Life Balance Therapy, LLC
Ph. 210-549-MOOD • Fax: 210-610-8291

PATIENT INFORMATION

**** Any changes to your phone number, address, or insurance should be reported to the front desk****
**** For your payment- We accept ONLY debit/credit cards OR exact CASH we do NOT take CHECKS****

PATIENT NAME: _______________________________ TODAY'S DATE: ___________________
DOB: _____/_____/_____ Social Security #: ____

For children under 18: Legal Guardian(s)/Parent(s):
NAME: ____ Phone: ________________________
Relationship to Client: _____________________________
NAME: ____ Phone:_________________________
Relationship to Client: _____________________________

(Information regarding the patient: Circle one)
Gender: Female Male
Marital Status: Married Single Divorced/Separated Widowed Child/Adolescent Other: _________
Legal Orders: Is this patient documented in any legal documentation such as but not limited to: Divorce Decree, Custody Orders, Adoption Documentation, Power of Attorney, etc. No Yes
If yes, please indicate the nature of the documentation and provide a copy to the Front Office for our records. ____
Employment: Employed Full-Time Student Part-Time Student Unemployed/Other

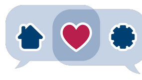
Residential Address: ____
City: _________________________ State: ________________ Zip Code: ________________
CELL: ___________________________HOME PHONE: ________________________________
EMAIL: ____
Preferred method for reminders: EMAIL TEXT PHONE CALL

Emergency Contact

NAME: ____________________________________ DOB: __________________________
Phone: __________________________________ Relationship to Client: ________________________
May we contact this person in case of an emergency? YES NO

Let us know who we can thank for referring you (circle how you were referred):

Google/Internet	Psychology Today	Theravive	Insurance
TV/Commerical	**Friend/Relative**	**Doctor's Office (please name):**	**Other (please specify):**



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Insurance Information

In order for our center to bill your insurance, this form will need to be completed in full in addition to providing the Front Office with a copy of your insurance card.

Primary Insurance: ____
Member/Subscriber Insurance ID: _________________________Group ID:___________________
Primary Insured/Cardholder: ____
DOB: ______________
Primary Insured/Cardholder Address:
Address: ____
City: _______________________ State: _______________ Zip Code: _______________
CELL: _________________________HOME PHONE: _____________________________

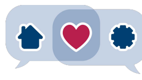
Secondary Insurance: ____
Member/Subscriber Insurance ID: __________________________Group ID:____________________
Secondary Insured/Cardholder: _______________________________________
DOB: _____________
Secondary Insured/Cardholder Address:
Address: ____
City: _______________________ State: _______________ Zip Code: _______________
CELL: _________________________HOME PHONE: _____________________________

PRIVATE PAY AGREEMENT

If you have requested to utilize our Private Pay services please review and sign at the bottom of this page.
The provider will not file a claim to Medicaid and/or other Private Insurance for services provided to you.
I understand that Life Balance Therapy is accepting me as a private pay client.
I, ______________________________ will be responsible for paying for any service I receive in the amount reflected below per session in accordance to my visit.

Service Description	Rates
Individual Psychotherapy with Master's Level Counselor	$100.00
Individual Psychotherapy with Doctoral Level Counselor	$120.00
Couples Psychotherapy	$120.00 - $130.00
Family Psychotherapy	$130.00 - $140.00

Patient Name (Print): _______________________________________
Patient or Legal Guardian Signature: ________________________________Date: _____ / _____ / _____



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Symptom Checklist

NAME: ___________________________
DATE: ____________________________

Please indicate any symptoms or concerns the patient has exhibited within the past 6 months.

- ❑ Death of family member/friend
- ❑ Parenting concerns
- ❑ Problems at school
- ❑ Hyperactivity/Attention problems
- ❑ Trouble concentrating
- ❑ ADHD/ADD evaluation
- ❑ Concerns about behavior
- ❑ Excessive energy
- ❑ Impulsive decisions/actions
- ❑ Easily distracted
- ❑ Fidgeting/squirming when seated
- ❑ Fatigue/low energy
- ❑ Feelings of guilt/shame
- ❑ Changes in sleep patterns
- ❑ Self harm or others
- ❑ Suicidal ideation
- ❑ Irritability
- ❑ Loss of interest in previous activities
- ❑ Low self-esteem
- ❑ Withdrawn/isolating
- ❑ Feelings of hopelessness
- ❑ Feelings of worthlessness
- ❑ Anxious/ Worry/ Nervous
- ❑ Feelings of losing control
- ❑ Restlessness
- ❑ Feelings of apprehension or dread
- ❑ Muscle Tension
- ❑ Headaches
- ❑ Obsessive thoughts/excessive fears
- ❑ Concerns about eating habits
- ❑ Concerns about spending habits
- ❑ Unusual thoughts
- ❑ Avoidance conflict
- ❑ Shy/uneasy around others
- ❑ Mood swings
- ❑ Issues with defiance/severe behavioral issues
- ❑ Loss of temper/outburst or tantrums
- ❑ Aggressive/Violent behaviors
- ❑ Physical Abuse (past or present)
- ❑ Verbal/emotional abuse (past or present)
- ❑ Sexual abuse (past or present)
- ❑ Substance abuse (past or present)
- ❑ Gender identity concerns
- ❑ Delay in speech and language skills
- ❑ Obsessive/unusual interests
- ❑ Unusual behaviors
- ❑ Problems with boundaries
- ❑ Problems with physical contact
- ❑ Difficulty starting and maintaining relationships
- ❑ Repeats works/phrases
- ❑ Repatative behaviors (rocks/ clapping etc)
- ❑ Perfectionism
- ❑ Recurrent flashbacks
- ❑ Confusion
- ❑ Feelings of stress
- ❑ Acute or chronic pain
- ❑ Communication issues
- ❑ Adjustment issues
- ❑ Medical/Health problems
- ❑ Others (please specify):____________________

Research has demonstrated positive outcomes in behavioral health when Psychotherapy is coordinated alongside Medication Management.

Are you currently receiving Medication Management to address your mental health needs?

Circle: Yes or No

If NO, would you be interested in a referral to initiate these services? Circle: Yes or No

Confidential: Not to be re-released without express written consent.

Patient Care Form

Patients: Please complete the highlighted areas only.

PRIMARY CARE PHYSICIAN (PCP): ____

PCP Practice Name: ____________________________________

PCP Phone #______________________ PCP Fax #_______________________

PCP Address _______________________________ City_________________ State _______ Zip__________

Your patient, ____, DOB _______________________,

was seen by ____.

Date of initial assessment: _________________________ Next appointment: ______________________.

Diagnosis and/or presenting problem: ____

____

Treatment Recommendations: ____

____

Please call if further information would be helpful.

Sincerely,

____ ______________________________

Counselor's Signature Phone

Authorization to Disclose Information

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations 42 CFR Part 2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

This consent shall expire one (1) year from the date of signature. I understand I may revoke my consent in writing at any time except to the extent that action has already been taken in reliance on it.

Patient, please check one:

_____ I agree to release this information to my physician listed above.

_____ I do not agree to release this information to my physician listed above. (Reason__________________________________)

_____ I do not have a physician.

Patient Signature ____ __Date _______________________________

Parent/Guardian Signature D ate