Abuse Consumer Records", 42 C.F.R. Part 2. In order to facilitate communication with other organizations that provide services such as legal advice, laboratory analyses or vocational services to our organization and consumers, this regulation permits us to establish a confidentiality agreement, known as a Qualified Service Organization Agreement (QSOA).

Under a QSOA LifeStream is permitted to share, without your consent, information about the substance abuse care that you are receiving with the other organization signing the QSOA. However, the QSOA requires that the other organization abide by these same federal confidentiality regulations in order to keep information about your substance abuse problem and the care you are receiving confidential. This means that the other organization must handle and store your information in a way that maintains its confidentiality. The organization cannot release your confidential information to anyone except back to LifeStream. In addition, it must resist in all judicial proceedings, any attempt to access your protected information.

Under no circumstances can LifeStream establish a QSOA with another organization providing substance abuse services similar to our own or with law enforcement agencies. Only you can give written permission to LifeStream before we can share confidential information about the treatment of your substance abuse problem with these types of organizations.

Uses and Sharing of Information Specifically Authorized by You:

Other uses and sharing of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

Marketing and Fundraising:
We may only use or share your health information in connection with limited marketing or fund-raising. We may disclose medical information to our foundation so that it may contact you in raising money. We would only release contact information such as: your name, address, and phone number, and the dates you received treatment or services. If you do not want the foundation to contact you about fundraising efforts, you must notify the Privacy Officer in writing in order to opt-out. Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information (PHI) for marketing purposes, and disclosures that constitute a sale of PHI require your authorization

Others Involved in your Healthcare:
With your consent, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to consent to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Uses and Disclosures That We May Make Unless You Object:

Emergencies:
We may use or share your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable. Finally, we may use or share your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted And Required Uses and Sharing That May Be Made Without Your Consent, Authorization Or Opportunity To Object. (Except as prohibited by 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Consumer Records)

We may use and share your protected health information in accordance with the requirements of law including the following instances:

Public Health:
As required by law, we may disclose your protected health information to state and federal public health, or legal authorities charged with preventing or controlling disease, injury, or disability. We may share your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may be at risk of getting or spreading the disease or condition. Information will be released to avert a serious threat to health or safety. Any disclosure, however, would only be to someone authorized to receive that information pursuant to law.

Food and Drug Administration (FDA):
We may disclose to the FDA health information relative to adverse events with respect to food, supplements product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Abuse, Neglect, Exploitation:
We may disclose your relevant protected health information if we believe that you have been a victim of abuse, neglect, exploitation or domestic violence to the governmental agency authorized to receive such information.

Health Oversight:
We may share your protected health information to health oversight agencies such as federal and state Departments of Health and Human Services, Medicare/Medicaid Peer Review Organizations, and the Florida advocacy councils for activities such as audits, investigations and inspections, compliance with civil rights laws and complaints concerning LifeStream.

Research:
We may disclose your protected health information to researchers when their research has been approved and the use or access to your protected health information has been determined to be necessary by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Coroners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose relevant protected health information to a funeral director, as authorized by law in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Law Enforcement/Legal Proceedings
We may disclose mental health records for law enforcement purposes as required by law or in response to a valid subpoena, discovery request or other lawful process. These law enforcement purposes include (1) legal processes and otherwise required by law; (2) limited information requests for identification and location purposes; (3) pertaining to victims of a crime; (4) suspicion that death has occurred as a result of criminal conduct; (5) in the event that a crime occurs on the premises of LifeStream, including its facilities; (6) medical emergency and it is likely that a crime has occurred; and (7) if you declare an intention to harm others, information sufficient to provide adequate warning to the person threatened with harm may be released. Also we may disclose information to government for national security and intelligence reasons. For example, during an FBI investigation we may release information in response to a lawful subpoena or order of the court.

Correctional Institution

Should you be an inmate of a correctional institution, we may disclose to the Department of Corrections, protected health information necessary for your health and the health and safety of other individuals.

