LAMPOST
WELLNESS CENTERS

AGREEMENT TO SUBSTANCE USE EVALUATION

While in evaluation at Lampost Wellness Centers, I will abide by the following:

1. I understand that the clinicians at Lampost Wellness Centers are state licensed clinical professionals and are mandated to report child abuse, elderly abuse, and any intent to harm self or others.

2. I understand that through evaluation I am choosing to potentially make changes to my thoughts, feelings, and behaviors. I am ultimately responsible for my life and the changes I make.

3. I agree to provide a credit/debit card to pay for evaluation and understand fees of $685/per evaluation will be charged (50% during the 48 hours preceding my appointment time and 50% when the report is submitted).

4. I agree to keep all my appointments unless I have given 48 hours' notice, either in person or on the phone. I understand my obligation to pay fully for my therapist's time if I fail to provide this cancellation notice. In rare and emergency situations, my therapist may make an exception to this obligation.

5. I understand and agree that Lampost Wellness Centers will keep all my personal information confidential but, without personal identification, the organization may use my issues and solutions for clinical supervision.

6. This agreement will remain in effect until I provide notice my evaluation is complete.

_____ _____

Name (Signature) Date

_____ _____

Evaluator's Signature Date

5410 McKinley Street Bethesda MD 20817
PH 301-841-8930 FAX 240-235-3707
www.lampostwellness.com

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EVALUATION INFORMATION FORM

Information you provide here is protected as confidential information.

Patient Name: _____

Name of parent/guardian (if under 18 years):
_____

Patient Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Address:
_____

_____
(City) (State) (Zip)

Mobile phone: _____May we leave a message? □Yes □No

Referred by:
_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner:

_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____

_____

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WHAT HAS PROMPTED YOU TO SEEK THIS EVALUATION?

_____Date_____
Patient Signature

_____Date_____
Authorization Signature
Parent or Guardian (IF NEEDED)

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MEDICAL HISTORY for EVALUATION

Please complete: This is very important information. Please feel free to add any additional information that you feel is needed.

Name_____

Address:_____City_____Zip_____

Phone:_____

Name of Psychiatrist (If you have one) or Primary Care Physician:
_____

Address:_____City:_____Zip_____

Medication and dosage prescribed by this doctor:_____

_____

Have you been hospitalized for emotional problems? Yes_____-No_____

If so: When_____Where_____

Have you had individual therapy? Yes____No_____ Dates:_____

Name of Therapist:_____Address:_____
City:_____Zip_____Telephone_____

Have you been treated for substance abuse? Yes _____Date: _____

Are you being treated now for substance abuse? Yes _____No_____

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FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following.

Alcohol/Substance Abuse
Anxiety
Bipolar disorder
Depression
Domestic Violence
Eating Disorders
Obesity
Obsessive Compulsive Behavior yes/no
Schizophrenia
Suicide Attempts

I authorize Lampost Wellness Centers (LWC) to contact the following medical professionals for the purpose of consulting and coordinating care for my evaluation and potential treatment. This authorization will remain in effect for the duration of my treatment, unless I notify LWC that I am revoking this release of information.

Doctor_____Address:_____

City:_____State_____Zip_____

Phone: ( )_____Fax: ( ) _____

_____Date_____
Your Authorization Signature

_____Date_____
Your Signature

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CLIENT RIGHTS AND PRIVACY PRACTICES

There may be times when we need to consult with a colleague or another professional about issues raised by clients in therapy. Client confidentiality is still protected during consultation by us and the professional consulted. Signing this disclosure statement gives us permission to consult as needed to provide professional services to you as a client.

CONFIDENTIALITY

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in the HIPPA Notice of Primacy Rights as well as other exceptions in Federal law. If a legal exception arises during therapy, if feasible, you will be informed accordingly. For example, some of the exceptions would include: suspected child abuse, molestation or incest, a client is in danger of hurting self or others, danger of violence, suspected abuse of the elderly or others unable to care for themselves, suspected threat to national security, subpoenaed testimony in criminal court cases, orders to violate privilege by judges in child custody and divorce cases.

CHILDREN AND ADOLESCENTS

A child fourteen or younger seen in this office must have the signature of a parent. In the case of divorce, the authorization must be signed by both parents or the court document presented giving sole custody

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices that are described in this Notice while it is in effect. The Notice takes effect April 14, 2003 and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION

In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences in your best interest in allowing another person to pick up health information.

We may use or disclose your health information when we are required to do so by law or when ordered to do so by a court having jurisdiction of an appropriate matter.

We must disclose your health information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or health or safety of others.

Access: You have the right to inspect or obtain copies of your health information, except for therapist's notes and certain other limited exceptions. If you request copies, we will charge you $1.00 for each page to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will change a cost based fee for printing your health information in that format.

ACKNOWLEDGMENT OF RECEIPT OF
CLIENT RIGHTS AND PRIVACY PRACTICES

_____
Patient Signature

_____
Date

_____
Therapist signature

_____
Date

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