Crossroads Counseling Services, PLLC

Bariatric Evaluation Form

Craig S. Laasch, Psy.D.

Client:_____

Appointment Date:_____

Appointment Time:_____

Thank you for choosing Dr. Craig S. Laasch at Crossroads Counseling Services, PLLC for your bariatric evaluation/counseling needs.

Please complete the enclosed form and bring it along with your insurance card(s) to your first visit. This will save time during your visit and allow the most time for Dr. Laasch to attend to your individual needs.

Any questions that you may have can be answered at your initial visit.

New Client Information

Client Last Name:	First:	Middle Initial:
Date of Birth:	Age:	Gender: M ☐ F ☐
Marital Status (Circle One):	**Married/Divorced/Single/Separated/Widow**	

Weight Loss History

What are your reasons for seeking weight loss surgery?

At what age did you become overweight? _____

What is the lowest weight you have maintained for a year since high school? _____

What was your age? _____

How many serious attempts have you made to lose weight in the last 12 months: _____

In the last 2 years: _____

In the last 5 years: _____

What is your current weight: _____ BMI (If known): _____ Height: _____

Have you ever vomited after eating an overly large meal? (Circle one): Yes / No

Have you ever used laxatives or diuretics to aid in your weight loss? (Circle one): Yes / No

If yes, which? _____

Have you ever maintained a program of exercise?	What exercise do you engage in currently?

Mark below the diets/methods you have used to lose weight (Circle/check as many as apply):

3 Day	Body Building	Suzanne Sommers	Grapefruit	The Zone	Low Sodium	Weight Watchers
48 Hour	Cabbage Soup	Diverticulitis	High Fiber	Vegetarian	Macrobiotic	Other:_____
Atkins	Calorie	Gluten Free	High Protein	Low Carbohydrate	Mayo Clinic	_____
Blood Type	Sugar Free	Gout	Hollywood	Low Cholesterol	Mediterranean	_____

Which of the following medications have you used for weight loss? (Circle/Check all that apply)

Xenical	Didrex
Meridia	Xenadrine
Adipex	Fenluramine
Bontril	Phentermine
Tenuate	Other, Please specify:_____

What factors do you believe were important in helping you succeed in prior weight loss efforts? Explain:

What were the contributing factors that caused you to regain weight in the past? Explain:

Past Psychiatric History

Have you ever seen a psychiatrist, psychologist, or therapist in the past? Yes /No

Were you ever prescribed a medication to help your mood, anxiety, or thinking? Yes / No

Have you ever been hospitalized in a psychiatric facility? Yes / No

If yes, where and when? _____

Do you have medical problems? Yes / No

If so, please list them: _____

_____

Do you use street drugs? Yes / No
If yes, list the drugs, frequency, quantity, and duration of use: _____

_____

Do you smoke cigarettes? Yes / No If yes, for how long? _____

Do you drink alcohol? Yes / No
If yes, how many drinks per day and how many days per week:
_____

Do you use cannabis?: _____

Family History

Does anyone in your family have psychiatric problems? Yes / No

If yes, please explain:_____

Has anyone in your family had problems with weight loss? Yes / No

Is there a family history of substance abuse? Yes / No If yes, please explain:_____

Other

Have you been under a lot of stress lately? Yes / No
If yes, explain: _____

Are you currently employed? Yes / No Do you enjoy your work? Yes / No

What is the highest level of education you have completed? _____

Have you ever suffered physical, emotional or sexual abuse? Yes / No

If yes, please explain:_____

Have you ever served in the armed forces? Yes / No

If yes, which branch, when and for how long? _____

What else is important for us to know?_____

_____

_____

Please check the following that apply:

- o Sad, blue or "blah" feelings
- o Low energy
- o Difficult concentration
- o Low motivation
- o Difficulty with memory
- o Low self-esteem
- o Hopelessness
- o Loss of control
- o Waking up at night
- o Sleeping too much
- o Changes in mood for no reason
- o Thoughts of not wanting to go on
- o Thoughts of ending your life
- o Plans to follow through on taking your life
- o Change in sexual interest
- o Feeling nervous
- o Feeling restless
- o Worrying a lot
- o Difficulty controlling worry
- o Low pep during the day
- o Onset of nervousness for no expected reason
- o Pounding heart or chest pains
- o Shortness of breath
- o Dizziness or unsteadiness
- o Upset stomach when nervous
- o Feeling of going out of your mind
- o Feelings of impending doom
- o Feeling like you might die
- o Feelings like you are out of your body
- o Feelings like things are not real

Have you ever:

