Intake Checklist

Please send all requested documents and completed paperwork to Life Skills Village **TWO DAYS BEFORE** your scheduled appointment. ***Failure to have these documents completed and to Life Skills Village two days prior to your appointment may result in your assessments being rescheduled.***

□ Client Registration form, including:

- Physical address where client currently resides
- Contact information for all case managers (both internal and external)
- List of guardians and caregivers
- List of all treating physicians (primary, neurology, PM&R, psychiatrist, etc.)
  List of all therapists involved in your care (psychologists, behaviorists, vocational, recreational, occupational, speech-language pathologists, physical therapists)
- Current insurance information

□ State issued identification (to be scanned at appointment)

□ Insurance cards (to be scanned at appointment)

□ Signed prescription from physician or referral from a psychologist

□ Signed Assignment of Benefits form

□ Signed HIPAA Authorization and Release forms

□ Current neuropsychological report (completed within the last 12 months)

□ Attorney contact information

□ Transportation contact information

Fax all completed forms to Life Skills Village at 248.788.4300.

Life Skills Village
248.788.4300 (phone)
248.605.8099 (fax)
25900 Greenfield Rd., Ste. 100
Oak Park, MI 48237

Community Reintegration Reimagined.
www.LifeSkillsVillage.com

Sheltered Workshop
914 West Nine Mile
Ferndale, MI 48220

Client Registration

Client Information

Name _____ Date of Birth _____/_____/_____ SSN _____-_____-_____ Date of Loss _____/_____/_____

Phone (_____) _____-_____ Alternate (_____) _____-_____ Email _____

Address _____City_____ State _____ Zip Code _____ Apt/Suite _____

Guardian Information

Guardian Name _____ Relationship to client _____ Phone (_____) _____-_____

Alternate (_____) _____-_____ Email _____

Address _____City_____ State _____ Zip Code _____ Apt/Suite _____

Case Manager Information

Case Manager _____ Phone (_____) _____-_____ Alternate (____) _____-_____

Fax (____) _____-_____ Email _____

Address _____City_____ State _____ Zip Code _____ Apt/Suite _____

Referral Information

Name of referring person _____ Title/Position _____

Company/Practice Name _____ Email/Website _____

Address _____City_____ State _____ Zip Code _____ Apt/Suite _____

Phone (____) _____-_____ Alternate (____) _____-_____ Fax (____) _____-_____

Reason for referral: _____

Diagnosis

Was the injury auto related? _____ Yes _____No

If no, what is the diagnosis? _____

Health Insurance Information (please provide copies of all insurance cards and ID)

Health Insurance: (circle one) y n Active Policy Dates _____Company: _____

Policy Number _____ Group Number _____

Mailing Address _____ City _____ State _____ Zip Code _____

Phone (___) _____-_____ Ext _____ Fax (____) _____-_____ Website _____

Auto Insurance Information

Auto Insurance: (circle one) Y N Company ____________________________________ Claim Number _______________________________

Adjuster __________________________________ Phone (____) _____-_________ Alternate (____) _____-_______ Fax (____) ____-_______

Mailing Address ____ City ______________________ Zip Code ___________ Suite _________

Transportation Information

Do you receive medical transportation? Y N Company ____ Phone (____) _____-________

Driver(s) ____ Phone (____) _____-________ Fax (____) _____-________

Address ____City__________________ State _______ Zip Code __________ Apt/Suite ______

Attorney Information

Do you or have you had an attorney? Y N Attorney _________________________________ Office Name ____________________________

Phone (____) _____-______ Alternate (____) _____-_______ Fax (____) _____-_______ Website/email _________________________________

Address ____City__________________ State _______ Zip Code __________ Apt/Suite _______

Have you ever received a settlement on your case? Y N if yes, please list date and amount ____

Are you currently in court regarding your auto claim and injury? Y N if yes, please list date case was opened ___________________________

Medical Provider Information

Are you currently seeing any doctors or therapists? Y N if yes, please list physician/therapist information below.

