LIGHTHOUSE
MENTAL WELLNESS

Thank you for choosing Lighthouse Mental Wellness. Please review the information below and contact us with any questions.

Instructions for completing the New Client Registration Packet

Please print and complete the New Client Registration Packet prior to your first appointment. Note the following:

- There are separate registration packets for children (under 18) and adults (18 and over). Please complete the appropriate packet based on the client's age.
- Each packet contains two Release of Information forms. One is for the client's therapist and the other is for the client's pediatrician (clients under 18)/primary care provider (clients 18 and over).

Preparing for your first appointment

As you prepare for your first appointment, please keep the following in mind:

- Arrive 15 minutes early for your appointment
- Bring your printed and completed New Client Registration Packet
- Bring copies of relevant documents, including a list of your current medications and doses
- All children (under 18) must be accompanied by a medical decision-maker
- Although we do not currently accept insurance, we will still need a copy of your insurance card to keep on file for medication/prescribing purposes. Please bring your insurance card and ID to your first visit.

Please do not hesitate to contact us at 781.427.7070 with any questions.

LIGHTHOUSE
MENTAL WELLNESS

Client Registration

Client Name:_____
(first) *(middle)* *(last)*

D.O.B: _____/_____/_____ Age: _____ Sex (please circle one): Male Female

Gender Identity: _____ Preferred Pronouns: _____

Address:_____City/State/Zip:_____

Home Phone:( ) _____voicemail? (y/n) **Mobile:**( ) _____ voicemail? (y/n)

Email:_____ Reminder preference: (call | text | email)

Occupation: _____ Employer:_____

Work Phone: ( ) _____ SSN:_____

Marital Status (must circle one): Single Married Widowed Divorced

Minor Clients: Parent/Guardian Name: _____

Primary Insurance Carrier: _____

Identification #: _____**Group #:** _____

Subscriber: _____ **Subscriber Phone: ( )** _____

Subscriber Address: _____

Date of Birth: _____/_____/_____ **Social Security #:**_____

Authorization #: _____**# of Visits:** _____ **Dates:** _____ **-** _____

Secondary Insurance Carrier _____

Identification #: _____Group #: _____

Subscriber: _____ Subscriber Phone: ( ) _____

Subscriber Address: _____

Subscriber Date of Birth: _____/_____/_____

I authorize the release of information necessary for the completion of any claim for insurance purposes. I further authorize appropriate medical payments to my provider. I acknowledge that I am responsible for such payments if not paid by my insurance carrier (s). Fees that are charged and not paid by the insurance company within 90 days are the responsibility of the client. I am aware that the use of cell phones does not guarantee confidentiality.

SIGNATURE: _____**DATE:** _____
(or signature of parent/guardian if under 18)

LIGHTHOUSE
MENTAL WELLNESS

Health Insurance Portability & Accountability Act (HIPAA)
Consent for Purpose of Treatment, Payment, and Health Care Operations

I consent to the use and disclosure of my protected health information (PHI) by Lighthouse Mental Wellness, PLLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations at Lighthouse Mental Wellness, PLLC.

I understand that diagnosis or treatment of me by Lighthouse Mental Wellness, PLLC, might be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have a right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or health care operations. Lighthouse Mental Wellness, PLLC, is not required to agree to the restrictions I request.

I understand that Lighthouse Mental Wellness, PLLC, uses a variety of electronic communication methods, including phone, text messages, and e-mail to communicate with me for the limited purposes of appointments, available services, and other healthcare-related communications. I authorize Lighthouse Mental Wellness, PLLC to disclose limited PHI to other persons who may answer my electronic communications (phone, text message, email, and voicemail). This may include information about appointments, available services, or other healthcare-related communications.

I have the right to revoke this consent, in writing, at any time, except to the extent that Lighthouse Mental Wellness, PLLC, has taken action in reliance on this consent.

Signature of Client or Guardian Date

Name of Client (please print)

LIGHTHOUSE
MENTAL WELLNESS

Office Policies

The providers at Lighthouse Mental Wellness, PLLC, are committed to providing you with mental health care that is both professional and thoughtful. Clients are expected to be involved in their care and actively participate in treatment. This includes making scheduled appointments and following through with treatment recommendations.

- If medication is prescribed, it is the client's right to receive information about the medication, including potential adverse effects.
- A legal guardian with medical decision-making authority must accompany minors. If there is split custody with joint medical decision-making authority, both guardians must be present to consent to treatment.

Fees and Payments

Payment is expected at the time services are rendered. Clients can pay by credit card or check. At this time, we do not accept insurance. Clients are responsible determining if insurance will reimburse them for care. You are responsible for determining insurance eligibility and tracking reimbursement. You are responsible for all charges not reimbursed by your insurance company.

Services fees are collected for any services provided outside of appointment times (e.g. completion of forms, phone calls, collaboration with schools, etc.). Insurance does not typically reimburse for these fees.