- o Seriously hurt someone else
- o Heard a voice when no one was there
- o Thought others might be out to hurt you
- o Thought something which you were not sure was true or not
- o Noticed a change in your personality
- o Had weakness or numbness in any part of your body?
- o Had new onset of headaches
- o Felt like you must do something repeatedly for no reason
- o Had a thought in your mind which you could not get out of your head.
- o Problems with respect or relationships
- o Fears that seem to interfere with your life

CROSSROADS COUNSELING SERVICES PLLC

(Revised 07/09/2020)

PATIENT INFORMATION-PLEASE COMPLETE ALL INFORMATION

PATIENT NAME (LAST, FIRST, M.)			DOB	AGE
ADDRESS: STREET		CITY	STATE	ZIP
SSN:	MARTIAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOW	**HOME PHONE: ( )** **MOBILE PHONE: ( )** **EMAIL ADDRESS:**		
Employer:		Address:		Phone:
Spouse Name:		DOB:		SSN:
Spouse Employer:		Address:		Phone:

If this Patient is a Minor please fill out information below.

MOTHER'S NAME (LAST, FIRST, M)		DOB:
ADDRESS (IF DIFFERENT THAN PATIENT)		PHONE NUMBER:
PLACE OF EMPLOYMENT AND ADDRESS:		SSN
WORK NUMBER:		
FATHERS NAME (LAST, FIRST, M)		DOB:
ADDRESS (IF DIFFERENT)		PHONE NUMBER
PLACE OF EMPLOYMENT AND ADDRESS		SSN
WORK NUMBER		

DIVORCE SITUATIONS: It is *<u>our policy</u>* that any amount left owed after insurance has paid is the responsibility of the *parent who brings the child for their appointments*. We do not bill to anyone other than the parent who initiated the appointment. No exceptions.

INSURANCE INFORMATION

1. PRIMARY INSURANCE NAME:		POLICY ID:	GROUP ID:
SUBSCRIBER'S NAME:		DOB:	SSN:
INSURANCE PHONE NUMBER:	PATIENTS RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER: EXPLAIN		
2. SECONDARY INSURANCE NAME:		POLICY ID:	GROUP ID:
SUBSCRIBER'S NAME:		DOB:	SSN:
INSURANCE PHONE NUMBER:	PATIENTS RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER: EXPLAIN		

What is your ethnic background? American Indian/Alaskan Native___ Caucasian___ Black/African American___ Native Hawaiian/Pacific Islander___ Asian___ Hispanic____ Decline to specify___

Preferred Language_____

IN CASE OF EMERGENCY

NAME OF CLOSEST RELATIVE:	RELATIONSHIP TO PATIENT	HOME/MOBILE PHONE #

The above mentioned is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I *<u>am financially responsible for any and all balances.</u>* I also authorize Crossroads Counseling Services, PLLC to release any information required to process my claims to the insurance. I also understand that if my account becomes delinquent and is sent over to collections there will be a 25% fee accessed on the account balance.

PATIENT/GUARDIAN SIGNATURE: **DATE:**

Crossroads Counseling Services, PLLC

FINANCIAL/INSURANCE POLICY

As a courtesy, Crossroads Counseling Services PLLC will bill your insurance company, responsible party or third-party payer. Insurance companies require that we collect all copays at each session. If your insurance company denies payment, denies coverage for services rendered or a deductible is owed, payment in full is required for the balance due.

If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise a missed appointment/late cancel fee will be charged. Those fees are as follows:

MD/DO/APRN:	$25/$50 missed appt./late cancel fee
LCPC/LCSW/CADC:	$65 missed appt./late cancel fee
Psy.D	$75 missed appt./late cancel fee
LPC/Sliding Scale Services	$30 missed appt./late cancel fee

Checks which are declared non-sufficient funds or stop payment, will be charged a $25.00 service fee.

Accounts turned over to a collection agency for non-payment will have a 25% fee accessed on the account balance.

Insurance will not reimburse for review of records, extensive phone consultation or correspondence, travel time, legal fees and time for responding to subpoena's or court orders, depositions, and missed appointments. These services provided for the client will be billed as separate fees and you may be required to pay a retainer before these services are rendered.

While we try to be as accurate as possible when verifying benefits, your fees may change depending on your eligibility and benefits during the date of your sessions. We can only estimate and will not know exact fee owed until we bill your insurance and get your explanation of benefits back from your insurance company.

My fee schedule has been discussed with me prior to initial appointment. _____
(Initials)

I authorize my insurance benefits to be paid directly to Crossroads Counseling Services PLLC. I understand that I am financially responsible for any balance. I also authorize Crossroads Counseling Services PLLC or insurance company to release any information required to process my claims. I have read and accept the Crossroads Counseling Services PLLC financial policy noted above.