Physician _______________________________________ Specialty __________________ Phone (____) ____-______ Fax (____) _____-______

Address ____City____________________ State ________ Zip Code __________ Apt/Suite ______

Physician _______________________________________ Specialty __________________ Phone (____) ____-______ Fax (____) _____-______

Address ____City____________________ State ________ Zip Code __________ Apt/Suite ______

Physician _______________________________________ Specialty __________________ Phone (____) ____-______ Fax (____) _____-______

Address ____City____________________ State ________ Zip Code __________ Apt/Suite ______

Physician _______________________________________ Specialty __________________ Phone (____) ____-______ Fax (____) _____-______

Address ____City____________________ State ________ Zip Code __________ Apt/Suite ______

Physician _______________________________________ Specialty __________________ Phone (____) ____-______ Fax (____) _____-______

Address ____City____________________ State ________ Zip Code __________ Apt/Suite ______

Medications

Are you currently taking any medications? Y N If yes, please list all medication below.

PATIENT HISTORY QUESTIONNAIRE

Date _____ Client Name _____ DOB

DOI _____

Unintentional weight loss >/= 10lbs in 2 mos.		
Difficulty eating >7days		
Spinal cord injury		
Liver problems/hepatitis		
Kidney/renal problems		
Dialysis		
Hiatal hernia		
Low blood sugar		
Hard of hearing		
Inflammatory disorder		
Arthritis ☐ rheumatoid ☐ osteo		
Osteoporosis		
Varicose veins, leg swelling, ulcerations		
Prostate problems		
Cancer		
Depression		
MRSA/VRE		
Recent infections		
Hospital w/in 30days		
Flu vaccine		
Pneumonia vaccine		

ALLERGIES AND REACTIONS	
Food Allergies	**Reaction**
Drug Allergies	**Reaction**
Other	**Reaction**
Iodine Allergy? ☐ yes no	
Allergic to tape? ☐ yes ☐ no	
Balloon, rubber, kiwi, or strawberry allergy? ☐ yes ☐ no	

FEMALE (childbearing age)	yes	no
Pregnant		
Breastfeeding		
Last menstrual period (date):		

Life Skills Village
248.788.4300 (phone)
248.605.8099 (fax)
25900 Greenfield Rd., Ste. 100
Oak Park, MI 48237

Sheltered Workshop
914 West Nine Mile
Ferndale, MI 48220

HAS ANYONE IN YOUR FAMILY HAD	yes	no
Heart problems		
High blood pressure		
Cancer		
Diabetes		
Blood clots		

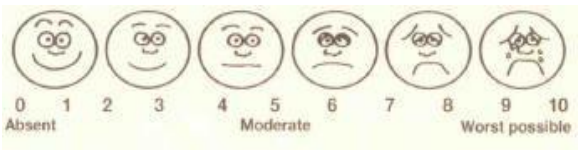
PREVIOUS SURGERIES/MAJOR HOSPITALIZATIONS	DATE

DIABETES ASSESSMENT	yes	no
Have you ever been told that you have diabetes or high blood sugar?		
Have you gone through diabetes education within the last 3 years?		

MEDICAL HISTORY	yes	no
Have you had…		
Abnormal bleeding problems		
Anemia/blood clots		
Blood transfusions		
Any abnormal reaction		
Sleep apnea		
Heart problems/angina/CHF ☐Pacemaker ☐implantable defibrillator ☐heart valve implant ☐heart stent		
High blood pressure		
Stroke/head injury/brain disease		
Has this affected ability to speak/comprehend		
Seizures		
Glaucoma/vision problems		
Thyroid problems		
Breathing/lung problems/asthma		
Emphysema		
COPD		
Tuberculosis		
Treated?		
GI problems/ulcers		

FUNCTIONAL MOBILITY STATUS		
Has your ability to perform the following tasks declined in the last 7 days? Check all that apply **☐ none ☐ walking ☐contractures** **☐Sitting ☐ standing ☐ moving from place to place** **Do you use:** **☐ walker ☐cane ☐wheelchair** **☐Brace ☐crutches ☐prosthesis**		
DO YOU HAVE/USE?	YES	NO
Night sweats		
Extended persistent cough		
Cough up blood		
An infection		
Nasal problems		
Mouth sores		
Difficulty swallowing/taking pills		
Ostomy		
Nutrition formula by tube or IV		
Need for special diet education		
History of a transplant		
Your name on a transplant list		
Dentures		
Loose teeth		
Caps		
Hearing aids		
Contacts		
Glasses		
DO YOU…	yes	no
Smoke		
Have you stopped smoking in the last year		
Use alcoholic beverages		
Use recreational drugs		
Use caffeine		
Object to blood transfusions		
Object to blood for life threatening conditions		
Donate own blood		

PAIN ASSESSMENT



Pain level at present is:
What number is acceptable to you (target no.)
Location of pain:

Describe pain:

Comfort measures used before:

	yes	no
Has pain at rest or pain that awakens at night		
Pain increases with initiation of activities		
Pain increases with weight bearing		
Pain interferes with activities of daily living		
Takes NSAIDs or meds to deal with discomfort		

LEARNING NEEDS ASSESSMENT		
Is English your primary language		
Do you need an interpreter		
What is the highest level of education you have completed?		
How do you learn best? ☐reading ☐seeing ☐hearing ☐doing		
SOCIAL STATUS		
Living situation: ☐ home ☐nursing home ☐group home ☐apartment ☐ assisted living ☐ other		
Living arrangement: ☐alone ☐with spouse ☐other		
Primary care giver: ☐self ☐spouse ☐child ☐relative ☐friend ☐paid attendant		
Is there anyone who can help with your care at home if needed? ☐Yes ☐no		
Are others dependent on you? ☐Yes ☐no		
Any major stressful events present in your life? ☐yes ☐no		
Have you ever used a Home Health Agency? ☐ yes ☐ no		
Name of agency:		
Have you recently been a victim of verbal, physical or sexual abuse? ☐ yes ☐ no		
MEDICAL EQUIPMENT		
Do you currently have any medical equipment at home? **Provided by:** **☐Oxygen** **☐Wheelchair** **☐Hospital bed** **☐other _____**		
MENTAL HEALTH HISTORY	**yes**	**no**
Alcohol abuse		
anxiety		
Bipolar		
Depression		
Drug abuse		
Eating disorder		
Obsessive compulsive disorder		
Psychosis		
schizophrenia		

CURRENT SYMPTOMS

Do you presently have any of the following complaints or symptoms?

	Yes	No		Yes	No		Yes	No
Fever			Sputum/phlegm prod.			Poor appetite		
Vomiting			Nausea			Stomach pain		
Sore throat			Cough			Persistent hoarseness		
Unusual thirst			Trouble breathing			Wheezing		
Black out spells			Frequent/severe headache			Dizziness/lightheaded		
Chest tight/pressure			Trouble seeing			Seeing double		
Pain in eyes			Difficulty/trouble sleeping			Feel unusually tired		
Easy bruising			Swelling			Leg pain		
Muscle weakness			Tremor			Joint pain/stiffness		
Joint swelling			Muscle or body ache			Neck pain		
Back pain			Heart palpitations			Numbness or tingling		
Itching			Skin rash			Unusual skin growth		
Changing skin mole			Recent weight gain _____#			Recent weight loss _____#		
Trouble swallowing			Coughing up blood			Vomiting blood		
Chest pain			Vaginal bleeding			Vaginal discharge		
Vaginal itching			Abnormal menstrual period			Discharge from penis		
Black stool			Bloody stool			Bloody urine		
Difficulty urinating			Frequent urination			Breast lump		
Burning or pain with urination			Diarrhea			Constipation		
Wear glasses			Memory loss			Nose bleeds		
Wear hearing aid			Ringing in ears			Earache		
Trouble hearing			Loss of balance			Personality change		
Feel nervous			Feel depressed			Feel suicidal		

Signature of person completing form
Date

_____

Patient Signature (if different)
Date

_____

AGREEMENT TO PARTICIPATE

I, _____, willingly agree to participate in all phases of the Life Skills Village community reintegration program. Life Skills Village therapy includes, but is not limited to, behavioral and cognitive therapies to improve vocational, educational, living, and social appropriateness and functioning. The purpose of this program is to help me regain independence and reclaim a healthy identity. I understand that this program may challenge and frustrate me before independence is gained. Next are some steps I need to take to get the most out of this program:

1. I understand that I need to have a positive attitude towards the program, the treatment approach, and the staff. The staff, both clinical and non-clinical, is here to work with me to help me achieve my goals. _____

2. I understand and agree that I need to set goals for myself and gradually increase my activity level based on the goal(s) that I set. I realize that I should try not to do more than my goal on a good day or less than my goal on a bad day. I also understand that as my goals are achieved, I may want to set new goals. _____

3. Consistency of treatment is essential for success. With that, I understand and agree that I need to attend Life Skills Village therapy on all of my scheduled days. My scheduled days to attend Life Skills Village will be determined on my first day of programming. I also understand that there is a minimum attendance requirement per my treatment plan._____