Fee schedule	
Initial Evaluation	$300
Follow-Up Appointments	$150
Missed Appointments (any appointment not cancelled 24 hours in advance)	$100
Additional Services (e.g. phone calls; letters; emails to schools, hospitals, primary care practitioners, and therapists; etc.)	$25 per 10 min (10 min minimum)
We cannot currently provide legal documentation (e.g. disability paperwork).	

Checks should be made payable to *Lighthouse Mental Wellness, PLLC*. You can also pay with Visa, Mastercard, Discover, and American Express

LIGHTHOUSE
MENTAL WELLNESS

Cancellations and No-Shows

We strive to provide you with professional psychiatric care. To accomplish this, clients must adhere to appointment times. Clients who do not cancel their appointment 24 hours in advance will be charged $100. This applies to missed appointments due to weather or traffic concerns.

Clients who are more than 10 minutes late for their appointment will not be seen and will be charged the missed appointment fee of $100.

Emergencies

For after-hours emergencies, please call 911 or go to the nearest emergency room.

Prescription Refills

Prescription refill requests should be made 72 hours in advance by voice message or text message at (781) 427-7070. Please include your full name, date of birth, pharmacy, and the medication you are requesting. We do not accept refill requests solicited by pharmacies; requests must be made directly by the client/guardian.

Feedback/Concerns

Lighthouse Mental Wellness strives to provide you with outstanding mental health care. If you are unhappy with your service, please speak directly with us so that we may try to address your feedback or resolve any concerns.

Professional Records

We maintain an electronic health record, which is standard practice in psychiatric care. Though clients are entitled to review these records, due to the sensitivity of the subject material and the possibility for misinterpretation, it may be deemed damaging to release these records to the client. If deemed potentially damaging, we can provide the full record to the mental health provider of your choice. In addition, we will gladly set up an appointment to review your record with you to discuss the contents of your record and/or provide you with a treatment summary.

Consent

By signing below, I am acknowledging that I have read this agreement and agree to all terms. I am also consenting to receiving prescription medications as deemed appropriate by my provider, including possible neuroleptic or scheduled medications. I understand that if I violate the terms of this agreement, treatment outcomes could be impacted and may require termination. My signature below acknowledges that I have received a copy of this document if I requested it.

CLIENT NAME:_____ DOB:_____

SIGNATURE OF RESPONSIBLE PARTY: _____DATE: _____

LIGHTHOUSE
MENTAL WELLNESS

REQUEST/RELEASE OF CONFIDENTIAL INFORMATION

CLIENT NAME: _____
Date of Birth: _____

I hereby authorize: (Name and address of **outside** provider)

_____
_____
_____

To □ send / □ receive the following information from the record of the above named client:

□ Psychiatric evaluation
□ Progress Notes; Psychotherapy Notes
□ Medical Exam/Lab Results
□ Psychological Testing Results
□ Case History
□ Hospital Admission and Discharge Summaries
□ Other _____
□ All health information, excluding _____

This information is needed for the purpose of coordination of care.

I understand that my record may contain information about infectious diseases including HIV/AIDS status, alcohol or drug abuse, STDs, information relative to the diagnosis and treatment of my mental or emotional conditions. I consent to this information being disclosed. I understand that the provider abides by Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191which protects the confidentiality of the record and that information in my record cannot be disclosed without consent unless otherwise provided for in the regulation.

I understand that this directive is subject to revocation at any time upon written request. Otherwise this consent will expire upon termination of care or from date: _____

I herewith release and hold harmless Lighthouse Mental Wellness, PLLC and any contractors, agents, employees, directors or volunteers from any liability for the release of information provided in accordance with this directive.

If information is requested, please send to:

Lighthouse Mental Wellness, PLLC
200 Cordwainer Dr
Norwell, Ma 02061

Phone: 781-427-7070
Fax: 781-427-7071

Signed under the pains and penalties of perjury:

Signature: _____ (Client/Guardian) **Date:** _____

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* **REVOCATION** OF REQUEST FOR INFORMATION- *To be signed when revoking this release.**

Signature: _____ (Client/Guardian) Date: _____

LIGHTHOUSE
MENTAL WELLNESS

REQUEST/RELEASE OF CONFIDENTIAL INFORMATION

CLIENT NAME: _____
Date of Birth: _____

I hereby authorize: (Name and address of **outside** provider)

_____
_____
_____

To □ send / □ receive the following information from the record of the above named client:

□ Psychiatric evaluation
□ Progress Notes; Psychotherapy Notes
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200 Cordwainer Dr
Norwell, Ma 02061

Phone: 781-427-7070
Fax: 781-427-7071

Signed under the pains and penalties of perjury:

Signature: _____ (Client/Guardian) **Date:** _____

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* **REVOCATION** OF REQUEST FOR INFORMATION- *To be signed when revoking this release.**

