REGISTRATION / INFORMATION WORKSHEET

Today's Date: _____ **Time of Arrival:** _____ **AM PM (Circle One)**

CONSENT:

I, _____, give the staff of **Lakeside Behavioral Health System**
(Patient/guardian signature)
permission to perform an assessment and to verify insurance benefits.

PATIENT INFORMATION:

Patient Name: _____ Patient SSN: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

County: _____ e-mail_____

Home Phone #: _____ Cell #: _____ W #: _____

Date of Birth: _____ Age: _____ Sex: _____ Race: _____ Marital Status: _____

Patient's Occupation: _____ Employer: _____

Employer's Address: _____

Employer's Phone #: _____ Length of Employment: _____

Do you have an Employee Assistance Program? **Y or N** If YES, Who? _____

Patient's Biological Mother: _____ Patient's Biological Father: _____

EMERGENCY CONTACT INFORMATION:

In Case of Emergency, contact: _____ Phone #: _____

What is their relationship to the Patient? _____

Additional Contact: Name _____ Phone #: _____

What is their relationship to the Patient? _____

PRIMARY CARE PHYSICIAN:

Primary Care Physician (PCP) Name: _____

PCP Address & Phone Number: _____

REFERRAL INFORMATION:

Who referred you for services at **Lakeside**? _____
What agency are they with (address)? _____

LEGAL INFORMATION:

Does the Patient have a Living Will? **Y or N** Effective Date: _____
Is there Durable Power of Attorney? **Y or N** If YES, who holds this? _____
Effective Date: _____

Guarantor/Guardian Information:

☐ *Check here if information is the same as the patient*

Guarantor/Guardian Name*: _____ Guarantor SSN: _____
*(the guarantor/guardian is the one who will actually be signing the paperwork should admission be necessary)

Guarantor Address: _____

City: _____ State: _____ Zip: _____ County: _____

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

Date of Birth: _____ Age: _____ Sex: _____ Race: _____ Marital Status: _____

What is the Guarantor's relationship to the patient? _____

Guarantor's Occupation: _____ Guarantor's Employer: _____

Guarantor's Employer's Address: _____

Employer's Phone #: _____ Length of Employment: _____

Do you have an Employee Assistance Program? Y or N If YES, Who? _____

Insurance Information – Must Provide both Primary and Secondary Insurance Policies

PRIMARY Insurance: _____ Policyholder Name: _____

Policyholder DOB: _____ Policyholder SSN: _____

Policy ID #: _____ Group Name or Number: _____

Insurance Customer Service or Verification Phone #: _____

Policyholder Employer, City and Phone #: _____

Relationship to Patient _____ Policyholder Home #: _____ Cell #: _____

Policyholder Address: _____

SECONDARY Insurance: _____ Policyholder Name: _____

Policyholder DOB: _____ Policyholder SSN: _____

Policy ID #: _____ Group Name or Number: _____

Insurance Customer Service or Verification Phone #: _____

Policyholder Employer, City and Phone #: _____

Relationship to Patient _____ Policyholder Home #: _____ Cell #: _____

_____: Initial here if you acknowledge that you DO NOT have a secondary policy.

If a staff member completes this form for the patient, please print your name here: _____
(*** staff members need to fully complete form and ask patient about both primary and secondary insurances)

If admission is required, what payment method will you be using today? (Please circle all that apply)
CASH / CHECK / MONEY ORDER / MASTERCARD / VISA / DISCOVER / AMERICAN EXPRESS

LAKESIDE
BEHAVIORAL HEALTH SYSTEM

Patient Identification _____

Initial Screening Form – Needs Assessment

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

Name of Person Completing Form: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____ Contact Number: _____

Assessment Information:

Have you had any previous psychiatric hospitalizations? ☐Yes ☐No When? _____

Name of Hospital: _____ Reason for admission: _____

What level of service are you seeking today?