4. I understand and agree that during my time at Life Skills Village, I have a specialized team of clinicians working with me to achieve my goal of independence. If I have outside therapists, I will relay this information to Life Skills Village staff so that they can work together to maximize my progress and treatment. I will not treat with other clinicians on my Life Skills Village goals. _____

5. I will carry over my increased activity level in my home environment. Therefore, participation by my family, caretaker, or significant other is expected and I will make every effort to have them participate in the program, when appropriate. _____

6. I understand and agree that if I do not participate in the programming provided to me by Life Skills Village (and staff), or if I have reached all of my goals without making new goals, that I may be discharged from the program. _____

7. I understand that at my discharge I may be "promoted" to Life Skills Academy, the alumnus program of Life Skills Village. In this program I may be required to schedule weekly meetings with a Life Skills therapist to discuss my progress or to engage in the group sessions at least twice per week. _____

To fully benefit from and successfully complete Life Skills Village programming, I understand that all parts of this agreement must be followed and that failure to comply with this agreement could result in my discharge from the program. By signing this agreement, I acknowledge that it has been discussed with me in detail and I understand all of the terms of this agreement.

Signed: _____Date/Time: _____

LSV Staff: _____ Date/Time: _____

LifeSkillsVillage

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Date: _____

Patient Name: _____ DOI: _____
Date of Birth: _____ SS #: _____

I, _____, (name of patient), do hereby authorize Life Skills Village, PLLC to use and/or disclose health information about me, as specified below, to:

- Any third party payer or insurance company (including Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, worker's disability compensation insurers, health maintenance organizations, preferred provider organizations, and managed care plans which are responsible in whole or in part for paying my bill;
- Any health care facility, physician, medical case manager, or mental health professional which is currently treating me or to which I am referred or transferred for continuity of care;
- For collection purposes; or for continuity of care with current treating providers listed below. I understand that fax data transmissions and email of notes and reports will be included in this release of information;
- Other (specify or write "None"). Release any/all records to:

Name: _____ Relationship: _____
Address: _____ Phone: _____
City, State, Zip: _____ Fax: _____

Name: _____ Relationship: _____
Address: _____ Phone: _____
City, State, Zip: _____ Fax: _____

Name: _____ Relationship: _____
Address: _____ Phone: _____
City, State, Zip: _____ Fax: _____

☐ **If you decline this release please check the box. Please know that we will not be able to release information without a new release being filled out and signed. We cannot accept verbal authorizations.**

This consent will terminate upon the cessation of treatment or written revocation by me. I understand that I have the right to revoke this consent upon notification of the releasing provider.

_____

Signature of client or legal guardian Date

_____

Witness Date

LifeSkillsVillage

AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION

Date: _____

Patient Name: _____ DOI: _____
Date of Birth: _____ SS #: _____

I, _____, (name of patient), do hereby authorize and request the release of any and all information concerning me from my medical records, including medical, psychological, neuropsychological, and social service records and substance abuse records:
Specific information to include:

_____ Records of psychological and neuropsychological services and all progress notes and reports

_____ Medical records including diagnostic test reports

_____ Other records: _____

_____
From the records of: _____

For the purpose of: _____

To be released and send to: Life Skills Village, PLLC
28555 Orchard Lake Rd., Suite 106
Farmington Hills, MI 48334
F: 248-605-8099 O: 248-788-4300

This consent for release of information shall terminate upon cessation of treatment or written revocation by me. I understand that I have the right to revoke this consent upon notification of the releasing provider.

_____

Signature of client or legal guardian Date

_____

Witness Date

LifeSkillsVillage

PHYSICIAN AUTHORIZATION

NAME:
PHYSICIAN: (please print)
ADDRESS:

Directions: **Please complete the following form in its entirety with your signature and date of completion. Person considered for Admission must have a Traumatic Brain Injury Diagnosis Classification.**

Please indicate diagnosis/disability classification: _____

Axis I :

Axis II :

Axis III:

Axis IV :

Axis V : _____

	UNRESTRICTED	RESTRICTED	COMMENTS
Sitting			**hrs. at a time hrs. in a 6 hr day**
Standing			**hrs. at a time hrs. in a 6 hr day**
Walking			**hrs. at a time hrs. in a 6 hr day**
Bending			
Squatting			
Kneeling			
Use of Fingers			
Handling			
Reaching			
Lifting			**Restricted to lbs.**
Carrying			**Restricted to lbs.**
Use of Kitchen Equipment			
Seeing/hearing			
Dietary Restrictions			
Other:			

_____ _____

Physician Signature Authorizing Program Admission **Date**

TREATMENT CONSENT

(Physician-Patient Understanding and Intent)

Dear Patient,

You are entering a program that is comprised of health care professionals committed to your overall well-being. Caring for you requires that we see you and treat you in the most objective manner possible. This means that we cannot afford any outside influences that may compromise the non-judgmental feelings for you. One such event that threatens a clinical relationship is when an attorney decreases our fees. Our fees represent multiple professionals from many disciplines working in concert so as to provide you with the rehabilitation and independence that you deserve. Relative to other programs in the field of brain injury rehabilitation our fees are very reasonable.