Workers Compensation
We may disclose protected health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Other uses and disclosures not described above in the Privacy Notices will be made only with authorization from you.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CONSUMER INFORMATION

If you are receiving alcohol or drug abuse services from LifeStream, information that would identify you as a person seeking help for a substance abuse problem is protected under a separate set of federal regulations known as "Confidentiality of Alcohol and Drug Abuse Consumer Records", 42 C.F.R. Part 2. Under certain circumstances these regulations will provide your protected health information with additional privacy protections beyond those that have already been described.

For instance, in general, any information identifying you as addressing a substance abuse problem cannot be shared outside of LifeStream without your specific consent in writing to do so. Exceptions to this rule include court orders to release your protected health information, the provision of your protected health information to medical personnel in an emergency, sharing information with

qualified personnel conducting research and for audits or program evaluations. For example, before your substance abuse health related information can be released to family, friends, law enforcement, judicial and corrections personnel, public health authorities, or other providers of medical services, we are required to ask for your written authorization to do so.

42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Consumer Records, does allow a health care provider to comply with the Florida statute requiring the reporting of suspected child abuse or neglect to the Department of Children and Family Services. However, before specific information pertaining to the care you are receiving for your substance abuse problem can be released, you must authorize the release in writing. Child abuse and neglect authorities may also pursue a court order to release the information without your written permission.

In those instances where you did authorize us to release your substance abuse related health information, the authorization will always be accompanied by a notice prohibiting the individual or agency/organization receiving your health information from re-releasing it unless permitted under 42 C.F.R., Confidentiality of Alcohol and Drug Abuse Consumer Records.

Notice of Privacy Practices Availability:

This notice will be prominently posted in the reception areas of each of our facilities. Individuals will be provided a hard copy and the notice will be available on the LifeStream website at www.lsbc.net.

You have the right to be notified following a breach of your unsecured protected health information.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

For More Information Or To Report A Problem

If you have questions and would like additional information, you may contact Tim Camp, the Privacy Officer at P. O. Box 491000, Leesburg, Florida 34749-1000 (515 W. Main Street, Leesburg); telephone number: 352-315-7511.

If you believe your privacy rights have been violated, you can file a complaint with LifeStream's Privacy Officer (above) or with the Office of Civil Rights; US Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, DC 20201; or OCR Hotlines-Voice: 1-800-368-1019. There will be no retaliation for filing a complaint.

LifeStream

INDIVIDUAL AUTHORIZATION

DISCLOSURE OF CONFIDENTIAL INFORMATION

I,_____ (DOB:),_____, by signing this Authorization form, authorize the use and disclosure of my health information in the manner described below. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or eligibility for health care benefits. I have signed this form voluntarily in order to document my wishes regarding the use and disclosure of the health information described below in Section 1.

1. Description of Health Information I Authorize to be Used and Disclosed.

(Check all that are appropriate.)

- ☐ All records
- ☐ Diagnosis
- ☐ Discharge Recommendations
- ☐ Evaluation Results
- ☐ Inpatient Treatment
- ☐ Outpatient Treatment/Services
- ☐ Laboratory or Medical Tests, inc. U/A
- ☐ Medication Profile
- ☐ Dates of Service Letter
- ☐ Educational Records
- ☐ Other_____

I understand that the above information I have authorized to be used and dis-closed may contain information related to HIV/AIDS, sexually transmitted diseases, mental health (excluding psychotherapy notes – a separate authorization is required), substance use disorders unless otherwise restricted by me.

List any restrictions:_____

_____

2. LifeStream May Release/Receive Information to/from the Following Person/Organization. (List any person or organization with whom LifeStream may communicate):

Purpose: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

2a. LifeStream May Release/Receive Information through a Health Information Exchange (HIE)to/from the following Organization (List the organization with whom LifeStream may communicate through an HIE):

Purpose: Continuity of Care _____

Name: _____

Portal: _____

Phone: _____ Fax: _____

NOTE: Confidentiality, HIPAA and 42 CFR, Part 2 requires one (1) Individual or Organization per Release.

3. Information Regarding the Release of Medical Records.

I understand that if the persons/organizations listed above are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and organization(s) may re-disclose my health information without obtaining my authorization, subject to the limitations imposed by 42 CFR, Part 2 regarding substance use disorders records. Therefore, I release LifeStream Behavioral Center from all liability arising from this further disclosure of my health information.