____Inpatient Treatment ____Intensive Outpatient ____Treatment Recommendations
____Partial (Day Treatment) ____Obtaining Psychiatrist/Psychologist ____Medication Management

Areas of Concern: (please explain)

_____ Appetite/Sleep Disturbance_____
_____ Martial or Relationship Stressor_____
_____ Problems at Work/School_____
_____ Feelings of Anger_____
_____ Excessive Worry or Unwanted Thoughts_____
_____ Having to do certain things over and over_____
_____ Difficulty Concentrating_____
_____ Depression/Sadness/Crying Spells _____
_____ Loss of Interest/Enjoyment in Sexual Activity_____
_____ Alcohol or Drug Use_____
_____ Easily Annoyed/Irritated/Tense/Nervous_____
_____ Temper Outbursts/Destructive to Property_____
_____ Impulsiveness/Acting Without Thinking_____
_____ History of Physical or Sexual Abuse_____
_____ Feelings that others are out to get you_____
_____ Seeing things that others do not see_____
_____ Hearing things that others do not hear_____
_____ Feelings of wanting to harm others_____
_____ Feelings of wanting to harm self_____
_____ List the date you last felt suicidal _____
_____ How strong is your desire to die right now? Strong _____ Moderate_____ Weak _____ None _____
_____ Do you have a plan as to how you would harm yourself? Yes _____No_____ Explain _____
_____ Have you ever attempted suicide in the past? _____ When? _____

What recent events/problems have brought about your request for help today? _____
_____

Influenza Screening

1. Have you recently had any flu like symptoms or been treated for flu? (fever, cough, body aches, vomiting, diarrhea) _____
2. Have you recently been exposed to anyone who has exhibited any of the above symptoms? _____

This brief questionnaire is a screening tool to help during the initial assessment process.

1. Do you currently have or have you ever had: OR Have you been vaccinated for:

Measles	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Mumps	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Rubella	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Influenza	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Chicken Pox	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Hepatitis A	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Hepatitis B	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Hepatitis C	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
HIV	☐ NO ☐ Yes	Date: _____		
Tuberculosis	☐ NO ☐ Yes	Date: _____		
Other:	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	Date: _____
MRSA	☐ NO ☐ Yes	Date: _____		

2. Are you now under the care of a physician or taking any medication for a communicable disease?
☐ NO ☐ Yes (Please note any current treatment for any areas checked): _____

3. Have you had recent contact with someone with any of the above illnesses? ☐ NO ☐ Yes
If yes which one (s) and when: _____

4. Have you ever been tested for Tuberculosis? ☐ NO ☐ Yes If yes, when? (Date) _____

5. Have you ever tested positive for TB? ☐ NO ☐ Yes
If yes, did you have a chest x-ray? ☐ NO ☐ Yes
Were you treated? ☐ NO ☐ Yes If yes, when? (Date):_____
What kind of treatment: _____

6. Please check yes or no to ALL symptoms as they apply to you – ***please mark current symptoms only***:

Productive cough (3 wks or more)	☐ NO ☐ Yes	Persistent Weight Loss without Dieting	☐ NO ☐ Yes
Persistent Low Grade Fever	☐ NO ☐ Yes	Night Sweats	☐ NO ☐ Yes
Loss of Appetite	☐ NO ☐ Yes	Swollen Glands, usually in the Neck	☐ NO ☐ Yes
Recurrent Kidney Infections	☐ NO ☐ Yes	Shortness of Breath **(current)**	☐ NO ☐ Yes
Chest Pain **(current)**	☐ NO ☐ Yes	Any recent falls?	☐ NO ☐ Yes

7. Are you currently pregnant? ☐ NO ☐ Yes Date of Last Menstrual Cycle: _____

8. **Other *current* medical conditions:**

Medical Status	**Yes**	**No**	**Medical Status**	**Yes**	**No**
Seasonal Allergies			Hypertension		
Asthma			Incontinence		
Diabetes			Open Wound		
Heart Disease			Sutures		
CVA (Stroke)			Active Bleeding		
Hearing/Vision Impaired			GI Dysfunction		
Sleep Apnea (different from insomnia)			Special Equipment (explain)		
Abdominal Pain (current)			Current Broken Bones/Fracture		
Muscle Pain (current)			Seizures		
Head Injury (recent)			Other (explain)		
Allergies (medications/food/etc.)	**List:**				

