Lake Psychological Services, LLC

Welcome to Lake Psychological Services and thanks for choosing our office for your health care needs.

Seeking treatment is not an easy decision and you may have questions about our practice. Below, we have attempted to address some of the most commonly asked questions by new patients and provide important information regarding our office policies and procedures.

We want to make sure your experience with us is a positive one.

Office Hours

- Each medical professional in the office will set their own schedule for appointment purposes. The administrative staff will cover the front office area Monday – Thursday 9:00 am – 5:00 pm. On Fridays it will be staffed 9:00 - 3:00 pm.
- Dr. Jeffords is the only psychiatrist in the office and she works only on Monday and Tuesdays . She can be reached via her answering service for emergencies.

First Visit

The first appointment is an initial assessment and evaluation. Please plan to arrive 1o minutes before your first scheduled appointment, bringing the completed new patient packet and insurance card(s) with you.

First Appointment with Psychiatrist: If the appointment is for a child under age of 17 the first appointment should be attended by the patient and the parent(s) / caregiver.

First Appointment with Psychologist/Therapist:
The child does not need to attend this session. The therapist will meet with the parent(s) or legal guardian to obtain a brief history and overview of presenting problem(s).

Appointments

- Appointments may be scheduled by calling our appointment line at 803-699-8887 Monday - Thursday between the hours of 9 am – 4 pm or Fridays from 9 am – 12 pm.
- Please call 48 hrs in advance to cancel or reschedule an appointment.
- NO SHOW policy:
  - Late cancellations or 'no-shows' are subject to a charge based on the length of the appointment. $25 for appointments less than one hour in length; $50 for appointments 60 minutes in length; $100 for appointments 2 hours in length.
  - Three no-shows will be cause for termination with health care provider.

Billing / Insurance

- Payment is due on the day of service.
- As a courtesy to our patients, we submit claims for up to two insurance policies. It is the patient's ultimate responsibility to pay any co-pays, co-insurance or deductible amounts or any other balance not paid by your insurance company.
- Our office accepts cash, check, Visa or MasterCard.

Prescription Medication/Refills

- Patients are responsible for keeping track of their supply of medication and should allow 48 hours turnaround for prescription requests.
- Bridge prescriptions: If a patient fails to keep a scheduled appointment and needs medication a two week prescription will be issued but the patient must schedule and keep their next appointment.
- Medication refills can be obtained during office visits or by calling or emailing with your specific request and pharmacy number.
- Stimulant medications like Ritalin, Focalin, Adderall, Metadate, Dexedrine, Concerta, Vyvanse are schedule II controlled substances. By Federal and State law these drugs can NOT be called, faxed, or given in 90 day mail order quantities. Prescriptions for these medications will only be written on Monday and Tuesday when Dr. Jeffords is in the office.

Emergencies /Correspondence/Forms:

Request for Medical Records, dictated letters, and completion of forms (i.e. disability, return to work statements, etc.) can be obtained for a charge. The charge varies by form needed and the length and complexity of the request. Fees must be paid when the form is presented.

I have read the information stated above and agree with the policies and procedures as presented.

_______________________________________ ___________________
(Signature of Client or Parent/Legal Guardian) (date)

Consent of Treatment:

I hereby give my consent for Lake Psychological Services to provide psychiatric and/or psychological treatment to the above named patient:

_______________________________________ ___________________
(Signature of Client or Parent/Legal Guardian) (date)

Assignment of Benefits:

I understand I am financially responsible for all charges whether or not they are paid by my insurance company. If I have provided health insurance information to you I hereby authorize the release of information necessary to secure payment from third party providers and assign payment to Lake Psychological Services (LPS) for any authorized medical services provided by the health care professional at LPS.

_______________________________________ ___________________
(Signature of Client or Parent/Legal Guardian) (date)

NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:

I hereby acknowledge I have read the notice of HIPAA privacy practice agreement from Lake Psychological Services and have been offered a copy for my personal possession.