The charge for copying medical records is as follows:

Outpatient	Specific documents	$15.00
Outpatient	Entire chart or multiple admissions	$25.00
Inpatient/Outpatient	Combination	$30.00
Inpatient	One Admission	$15.00
Inpatient	Multiple Admissions	$25.00
Psychiatric Evaluation	Only	$ 3.00

4. Your Rights with Respect to this Authorization.

I understand that under the confidentiality provisions of Florida Statute 394.4615 (2), 397.501(7) and Federal Regulation 42 CFR Part 2, only the above specified information can be disclosed to the above-named person(s) or agency(s). I also understand according to state and federal law that I may revoke this authorization at any time, provided that if I do so in writing, except to the extent that action has been taken in reliance upon this authorization. To obtain a copy of an authorization revocation form I may contact the Privacy Officer. Subject to certain restrictions imposed by state and federal law, I understand that I have the right to inspect or copy health information or obtain copies of my health information by contacting the Privacy Officer. I understand that I may request a log of the disclosures made if the release of information is subject to requirements of 42 CFR, Part 2 as amended and effective August 2020. I understand that if I agree to sign this authorization, I must be provided a signed copy of it.

5. Expiration of Authorization.

This authorization will expire 365 days from the date of signing or until the occurrence of the following event(s) related to the purpose of this authorization: _____

_____ _____
Signature of Individual Signature of Parent or Personal Representative (where required

_____ _____
Date of Signature Description of Personal Representative's Authority

_____ _____
Witness Individual's Client ID

LifeStream

OUTPATIENT MEDICAL ASSESSMENT

CONSUMER:	**CID #:**
DATE:	**STAFF:**
PROGRAM:	

GENERAL HEALTH: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

INFORMATION SOURCE: ☐ No Historian ☐ Consumer ☐ Other: _____

LIST CURRENT & PREVIOUS MEDICAL PROBLEMS

Date: Medical History:

Diagnosis/Presenting Problem:

Treatment:

Comments:

LIST CURRENT & PREVIOUS MEDICAL MEDICATIONS

Date: Medication: Strength:

Frequency: Route: Dose:

Instructions: Date Begun: Currently Taking: ☐Yes ☐No ☐Discontinued

Physician First Name: Last Name:

ALLERGIES

Date: Staff: Program:

Allergy Type: Allergy: Type:

Start Date: End Date:

Status: ☐ Active ☐ Inactive Source: ☐Consumer ☐Family/Friends ☐Agency/Professional ☐Other

Severity: Validity: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe ☐ Life Threatening Severity ☐ Fatal

Reaction:

STAFF VERIFICATION

Date: Staff Verified By:

☐ Verified ☐ Trustworthy ☐ Uncertain ☐ Unknown

Are you on a special diet?

Do you have physical limitations?

What kind?

FEMALES ONLY:

Last Menstrual Period _____ ☐ Menopause ☐ Post Menopause

Date of Last Physical _____

Consumer: _____ Date: _____

NECK
- ☐ Goiter in Neck
- ☐ Neck Lump or Swelling
- ☐ Neck Pain or Stiffness

THROAT AND MOUTH
- ☐ Frequent Sore Throat
- ☐ Hoarseness
- ☐ Bleeding Gums

EARS
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Earache or Discharge
- ☐ Ear Infections

VISUAL
- ☐ Eye Strain
- ☐ Seeing Double
- ☐ Seeing Halos About Light
- ☐ Contact Lens

HEART AND LUNGS
- ☐ Chronic Cough
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Night Sweats
- ☐ Chest Pain or Pressure
- ☐ Palpitations or Fluttering
- ☐ Swollen Ankles

NEUROLOGICAL
- ☐ Frequent Headaches
- ☐ fainting Spells
- ☐ Convulsions (Seizures)
- ☐ Paralysis or Weakness
- ☐ Dizzy Spells

BREAST
- ☐ Lump in Breast
- ☐ Pain in Breast

EXTREMITIES
- ☐ Arthritis
- ☐ Varicose Veins
- ☐ Cramps in Legs

INTESTINAL
- ☐ Loss of Appetite
- ☐ Trouble Swallowing
- ☐ Nausea or Vomiting
- ☐ Vomiting Blood
- ☐ Pain in Abdomen
- ☐ Gall Bladder Trouble
- ☐ Belching Bloating
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool/Hemorrhoids