FOR STAFF USE ONLY

After review of answers, what actions were taken: _____
Reviewed By Nursing: _____ Date/Time: _____

Vital Signs: BP: _____ Pulse: _____ Respirations: _____ Temp: _____ O2 Sat.:_____ Breathalyzer: _____

Date/Time: _____ N**ARC Assessor**: _____ (signature) **Q15Checks:** Y or N

DOCUMENT ATTEMPT TO CONTACT POA/NEXT OF KIN IF PATIENT IS UNABLE OR UNWILLING TO COMPLETE THIS FORM:
Person Contacted: _____ Date/Time: _____
Person Contacted: _____ Date/Time: _____

Respecting Your Privacy

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

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect the privacy of your health information. We call it "Protected Health Information" (PHI).

Staff members, employees and volunteers of this hospital/facility must follow legal regulations with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services
- Ask you to contribute to our charitable activities unless you tell us not to ask.

Your Authorization May Be Required

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a workers compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds,reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You have the right to receive confidential communication from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with the facility or the Secretary.

- To file a complaint with us, please contact the hospital's Risk Management Department or call the UHS Compliance Hotline at **1-800-852-3449**. Your complaint should provide specific details to help us in investigating a potential problem.

- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C.20201 or call **1-877-696-6775**.

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our privacy practices. This document is our notice. We will abide by the privacy practices set forth in this notice. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law.

If we change our notice of privacy practices, we will provide our revised notice to you when you next seek treatment from us.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

EFFECTIVE DATE: This notice takes effect on April 14, 2003. Version #10808E

LAKESIDE
BEHAVIORAL HEALTH SYSTEM

Receipt of Notice of Privacy Practices

- ☐ Over 18 years of age
- ☐ Under 18 years of age
- ☐ Emancipated minor child
- ☐ Over 18 but still dependent

Acknowledgement

I acknowledge that I have received Lakeside Behavioral Health System Notice of Privacy Practices.

_____ _____
Patient's Signature **Date**

_____ _____
Patient's Authorized Representative Signature/Relationship **Date**

_____ _____
Witness Signature **Witness Job Title**

Patient is unable to sign this receipt because:_____

Patient has requested no exceptions to the use or disclosure of PHI at this time.

HIM Staff entered receipt on chart:_____ **initials**_____
Date **HIM Staff**

LAKESIDE
BEHAVIORAL HEALTH SYSTEM

Statement About Safety

We are honored that you chose Lakeside for your behavioral health needs.

As a customer in our Assessment Center, please take a moment to read the ***Assessment Passport*** that has been provided and explained to you during your initial triage. It will describe the assessment process. Please feel free to ask your assessor any questions regarding your passport.

We strive to keep our buildings free of potentially hazardous items. When our assessment department calls you back to begin the assessment process, they will use a portable metal detector to ensure you have no weapons of any kind. We will be respectful during the process, which takes only a few minutes.

Items that are prohibited in the assessment area include, but are not limited to; firearms, knives, pockets knives, pepper spray, lighters and purses. If you, a family member or a friend have any of these items, we ask that the items be immediately secured in your car or allow the Operator behind the sliding glass window to hold these items until you are ready to leave.

All patients who are admitted to inpatient or residential treatment will have a second safety search conducted by the assessment staff prior to leaving the assessment area to go to your respective treatment unit. The process for the safety search will be carefully explained to you.

We appreciate your cooperation with our safety search process. It is an important part of our goal to provide the safest environment for patients, family members, visitors and employees.

Medication Note: As per hospital policy, we do not routinely administer medications in the assessment area. Please notify a staff member if you require any medications administered during the assessment process and we will follow the necessary protocol.

Thank you again for choosing Lakeside Behavioral Health System.

_____
Print Name

_____ _____
Acknowledgment Signature Date

_____ _____
Security Wand Staff Date/Time

NAR-VIS 6/12