When settlements occur we are at times asked by your attorney to settle our bills for substantially less than our charges. We do not artificially inflate our fees nor do we operate a practice based on lowering fees. We are a clinically relevant institution with the single aim of getting you better. We are not a legal institution whose aim may be for negotiations and settlement of funds. While we do not minimize the importance of having an attorney fight for your rights, it is not the nature of our business to reduce our fees or enter the world of negotiations. These events only detract from our ability to focus and objectively care for you.

This document, in its entirety states that Life Skills Village, PLLC is entitled to our full fees from you, the responsible party without reduction for other expenses, attorney fees, or so-called collection fees. You acknowledge that only Life Skills Village, PLLC and its own designated attorney, not yours if you have one, is authorized by you to accept payment of Life Skills Village, PLLC fees or negotiate these fees. The remainder of this agreement documents the clinically relevant intent and agreement between us that protects our relationship from the moment we begin to treat you. **PLEASE READ THE ENTIRE DOCUMENT CAREFULLY AS IT CONTAINS LEGALLY ENFORCABLE RIGHTS**.

ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with this office. Necessary forms will be completed to file for insurance carrier payments. Patient/responsible party agrees to cooperate with this office and patient's insurer to comply and fulfill duties necessary to perfect timely payment of bills for services rendered.

Assignment of Benefits

Patient/Responsible Party hereby assigns all medical treatment benefits provided by Life Skills Village, PLLC, including automobile, "No Fault" personal protection insurance benefits, major medical, workmen's compensation to Life Skills Village, PLLC. I direct that the insurers issue payment checks directly to Life Skills Village, PLLC for treatment services rendered to myself and/or my dependents.

Patient/ Responsible Party hereby specifically agrees and acknowledges that Life Skills Village, PLLC is acting as patient/responsible party's attorney in fact for purposes of collecting bills incurred by patient for treatment and services rendered by Life Skills Village, PLLC. Patient/responsible party directs the insurance co, including auto insurer or workmen's compensation insurer, to pay Life Skills Village, PLLC; Amounts incurred pursuant to this agreement can only be satisfied by payment directly to Life Skills Village, PLLC with a check naming them as payee under their written designation and agreement. Life Skills Village, PLLC will maintain exclusive right to payment through their written acknowledgement of checks, acceptance and satisfaction by Life Skills Village, PLLC.

Patient/Responsible Party also understands and agrees to be responsible for the total amount for services rendered and that Life Skills Village, PLLC is entitled to full payment whether from my insurance or myself.

Authorization to Release Information

I hereby authorize Life Skills Village, PLLC to (1) release any information to insurance companies necessary to provide payment for treatment; (2) process insurance claims generated during the course of treatment; and (3) allow a photocopy of my signature to be used to process insurance claims until full payment is received during the entire course of treatment.

Lien In Favor of Life Skills Village, PLLC for Life Skills Village, PLLC Rendered Services

I hereby agree and acknowledge that Life Skills Village, PLLC shall have an exclusive lien enforceable by direct action against my insurance company, and attorneys with a right to intervene in any related lawsuit or action, for any and all amounts due for treatment services rendered and that such lien may be enforced to collect on my behalf.

I promise my complete cooperation and instruct my attorney to withhold from any and all judgments, settlements or other recoveries, all monies incurred and due for treatments provided by Life Skills Village, PLLC in the exact amount of the bill without reduction for fees, such as collections or attorney fees. It is my express agreement ,with knowledge that I am responsible for full payment of charges for services rendered, that Life Skills Village, PLLC shall be paid in full prior to any distribution of any proceeds to me and before any disbursement of any attorneys' fees pursuant to my agreement with my attorney.

_____

Patient Signature Date

_____

Patient's Responsible Party or Guardian (if applicable)/Relationship to patient Date

_____

Witness Date