KIDNEYS
- ☐ Albumin or Sugar in Urine
- ☐ Blood or Puss in Urine
- ☐ Kidney or Bladder Infection
- ☐ Trouble Starting Urine Stream
- ☐ Getting up at Night to Urinate

  How many times? _____

GENERAL
- ☐ Unusual Fatigue
- ☐ Unusual Weakness
- ☐ Abnormal Thirst
- ☐ Unable to Sleep
- ☐ HIV or AIDS exposure
- ☐ Sexual Functioning
- ☐ Physical/sexual abuse
- ☐ Abuse of Prescription or Over the Counter Drugs
- ☐ Anemia
- ☐ Swollen Glands
- ☐ Skin Trouble
- ☐ Back Pain

GYNECOLOGICAL

Number of live births _____

Number of miscarriages _____

Number of abortions _____
- ☐ Problems with Period

Drug
- ☐ Non-Prescription

ILLNESSES IN FAMILY

CURRENT ILLNESSES WHICH RUN IN YOUR FAMILY

	YOU	FAMILY
Diabetes	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Seizure/Epilepsy	☐	☐
Tuberculosis	☐	☐
Sickle Cell Diseases	☐	☐
Stroke	☐	☐
Bleeding Tendency	☐	☐
Cancer	☐	☐
Nervous Breakdown	☐	☐
Suicide	☐	☐
Alcohol or Drug Abuse	☐	☐
Physical/Developmental	☐	☐
Disabilities	☐	☐

Other _____

RECOMMENDATION

☐ Yes ☐ No ☐ Other

DISPOSITION:

_____
_____
_____
_____
_____

PHYSICIAN/RN COMMENTS REGARDING MEDICAL REFERRAL OR FOLLOW-UP:

_____
_____
_____
_____
_____

PHYSICIAN / RN _____

SIGNATURE DATE _____

FAMILY HEALTH HISTORY

First Name: Last Name: Relationship: Gender: ☐ Male ☐ Female ☐ Other

Pri Race:
- ☐ Consumer Declined to Provide
- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Multi-Racial
- ☐ White

Sec Race:
- ☐ Consumer Declined to Provide
- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Multi-Racial
- ☐ White

Ethnicity:
- ☐ Consumer Declined to Provide
- ☐ Cuban
- ☐ Haitian
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Other Hispanic
- ☐ Puerto Rican
- ☐ Spanish/Latino

Date of Birth: ☐ Identical Twin ☐ Fraternal Twin ☐ Adopted ☐ Not Living

Problem:

Approx Onset Age: _____yrs

Consumer: _____ **Date:** _____

SCREENS

HIV SCREEN – HIGH RISK BEHAVIORS FOR HIV, HEPATITIS C, TB

Has Client…

- Had any blood transfusions in the past ten years?	☐ Yes ☐ No ☐ Unk
- Used intravenous drugs?	☐ Yes ☐ No ☐ Unk
- Engaged in unprotected sex with multiple partners in the past ten years?	☐ Yes ☐ No ☐ Unk
- Ever had herpes, hepatitis A/B/C, syphilis, gonorrhea, Chlamydia, genital sores?	☐ Yes ☐ No ☐ Unk
- Ever tested positive for TB?	☐ Yes ☐ No ☐ Unk
- Expressed interest in counseling?	☐ Yes ☐ No ☐ Unk
- Expressed interest in testing for HIV, Hepatitis C, or TB?	☐ Yes ☐ No ☐ Unk

OCCUPATIONAL HAZARDS

Occupation/Former Occupation: Exposure to Hazards? ☐ Yes ☐ No ☐ Unk

ASSISTIVE DEVICE ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other

Do you need an assistive device? ☐ Yes ☐ No

Vision:	**Hearing:**	**Dental:**
☐ Normal	☐ Normal	☐ Intact ☐ Poor Condition
☐ Impaired	☐ Impaired	☐ Chipped ☐ Missing Teeth
☐ Glasses	☐ Deaf Right Ear	☐ Loose ☐ Removable Bridge
☐ Contacts	☐ Deaf Left Ear	☐ Capped ☐ Permanent Bridge
☐ Glaucoma		☐ Braces ☐ Retainer
☐ Cataracts		☐ Dentures Upper ☐ Dentures Lower
☐ Blind		
☐ False Right Eye		
☐ False Left Eye		
Last Eye Exam: _____	Last Hearing Test: _____	Last Dental Exam: _____