Signature_____Date_____
(Client signature 12 years and older)

Signature_____Date_____
(Parent/Legal Guardian-Guarantor)

Revised 07/09/2020
Approved by A. Solis

INFORMED CONSENT

Thank you for choosing _____ at Crossroads Counseling Services.
(Your Therapist/Clinician's Name)

Today's appointment will take approximately 50-60 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

All the providers at Crossroads Counseling Services, PLLC are licensed and or credentialed in their respective fields. Crossroads Counseling Services, PLLC has providers that include professionally licensed independent contractors. Therapists practice standard cognitive-behavior therapy for most conditions, although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy, plan limitations and risks will be discussed with you today. In the unlikely event that your provider is unable to provide ongoing services, Angela Solis or another assigned licensed clinician through Crossroads Counseling Services will provide those services or we may refer you to an establishment outside of Crossroads Counseling Services, PLLC. Angela Solis, LCPC, CADC may be contacted at 815-941-3882. Your medical records will be either on-site or with your treating provider for seven years.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your verbal communication and clinical records are strictly confidential except for:

a) Information shared with our medical director when medically necessary,
b) Information (diagnosis and dates of service) shared with your insurance company to process your claims
c) Information you and / or your child or children report about physical, sexual or elder abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services,
d) Where you sign a release of information to have specific information shared and
e) If you provide information that informs me that you are in danger of harming yourself or others
f) Information necessary for case supervision or consultation and
h) Or when required by law.

If you are determined to be a clear and present danger to yourself or others, developmentally or intellectually disabled then we are mandated to report you to the Department of Human Services.

It is the policy of Crossroads Counseling Services, PLLC to treat all individuals in a way to not discriminate with regard to race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, or disability.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Crossroads Counseling Services, PLLC clinicians will follow those emergency services with standard counseling and support to the client or the client's family.

E-mail, text messages and social networking sites are not confidential, and we may not be able to respond.

Signature(s)_____ Date_____
(Client signature 12 years or older)

Signature(s)_____ Date_____
(Parent / Legal Guardian)

RIGHT TO RECEIVE CHANGES IN POLICY

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

RIGHT TO REFUSE TREATMENT

You have the right to refuse treatment or any specific treatment procedure and a right to be informed of the consequences resulting from such refusal.

Signature: _____ Date: _____

NOTICE OF HIPAA PRIVACY PRACTICES AND CLIENT RIGHTS:

I / We have read and received a copy of the HIPAA Notice of Privacy Practices and Client Rights document.

Signature(s)_____ Date_____
(Client signature 12 years or older)

Signature(s)_____ Date_____
(Parent / Legal Guardian)

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I / We consent that _____ may be treated as a client by
(Client Name)
Crossroads Counseling Services, PLLC. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.

Signature(s)_____ Date_____
(Parent / Legal Guardian)

CONSENT FOR COMMUNICATION:

I/We consent that _____ may be contacted by Crossroads Counseling Services, PLLC
(Client Name)

Please Circle One:
I prefer appointment reminders to be sent to me via this communication: Phone E-mail

E-mail Address: _____
Preferred Phone Number (for appointment reminders): _____
Other:_____

HIPPA NOTICE: Your Information. Your rights. Our responsibilities

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.

Effective date: February 14, 2020

Crossroads Counseling Services, PLLC has been and will always be totally committed to maintaining client confidentiality. **Angela Solis** is our Privacy Officer and can be contacted at **815-941-3882.** We are required by law to maintain the privacy and security of your protected health information. We will follow the duties and privacy practices in this notice. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

Uses and disclosures of your health information for the purposes of providing services and your rights. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

Treatment: We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants, other professionals who are treating you and potential referral sources.

Payment: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

Healthcare Operations: We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent: There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Reporting suspected abuse, neglect, or domestic violence. Preventing or reducing a serious threat to anyone's health or safety. As stated in the informed consent section, Confidentiality and Emergency Situations, for other uses or restrictions of your information based on State or Federal law. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Right to request how we contact you: It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right to inspect and copy your medical and billing records: You have the right to inspect and obtain a copy of your information contained in your medical records. To request access to your billing or health information, contact the Privacy Officer. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records: If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the Privacy Officer. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures: You may request an accounting of disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosures made for a specific time period no longer than six years, please submit your request in writing to the privacy officer. We will notify you of the cost involved in preparing this list.

Right to release or request restrictions on uses and disclosures of your health information: You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our Privacy Officer. However, we are not required to agree to such a request.

Right to complain: If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services 200 Independence Ave. S.W., Washington, D.C. 20201 or 877-696-6775. An individual will not be retaliated against for filing such a complaint.

Right to receive a copy of this and any changes in policy: You have the right to receive a copy oy this document and any future policy changes secondary to changes in state and federal laws. This can be obtained from the Privacy Officer.

Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.