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.

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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)

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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

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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
□ Medical Exam/Lab Results
□ Psychological Testing Results
□ Case History
□ Hospital Admission and Discharge Summaries
□ Other _____
□ All health information, excluding _____

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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: _____

Name_____ Date_____

DEPRESSION SCALE

INSTRUCTIONS

This questionnaire includes questions about symptoms of depression. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

RATING GUIDELINES

0=not at all true (0 days)
1=rarely true (1-2 days)
2=sometimes true (3-4 days)
3=often true (5-6 days)
4=almost always true (every day)

During the PAST WEEK, INCLUDING TODAY....

1.	I felt sad or depressed	0	1	2	3	4
2.	I was not as interested in my usual activities	0	1	2	3	4
3.	My appetite was poor and I didn't feel like eating	0	1	2	3	4
4.	My appetite was much greater than usual	0	1	2	3	4
5.	I had difficulty sleeping	0	1	2	3	4
6.	I was sleeping too much	0	1	2	3	4
7.	I felt very fidgety, making it difficult to sit still	0	1	2	3	4
8.	I felt physically slowed down, like my body was stuck in mud	0	1	2	3	4
9.	My energy level was low	0	1	2	3	4
10.	I felt guilty	0	1	2	3	4
11.	I thought I was a failure	0	1	2	3	4
12.	I had problems concentrating	0	1	2	3	4
13.	I had more difficulties making decisions than usual	0	1	2	3	4
14.	I wished I was dead	0	1	2	3	4
15.	I thought about killing myself	0	1	2	3	4
16.	I thought that the future looked hopeless	0	1	2	3	4

17. Overall, how much have symptoms of depression interfered with or caused difficulties in your life during the past week?
    0) not at all
    1) a little bit
    2) a moderate amount
    3) quite a bit
    4) extremely

18. How would you rate your overall quality of life during the past week?
    0) very good, my life could hardly be better
    1) pretty good, most things are going well
    2) the good and bad parts are about equal
    3) pretty bad, most things are going poorly
    4) very bad, my life could hardly be worse

Zimmerman M, Chelminski I, McGlinchey JB, Posternak MA: A clinically useful depression outcome scale. Comprehensive Psychiatry, 49:131-140, 2008.

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.