mental healthcare individualized to
fit your needs…

Phone: 678-344-8268
Fax: 888-627-6444

PATIENT UPDATE FORM 2019

PATIENT INFORMATION

Patient Full Name: ____ Maiden Name: ___________________

Date of Birth: __________________________ Age: _____ Social Security #: ______________________________

Gender: □ Male □ Female Height: __________ Weight: ___________

Sexuality: □ Heterosexual □ Homosexual □ Bisexual □ Other

Ethnicity: □ American Indian □ Hispanic/Latino □ Asian □ African American □ Pacific Islander □ White/Caucasian

Address: ____

City: ____________________________ State: ______ Zip: ____________ County: _________________________

Home Phone: _______________________________ Cell Phone: ____

Email: ____

Appointment Reminders: □ Text Message □ Email (the system will automatically default to all unless otherwise specified)

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Domestic Partnership

# of marriages: _____ Do you have children: □ No □ Yes: ____# of Sons ____# of Daughters Any Deceased: ______

EMERGENCY CARE INFORMATION

Name: ________________________________ Relationship: ________________ Phone: ______________________

PHARMACY

Pharmacy Name: ____ Phone: ________________________________

Address: ____ City: __________________________________

MEDICAL HISTORY

Primary Care Physician: ______________________________________ Phone: ____________________________

Do you have/had any of the current conditions listed below? (Please check all that apply)

□ High Blood Pressure □ Cancer □ Asthma □ Heart Disease □ Stroke

□ Diabetes □ High Cholesterol □ Migraines □ Fibromyalgia □ Seizures

□ Thyroid Problems □ COPD □ Anemia □ Acid Reflux □ Sleep Apnea

Major Surgeries/Illnesses/Accidents/Hospitalizations: ____

____

May we contact your personal physician to discuss medical or medication issues and/or coordinate your care?

No _____ Yes _____ If yes, please complete/sign a medical records release form.

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MEDICATIONS

Please list ALL CURRENT MEDICATIONS with STRENGTHS and INSTRUCTIONS, including over the counter medications:

Name of medication:	Dose	Directions
____	____________________	_________________________
____	____________________	_________________________
____	____________________	_________________________

ALLERGIES

Allergy to:	Onset (Child, Adult)	Severity	Reaction
___________________	___________________	___________________	___________________
___________________	___________________	___________________	___________________

Last Flu Vaccine: ______________________☐ Never   Last Pneumonia Vaccine: ______________________☐ Never

PHYSICAL HEALTH STATUS

Tobacco Use:	☐ Current	☐ Former	☐ Never	**Illicit Drugs**:	☐ Current	☐ Former	☐ Never
Alcohol Use:	☐ Daily	☐ Socially	☐ Never	**Rehab**:	☐ Yes	☐ No	

Exercise:	☐ Regularly	☐ Occasionally	☐ Rarely	☐ Never
General Diet:	☐ Healthy	☐ Questionably Healthy	☐ Not Very Healthy	☐ Varies/Changes
General Health:	☐ Excellent	☐ Good	☐ Fair	☐ Poor

TREATMENT CONSENT & RELEASE FOR BILLING ACKNOWLEDGEMENT

RELEASE FOR BILLING: By signing below you are giving consent to Life Healing Center, PC to release any medical psychiatric or psychological information deemed necessary to the appropriate insurance companies in order to bill for services rendered. You are also agreeing to accept full responsibility of any balances, copays, and/or charges that are not covered by your insurance companies.

CONSENT FOR TREATMENT: By signing below, you are giving consent to all treatment by Life Healing Center PC, its agents, employees and contractors as deemed necessary by your providers or his/her consultants, associates or designees. You are giving informed consent to mental health treatment based on full, fair and truthful disclosure of known and reasonably foreseeable benefits, risks and hazards of the proposed treatment and of alternative treatments. Please note; for continuity of care, your treatment plan, progress and case notes may be discussed with any member of the treatment team to provide an integrative approach to your care.

ACKNOWLEDGEMENT OF POLICIES: Your signature below indicates that you were offered, have read and agreed to the LHC office policies, HIPAA Notice of Privacy Policies, Crisis Information, and LHC treatment consent form. These policies contain information on behavioral/mental health services, sessions, cancellation and no-show policies, billing and payments, insurance reimbursement, contacting us, professional records, confidentiality, and practice status; and you agree to abide by its terms during our professional relationship.

Patient / Guardian Signature: ____ Date: ____________________

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PSYCHIATRIC & CONTROLLED MEDICATIONS POLICY

As of January 1, 2012, the State of Georgia has issued new laws regarding the prescribing of psychiatric and controlled medications. In order to meet the requirements as they pertain to the Life Healing Center, PC, we have put into place the following guidelines:

- Patients must maintain regular appointments as determined by the physician in order to receive these medications. If you missed your scheduled appointment, we are unable to refill any medications until you see the doctor again.
- Early refills are not allowed on any controlled medications. No exceptions.
- Temporary supplies will not be given on any controlled medications.
- Life Healing Center, PC does not allow a 90- day supply on controlled medications.
- If a psychiatric medication or prescription is lost or stolen, the patient must contact the police and file a police report. This report will have to be sent to Life Healing Center, PC and placed in your chart. Please note that replacement prescriptions may not be possible depending on the medication, the availability of the physician and the circumstances in which the prescription was lost or stolen. Replacement prescriptions are never provided for controlled medications.
- If we suspect a patient of abusing prescription medications or any other substances, at any time, the patient will be discharged from the Life Healing Center, PC.
- If you receive duplicate medications from another physician, you will be discharged from Life Healing Center, PC as it is a violation of our policies and against the law.
- Any changes in medications or requests for additional medications will require an appointment with the doctor.
- Please be sure to call in your refill requests to our prescription line and allow up to 2 business days for processing. All medications will be e-prescribed to your pharmacy.

All pharmacies are required to report all controlled prescription medications to the Georgia Prescription Drug Monitoring Program as they are filled. Pharmacists and prescribers have access to this system to prevent fraud and abuse of controlled prescription medications. Therefore, we regularly check this database to ensure patient compliance to medications and do our part in helping to prevent fraud and abuse.

By signing below, you are agreeing to the above policy as it has been stated and are authorizing Life Healing Center, PC to send prescriptions electronically to your pharmacy. You are also authorizing Life Healing Center, PC to access your pharmacy/prescription history as well as controlled prescription history through the Georgia Prescription Drug Monitoring Program. **This form must be signed to receive any prescriptions from our office.**

Patient Name (PLEASE PRINT): ____

Patient / Guardian Signature: ____ Date: ______________________