Signature: _____ (Client/Guardian) Date: _____

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number _____

Score _____

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	_____	_____	_____	_____
2. I did not feel like eating, I wasn't very hungry.	_____	_____	_____	_____
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	_____	_____	_____	_____
4. I felt like I was just as good as other kids.	_____	_____	_____	_____
5. I felt like I couldn't pay attention to what I was doing.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	_____	_____	_____	_____
7. I felt like I was too tired to do things.	_____	_____	_____	_____
8. I felt like something good was going to happen.	_____	_____	_____	_____
9. I felt like things I did before didn't work out right.	_____	_____	_____	_____
10. I felt scared.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	_____	_____	_____	_____
12. I was happy.	_____	_____	_____	_____
13. I was more quiet than usual.	_____	_____	_____	_____
14. I felt lonely, like I didn't have any friends.	_____	_____	_____	_____
15. I felt like kids I know were not friendly or that they didn't want to be with me.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	_____	_____	_____	_____
17. I felt like crying.	_____	_____	_____	_____
18. I felt sad.	_____	_____	_____	_____
19. I felt people didn't like me.	_____	_____	_____	_____
20. It was hard to get started doing things.	_____	_____	_____	_____

Child Name: _____
Date: _____

YMRS - PARENT VERSION

Directions: Please read each question below and circle the answer number which most closely describes your child.

1. Mood - ***Is your child's mood higher (better) than usual?***

0. No
1. Mildly or possibly increased
2. Definite elevation- more optimistic, self-confident; cheerful; appropriate to their conversation
3. Elevated but inappropriate to content; joking, mildly silly
4. Euphoric; inappropriate laughter; singing/making noises; very silly

2. Motor Activity/Energy - ***Does your child's energy level or motor activity appear to be greater than usual?***

0. No
1. Mildly or possibly increased
2. More animated; increased gesturing
3. Energy is excessive; hyperactive at times; restless but can be calmed
4. Very excited; continuous hyperactivity; cannot be calmed

3. Sexual Interest - ***Is your child showing more than usual interest in sexual matters?***

0. No
1. Mildly or possibly increased
2. Definite increase when the topic arises
3. Talks spontaneously about sexual matters; gives more detail than usual; more interested in girls/boys than usual
4. Has shown open sexual behavior- touching others or self inappropriately

4. Sleep - ***Has your child's sleep decreased lately?***

0. No
1. Sleeping less than normal amount by up to one hour
2. Sleeping less than normal amount by more than one hour
3. Need for sleep appears decreased; less than four hours
4. Denies need for sleep; has stayed up one night or more

Name: _____
Date: _____

YMRS-Parent Continued…

5. Irritability - ***Has your child appeared irritable?***

0. No more than usual
2. More grouchy or crabby
4. Irritable openly several times throughout the day; recent episodes of anger with family, at school, or with friends
6. Frequently irritable to point of being rude or withdrawn
8. Hostile and uncooperative about all the time

6. Speech (rate and amount) - ***Is your child talking more quickly or more than usual?***

0. No change
2. Seems more talkative
4. Talking faster or more to say at times
6. Talking more or faster to point he/she is difficult to interrupt
8. Continuous speech; unable to interrupt

7. Thoughts - ***Has your child shown changes in his/her thought patterns?***

0. No
1. Thinking faster; some decrease in concentration; talking "around the issue"
2. Distractible; loses track of the point; changes topics frequently; thoughts racing
3. Difficult to follow; goes from one idea to the next; topics do not relate; makes rhymes or repeats words
4. Not understandable; he/she doesn't seem to make any sense

8. Content - ***Is your child talking about different things than usual?***

0. No
2. He/she has new interests and is making more plans
4. Making special projects; more religious or interested in God
6. Thinks more of him/herself; believes he/she has special powers; believes he/she is receiving special messages
8. Is hearing unreal noises/voices; detects odors no one else smells; feels unusual sensations; has unreal beliefs

Name: _____
Date: _____

YMRS-Parent Continued…

9. Disruptive-Aggressive Behavior - ***Has your child been more disruptive or aggressive?***

0. No; he/she is cooperative
2. Sarcastic; loud; defensive
4. More demanding; making threats
6. Has threatened a family member or teacher; shouting; knocking over possessions/ furniture or hitting a wall
8. Has attacked family member, teacher, or peer; destroyed property; cannot be spoken to without violence

10. Appearance - ***Has your child's interest in his/her appearance changed recently?***

0. No
1. A little less or more interest in grooming than usual
2. Doesn't care about washing or changing clothes, or is changing clothes more than three time a day
3. Very messy; needs to be supervised to finish dressing; applying makeup in overly-done or poor fashion
4. Refuses to dress appropriately; wearing bizarre styles

11. Insight - ***Does your child think he/she needs help at this time?***

0. Yes; admits difficulties and wants treatment
1. Believes there might be something wrong
2. Admits to change in behavior but denies he/she needs help
3. Admits behavior might have changed but denies need for help
4. Denies there have been any changes in his/her behavior/thinking

Signature of Parent / Guardian: _____