I am aware that maintaining my health is important, especially when taking medications. As such I am aware of the necessity to schedule yearly physical and eye exams. It is also important to get routine lab work (CBC, Chemistry Profile, and Urinalysis); EEG (electrocardiogram), and Thyroid Profile whenever it is recommended. Because I am on medication I will be asked to get lab tests done to test my medication level, for example, Lithium Level. I understand it is my responsibility to follow through with the above recommendations.

SIGNATURE (Consumer or Parent/Guardian): _____ Date: _____

FOR CLINICIAN/COUNSELOR USE ONLY

☐ Consumer advised to follow-up with primary care physician.

☐ Referred to LifeStream MD for Psych/Medical consult. ☐ No follow-up instructions given

Comments: _____

REVIEWED BY (Clinician / Counselor): _____ Date: _____

LifeStream
Where Hope Comes to Life

EXPRESS AND INFORMED CONSENT FOR TREATMENT

Consumer Name: _____ Client ID: _____

I, the undersigned, a ____consumer, ____guardian, _____guardian advocate, _____health care surrogate/proxy, hereby authorize the professional staff of this facility to administer substance abuse and/or mental health assessment and treatment.

I understand that I am responsible for fees for services rendered.

I understand that more information will be provided to me before my informed consent will be requested for the administration of psychotropic medications.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

I have received detailed information about the proposed treatment, its purpose, alternative treatments, approximate length of care, and indications and contraindications of the treatment.

I have read and had this information fully explained to me and have had the opportunity to ask questions and receive answers about the treatment.

I understand that my records are confidential, but that there are some exceptions. LifeStream agrees not to release any information about you, other than to LifeStream staff on a need to know basis (clinical supervision, case staffings, consultations, transfers within LifeStream), without getting your permission in writing. Florida and Federal law protects such information. Violations of these regulations may be reported as a crime. However, there are times when the law also says that information must be shared. These include cases where there is physical and sexual abuse or neglect of children, elders, or disabled persons; there is expression of intent to harm self or others; there is a threat or commission of a crime on LifeStream's premises or to staff; a court order is issued requiring LifeStream to release information; we learn of a contagious disease which may harm others; and/or the State requires that we report consumer data for follow-up study.

Informed Consent for Electronic Messaging ___ Agree ___ Disagree

I understand that I must provide written consent, recognizing that email is not a secure form of communication. There is some risk that any protected health information (PHI) that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. I understand that LifeStream staff will use the minimum necessary amount of protected health information to respond to a query and that the initiation of the email exchange will be by the consumer and never LifeStream staff.

I hereby ____GIVE ____DO NOT GIVE LifeStream permission to contact me.
(We may want to contact you to remind you of appointments or to find out how you are doing during or upon completion of your treatment.)

I hereby ____GIVE ____DO NOT GIVE permission for the Florida Department of Mental Health and Substance Abuse to contact me for follow up study.

You can call me at (_____) _____-_____ During these times: _____

_____ _____
Signature of Consumer Date: mo/day/year

_____ _____
Signature of Witness for Consumer Date: mo/day/year

_____ _____
Signature of (circle appropriate identifier) Parent/Guardian, Guardian Advocate, Health Care Surrogate, Health Care Proxy Date: mo/day/year

LifeStream

CONSUMER RIGHTS AND RESPONSIBILITIES
Non-Hospital

Consumer: _____ CID #: _____

While receiving services from ***LifeStream Behavioral Center***, you have the **right** to ...