_______________________________________ ___________________
(Signature of Client or Parent/ Legal Guardian) (date)

Lake Psychological Services Today's Date: ___/___/_____

Patient Name: ___________________________________

Date of Birth: ___/___/_____

Gender: ________________ Marital Status: ____________

Address: ___________________________________

City, State, Zip: ___________________________________

Contact Information

Email	
Cellphone	
Home	
Work	

For Minors Only: Parent / Guardian Information:

Name	Phone	Relationship to Minor

Insurance Information:

Primary Insurance Company: ______________________________

Insurance ID Number: ______________________________

Relationship to Policy Holder: ___ Self ___ Spouse ___ Child

Policy Holder Name: ____________________Date of Birth___________

Secondary Insurance: ____

Lake Psychological Services, LLC
115 Atrium Way, Suite 221
Columbia, South Carolina 29223
803-699-8887, 803-699-8824 (fax)

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: ________________

Patient Name: ____
First Middle Initial Last

Date of Birth: ________________ Gender: ________________

Parent/Guardian Names and Contact Information (if appropriate):
____
____

Primary Care Physician: ____
Referred by: ____

- If referred by another clinician, would you like for us to communicate with one another?
  Yes No

Please list primary concerns and reason for referral:
____
____

Please list all physicians involved in your (or your child's) care and contact information (phone/fax):
____
____
____
____
____

Current Medications (including any over the counter or herbal preparations)

Medication	Dosage	For what reason?	How long?	Side effects

Current Pharmacy: ____ Phone: ____________________

Allergies: ____

Has client/patient experienced any of the following (past or present)?

Symptoms/Condition	Present	Past	Symptoms/Condition	Present	Past
Alcohol			HIV/AIDS		
Anemia			Liver Disease		
Blackouts/Fainting			Nausea		
Blood Pressure			Numbness/Tingling		
Blood Sugar			Pain		
Cancer			Pregnancy		
Chemical Exposure			Rheumatic Fever		
Developmental Concerns/Delays			Seizures		
Difficulty Walking			Sexual Dysfunction		
Easy Bruising			Shortness of Breath		
Eating Problems			Sickle Cell Disease		
Fatigue			Skin Problems		
Fever			Sleeping too little		
Gallstones			Sleeping too much		
Glaucoma			Street Drugs		
Headaches			Thyroid Problems		
Hearing			Trauma		
Heart Disease			Ulcers		

Have you or any family members had any of the following?

	Present	Past	Which family member?
Abnormal Heart Rhythm			
ADHD			
Alcohol/Drug Problem			
Anxiety Disorder			
Asthma			
Autism Spectrum Disorder			
Bipolar Disorder			
Cancer			
Dementia			
Depression			
Diabetes			
Eating Disorder			
Heart Problems			
High Blood Pressure			
Hoarding			
Learning Disabilities			
Obsessive/Compulsive Disorder			
Personality Disorder			
Schizophrenia			
Seizures			
Stomach Problems			
Stroke			
Sudden Death			
Suicide/Attempted Suicide			
Tics			
Thyroid Disorder			
Traumatic Brain Injury			

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If your reason for referral for psychological services is related to a medical diagnosis,
please ask your providers to share any relevant medical records prior to your appointment.

MEDICAL HISTORY:

Please explain any significant medical diagnoses, problems, surgeries, or illnesses you (or your child) have had:
____
____
____

If you (or your child) have had a brain injury/concussion, please provide detailed information about the injury and symptoms:
____
____
____

Previous medical hospitalizations (Approximate dates and reasons): ____________________
____
____

FAMILY HISTORY:

Who is currently living in your home (relationship to you, age, gender)?
____
____

If a child, are parents married/living together or did they separate/divorce?______________ If they divorced, how old was the child when the parents separated and is either parent remarried or in a long-term relationship?
____
____

EDUCATIONAL/OCCUPATIONAL HISTORY:

If an ADULT, please describe education completed and current employment status:
____
____
____

Have you (or your child) ever been suspended, expelled, or asked to repeat a grade?
____

If a CHILD, name of your child's school: ______________________________ Grade: ________
Primary contact at school or primary teacher: ______________________________
May we have your permission to speak with this contact person at your child's school? Yes No
Does your child have an IEP or 504 plan? __________ *Please bring copies of these plans to appointment*
Please describe your child's academic history in terms of grades, behavior, placement, strengths, weaknesses, attitude toward homework, etc. ______________________________
____
____

PSYCHOLOGICAL HISTORY:

Have you (or your child) received any previous psychological or psychiatric evaluation, treatment, or counseling?
***If you (or your child) have had any previous psychological testing, please bring a copy of the report to your initial appointment.

By Whom?	When?	Diagnosis	Type of treatment	Were you hospitalized?

LEGAL HISTORY:

Are you currently involved in any legal proceedings (please describe briefly)?
____

Are you seeking (or have you previously been approved for) disability status? ________________________

What are your goals for evaluation or therapy?

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Written by: ____

Insurance ID Number: ____