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: ____________________

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: ____

Insurance ID Number: ____

Medical History Self Report

Patient:____________________ Date of Birth:_____________

Current Physician:__________________________________

Pharmacy: ____________________________Phone:_________________

Allergies:_____________________________________

Are there currently OR have there previously been problems with any of the following:

Condition	Yes	No	Condition	Yes	No
Skin Problems			Eating		
Easy Bruising			Alcohol		
Glaucoma			Street Drugs		
Hearing			Blood Pressure		
Headaches			Heart Disease		
Black outs / Fainting			Rheumatic Fever		
Numbness / Tingling			Nausea / Vomiting		
Thyroid Problems			Ulcers		
Blood Sugar			Liver Disease		
Sickle Cell			Pregnancy		
HIV/AIDS			Sexual function		
Fatigue			Difficulty Walking		
Anemia			Pain		
Shortness of breath			Sleeping too much		
Fever			Sleeping too little		
Gallstones			Chemical Exposure		
Cancer			Seizures		

Have any family members had any of the following?

	Yes	No	Who
Depression	*	*	________________________
Bipolar Disorder	*	*	________________________
Suicide	*	*	________________________
Schizophrenia	*	*	________________________
Eating Disorder	*	*	________________________
Anxiety Disorder	*	*	________________________
Alcohol/Drug Problems	*	*	________________________
ADHD	*	*	________________________
Thryoid Problems	*	*	________________________
Asthma	*	*	________________________
Diabetes	*	*	________________________
Stroke	*	*	________________________
Dementia	*	*	________________________
Stomach Problems	*	*	________________________
Seizures	*	*	________________________
Heart Problems	*	*	________________________
Cancer	*	*	________________________
High Blood Pressure	*	*	________________________
Abnormal Heart Rhythm	*	*	________________________
Sudden Cardiac Death	*	*	________________________
Tics	*	*	________________________

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

Medication	Dosage	For What Reason?	How Long?	Side Effects

Psychiatric care in the past? (such as psychiatrist, psychologist, social worker, nurse, counselor, or testing)

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

Patient Name: ____

Please briefly describe the reason you scheduled this initial appointment. ____

____

____

____

____

____

____

____

____

____

____

____

LAKE PSYCHOLOGICAL SERVICES
115 Atrium Way
Suite 221
Columbia, South Carolina 29223

- **NOTICE OF HIPAA PRIVACY PRACTICES PROTECTIVE SUMMARY**

This notice of HIPAA privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

This document tells you the ways this practice may use and disclose medical information about you and lists your rights regarding the use and disclosure of medical information. Disclosure means providing your medical information to someone else. You have a right to a copy of this notice.

This practice is permitted to use and disclose medical information about you for:

Treatment: This practice may use and disclose medical information about you to provide, coordinate, and manage your health care and related services. This may include disclosing your medical information to people who may be involved in your total treatment plan, such as family members, clergy, therapists or physicians, with your consent. Parents/legal guardians for minors may give consent.

Payment: This practice may use and disclose medical information about you to bill and obtain payment for the treatment and services provided to you.

Medical information about you may be used or disclosed without your authorization for the following purposes:

- Uses and disclosures required by law, such as reporting child abuse and neglect. Your information will be shared in this type of situation.
- Disclosures about victims of abuse, neglect or domestic violence. Information about the victim may be shared with a government authority or protective service agency to prevent harm to the individual or others.
- Disclosures for judicial and administrative proceedings, such as responding to a subpoena, discovery request, or other lawful process.
- Disclosures for law enforcement purposes, such as reporting certain physical injuries or responding to a grand jury subpoena or law enforcement investigation.
- Uses and disclosures to coroners, medical examiners, or funeral directors, such as identifying a deceased person or determining cause of death.
- Uses and disclosures to avert a serious threat to health or safety, such as, law enforcement may need to identify or apprehend an individual.

Listed below are your rights with respect to protected health information (PHI) about you. All requests must be made in writing.

- Right to inspect and copy your medical information with some restrictions.

- Right to request amendment to your protected health information, although provider does not have to agree to this request.
- Right to request restrictions on certain use and disclosure, although provider does not have to agree to this request.
- Right to request confidential communications from provider to you.
- Right to receive an accounting of disclosures of your medical information.
- If you have a complaint regarding use or disclosures of confidential information about you, you may file a written complaint with U.S. DHS, Atlanta Federal Center, Ste 3B70, 61 Forsyth Street, SW, Atlanta, GA 30303-8909.

Any use or disclosure of your medical information other than those listed above requires your written authorization or authorization from your personal representative. You further have the right to revoke such authorization by requesting and signing a revocation of authorization form. This practice will provide you an Authorization Form to sign. This practice reserves the right to change the terms of this notice and make the new notice provisions effective for all protected health information that I maintain. You will be provided with any changes.

Written by: ____