1. An environment that preserves dignity and contributes to a positive self-image.
2. Be assigned a primary treatment staff member to provide services, make referrals, and coordinate treatment efforts.
3. Be served in the least restrictive treatment alternative available and consistent with your treatment needs.
4. Have all identifying and treatment information held in a confidential manner.
5. Know that information disclosed concerning abuse, neglect or exploitation of a child, disabled adult, or the elderly MUST be reported to the Department of Children and Families for possible investigation (under Florida State law).
6. Be involved in the development and review the clinical records compiled as a result of treatment.
7. Refuse care, treatment or services at any time (a Court Order may impact this decision).
8. Treatment free from mental, physical, sexual and verbal abuse, neglect and any form of exploitation, or any form of corporal punishment.
9. Review program specific procedures with your counselor.
10. To be informed (and when appropriate, family members and/or the referral source) about the outcomes of care, including unanticipated outcomes.
11. Access protective and advocacy services.
12. Pain management directly or through referral(Inpatient & Residential).
13. Exercise citizenship privileges if you are in an inpatient or residential program.

Grievance Procedure: If you believe that any of your rights, including your rights under Title VI of the Civil Rights Act of 1964 regarding discrimination based on your race, color, sex, national origin, handicap, age or religion have been abridged, you may file a Grievance to address your complaints. Grievance forms may be acquired from the Office Manager or the Center's Administrative Office at 1616 S 14th St., Leesburg. You also have the right to contact the Department of Children and Families' Abuse Registry at 1-800-96-ABUSE to record complaints, SAMH office at 407-317-7000 or the Florida Advocacy Council at 1-800-342-8825.

-Continued on back-

As a consumer of LifeStream you have the **responsibility** to ...

1. Provide accurate and complete information.

2. Schedule appointments during normal office hours from 9 a.m. to 5 p.m. Monday thru Friday or arrange evening hours with your counselor.

3. Meet financial commitments by:
   a) providing annual proof of income to request a reduced fee for services,
   b) paying the established fees for services rendered,
   c) being financially responsible for missed appointments.

4. Ask questions when you do not understand your care or do not know what is expected of you.

5. Show respect and consideration towards staff and others receiving care. You may be held legally responsible for any verbal or physical abuse towards LifeStream staff or other consumers.

6. Follow rules and regulations set forth by program staff.

7. Attend medication appointments to obtain prescription refills.

8. Accept the consequences for outcomes if you do not follow treatment recommendations.

By signing this form, I am verifying that I have read and received a copy of my ***Rights and Responsibilities*** form.

Consumer Signature: _____ Date: _____

- COPY TO CHART -

LifeStream Where Hope Comes to Life	**COORDINATION OF SERVICES / RECONCILIATION OF MEDICATION**

CONSUMER : _____ DOB: _____ Client ID #: _____

To:	**Primary Care Provider** / Center Name:			
	Address:	City:	State:	Zip:
	Phone:	Fax:		
To assist with continuity of care please see attached for a list of medications prescribed by LifeStream in the past year as well as the person's current diagnosis.				

I, _____, hereby authorize the above named healthcare provider to provide to and receive information from: LifeStream Behavioral Center
P. O. Box 491000
Leesburg, FL 34749-1000

LifeStream Contact: Medical Records Phone: (352) 315-7467 Fax: (352) 315-7892

Any and all information which they possess relating to my examinations and illnesses including psychiatric and/or psychological information which may be a part of the medical record. This may include information on substance abuse and/or HIV.

This information is released and/or requested for the purpose of obtaining medical information to integrate care. Your cooperation in sending the following information is appreciated: **Lab results, EEG, EKG, any medications and current medical status for past twelve (12) months.**

I understand that under the confidentiality provisions of Florida Statute 394.495(9) and Federal Regulation CRF 42, only the above specified information can be exchanged with only the above specified person or agency. I also understand that according to State and Federal law I may revoke this exchange of information at any time, providing that I notify LifeStream Behavioral Center in writing to this effect but that revocation has no effect on action previously taken. I further agree that a photocopy of this form shall be as effective as an original.

This exchange of confidential information will automatically expire twelve (12) months from the date of signature or _____.
Expiration Date

_____ _____ _____
Signature of Consumer or Legal Guardian Consumer's Client ID Witness

_____ _____
Date of Signature Date of Signature

LifeStream Behavioral Center is a non-profit organization providing mental health and substance abuse services. Medical records to other health care providers are provided at no cost as a professional courtesy. We gratefully request that this courtesy be extended by your facility for the above requested information.

LifeStream
Where Hope Comes to Life

STRENGTHS NEEDS ABILITIES PREFERENCES

SURVEY FOR

Name: _____ Client ID #: _____ Program: _____

At LifeStream we believe that each person has the strengths and abilities needed to solve their own problems or to recover from the difficulties in their lives. You might be seeking recovery from mental health problems, substance abuse, behavior problems or other life challenges. By answering these questions you can help us understand your individual needs and choices and what talents and skills you have that you could use to make the changes you want.

S

Everyone has <u>strengths</u> like patience, education, faith, a good home or other things that they can use to help them reach their goals. Some of my strengths are:

_____
_____
_____

N

No one's life is perfect and we might have needs that brought us to LifeStream or that make our lives harder or keep us from reaching our goals. I need:

_____
_____
_____

A

We all have <u>abilities</u> or special skills or talents like writing, arts, sports or hobbies that we are good at doing. These can make our lives better. Some of my talents or abilities are:

_____
_____
_____

P

Having choices or <u>preferences</u> makes changing or reaching goals a little easier. Choices could include things like when or where I have my appointments or whether I am part of a group or working with a counselor alone. My choices or preferences are for:

_____
_____
_____

READY? How ready am I to make changes? Please circle where you are now:

Not ready		Unsure			Ready		Already Trying		
1	2	3	4	5	6	7	8	9	10

Thank you for helping us to prepare to help you!

_____ _____
Consumer Date LSBC Staff Date

Note: File With Assessment
GEN:650:R:06/11

CONFIDENTIAL AND PRIVILEGED
For Professional Use Only

LifeStream
Where Hope Comes to Life

CONSUMER QUESTIONNAIRE

NAME: *Last, First, Middle*	**CLIENT ID #:**
SSN#:	**DATE:**

Instructions: *Please check any item which you have ever experienced or are currently experiencing.*

- ☐ Marital stress
- ☐ Other family problems
- ☐ Other relationship problems
- ☐ Problems at work/school
- ☐ Health problems
- ☐ Financial problems
- ☐ Legal problems
- ☐ Sad/depressed
- ☐ Loss of appetite
- ☐ Loss of weight
- ☐ Weight gain
- ☐ Difficulty sleeping
- ☐ Difficulty concentrating
- ☐ Quick change of moods
- ☐ Problems with controlling anger or urges
- ☐ Feeling suicidal
- ☐ Feeling worthless
- ☐ Drawing away from people
- ☐ Lack of interest/enjoyment
- ☐ Too many drugs
- ☐ Too much alcohol
- ☐ Sexual problems
- ☐ Less energy than usual
- ☐ Very talkative
- ☐ Restless/can't sit still
- ☐ Nervous/tense
- ☐ Panicky
- ☐ Shaky/trembling
- ☐ Hard to trust anyone
- ☐ Problems controlling my thoughts
- ☐ Too much worry
- ☐ Too many fears
- ☐ Feeling guilty
- ☐ Feeling angry/ frustrated
- ☐ Nightmares
- ☐ Too much pain
- ☐ Memory problems
- ☐ See/hear strange things
- ☐ Feeling others are out to get me
- ☐ Watched/talked about by others

Comments:

_____ Consumer's Printed Name

_____ Consumer's Signature

LifeStream

PATIENT PORTAL REGISTRATION

Welcome to LifeStream's Patient Portal Registration. In order to register for the Patient Portal, you will need to supply the following information:

Consumer's Name: _____ CID #: _____

Name of Provider you will see today: _____

E-mail address: _____

Create a Password (must be 8 characters and include a number): _____

Consumer's Date of Birth: _____

If the consumer is under 14 years of age: Parent's Name, DOB, Parent's phone number and zip code and Child's Name and DOB, are required.

Parent's Name: _____ **Date of Birth**: _____

Phone Number: _____ **Zip Code**: _____

Child's Name: _____ **Date of Birth:** _____

PIN # (Issued by front desk staff): _____

Security Question (Choose one):

Where were you born? Answer: _____

Mother's Maiden Name? Answer: _____

Name of first pet? Answer: _____

I agree to allow LifeStream Behavioral Center to register me or my child for the Patient Portal using the above information provided by me.

_____ **Date:** _____

Consumer/Guardian Signature