Eating Disorders Associates

MEDICAL STABILIZATION PROGRAM

Phone (310) 325-4353 • Fax (310) 325-5732

application@drschack.com • www.EatingDisordersAssociates.com

Linda Schack, MD • Lindsey Brucker, MD • Lori Schur, RN, PhD

Jennifer Kromberg, PsyD • Bobbi O'Brien, PhD • Lauren Warren, LMFT

In order to schedule your admission appointment, please complete all included documents. The checklist below has been provided to assist you.
Fax to (310) 325-5732 or scan and email to application@DrSchack.com

Before returning, please double-check that you have filled out the admission packet as completely as possible. Incomplete information will delay the admission process.

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PATIENT INFORMATION

Please print clearly.

Date _____

Patient Name _____
Last *First* *Middle Initial*

Birthdate____/____/_____ Marital Status _____ email _____

Occupation_____SSN_____-_____-_____

Home address _____

City, State Zip _____

Home Phone _____Mobile Phone _____

RESPONSIBLE PARTY

Person financially responsible for treatment.

Responsible Party Name _____ Birthdate___/___/_____
Last *First* *Middle Initial*

Email_____Relationship to Patient _____

Occupation_____SSN_____-_____-_____

Home address _____

City, State Zip _____

Home Phone _____Mobile _____

EMPLOYMENT

☐ *Patient* *or* ☐ *Responsible Party*

Employer_____Job Title:_____

Business address _____

City, State Zip _____

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SIGNIFICANT OTHER

☐ *Second Parent* ☐ *Spouse* ☐ *Domestic Partner*

Name_____email _____

Last *First* *Middle Initial*

Birthdate_____/_____/_____ Relationship to Patient _____

Occupation_____SSN_____-_____-_____

Home address _____

City, State Zip _____

Home Phone (_____)_____Mobile Phone (_____) _____

EMERGENCY CONTACT

Primary Care Physician _____

Phone (_____)_____Fax (_____) _____

Emergency Contact Name:_____

Relationship _____

Home Phone (_____)_____Mobile (_____)_____

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CONFIDENTIALITY AGREEMENT

To be completed by patient.
If patient is under 18, to be completed by patient and parent.

I understand that Lauren Warren, LMFT, and Doctors Schack, Brucker, Kromberg, O'Brien, and Schur will maintain confidentiality, except in the following circumstances:

1. I am threatening physical harm to myself or another.
2. Receipt of a court order mandating information.
3. I am found to be involved in the abuse of a minor, dependent adult, or elder.
4. I have given written consent to release information to a specified party.
5. Doctors Schack, Brucker, Kromberg, O'Brien, and Schur will communicate with each other, and with treatment professionals directly involved in my care, as needed.

I understand that Linda E. Schack, M.D. is an adolescent medicine specialist, certified by the American Board of Pediatrics Subboard of Adolescent Medicine.

I understand that Lindsey Brucker, M.D. is an adolescent medicine specialist, certified by the American Board of Internal Medicine.

I understand that Jennifer Kromberg, Psy.D. is a clinical psychologist, CA License PSY 17691.

I understand that Bobbi O'Brien, Ph.D. is a clinical psychologist, CA License PSY 18147.

I understand that Lori Schur, RN, Ph.D. is a clinical psychologist, CA License PSY 14195.

I understand that Lauren Warren, LMFT is a licensed marriage and family therapist, LMFT 94034.

More biographical information is available at www.EatingDisordersAssociates.com.

I understand that information will be provided to me by Lauren Warren, LMFT and Drs. Schack, Brucker, Kromberg, O'Brien, and Schur regarding evaluation and treatment, including goals, risks, and benefits of treatment and that I will have the opportunity to discuss this and to ask any questions needed to clarify my understanding.

Name of patient (please print)	*Date*
Signature of patient	*Date*
Signature of parent or legal guardian if patient is under 18	*Date*

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PATIENT TREATMENT AGREEMENT

Patient to Complete and initial items 1-8.
Parent(s) to initial item 8.
For patients under 18, parent to co-sign at bottom.

I,_____, agree to comply with all recommended treatment. Specifically, I agree to:

Patient's name

1. Have a complete physical examination. *Patient's Initials* _____
2. Consume recommended food calories daily, by eating all of presented meals or any portion of meals plus an amount of liquid supplement calorically equivalent to the uneaten portion. *Patient's Initials* _____
3. Take recommended medications. *Patient's Initials* _____
4. Allow laboratory testing as ordered. *Patient's Initials* _____
5. Participate in psychotherapy sessions. *Patient's Initials* _____
6. Comply with program requirements. *Patient's Initials* _____

   (For more information see Frequently Asked Questions included in this packet.)

7. I understand that unhealthy behaviors are not permitted, including cigarette smoking. *Pt's Initial* _____
8. Parent(s), caregivers, or significant other(s) agree to attend a minimum of two sessions of family education/support, once per week. *Parent's Initial* _____

_____ _____

Signature of patient *Date*

_____ _____

Signature of parent or legal guardian if patient under 18 *Date*

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COMMUNICATION PREFERENCES

All patients 18 and older must complete.

I,_____give permission for Lauren Warren, LMFT, and Drs. Schack, Brucker, Kromberg, O'Brien and Schur to communicate with the following people regarding the treatment of my eating disorder for the duration of my medical hospitalization *(it is strongly recommended that both parents be listed if both are living and in contact with you)*. Please also list at least one parent or other adult close friend, partner, or relative:

_____ _____

Name *Relationship*

(_____)_____ (_____)_____

Phone *Alternate phone* ☐ *Home or* ☐ *Mobile*

_____ _____

Name *Relationship*

(_____)_____ (_____)_____

Phone *Alternate phone* ☐ *Home or* ☐ *Mobile*

_____ _____

Name *Relationship*

(_____)_____ (_____)_____

Phone *Alternate phone* ☐ *Home or* ☐ *Mobile*

_____ _____

Signature of Patient *Date*

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CURRENT TREATMENT PROFESSIONALS

To be completed by patient and/or parent.

Referring Institution (if applicable) _____

Name of Program _____

Program Director _____

Phone_____ Fax _____

Please list all health professionals currently involved in the treatment of your eating disorder:

Primary Care Physician_____

Phone_____ Fax_____

Primary Therapist _____

Phone_____ Fax_____

Dietitian_____

Phone_____Fax_____

Psychiatrist _____

Phone_____Fax_____

Other *(family therapist, athletic trainer, alternative medicine provider, etc.)*

Name_____ Specialty _____

Phone_____ Fax_____

Name_____ Specialty _____

Phone_____ Fax_____

I agree to the release of information between the Torrance Memorial Medical Stabilization Program professionals and my previous treatment professionals.

Patient signature_____ Date_____

Date of Birth_____

Parent Signature_____ Date_____

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FEES

Program Fee

There is a non-refundable program fee of $650, which will be due prior to admission (covers materials, administration and outside professional consultation). If the hospitalization extends beyond 2 weeks, there may be an additional program fee of $350 per week, charged to your credit card, unless other arrangements are made.

Insurance

Dr. Schack's billing is separate from the hospital's. Her office bills your insurance company. If you receive a reimbursement check for Dr. Schack's portion of your hospitalization, we appreciate you promptly sending us a check for the same amount. Dr. Schack will accept this amount as payment in full for her services provided during your hospitalization.

Micronutrient Testing

Micronutrient testing is also recommended in order to identify specific deficiencies and target supplementation to your needs. We use Spectracell Labs for our testing, and they require a co-pay to be sent along with your specimen. The co-pay is $190 for most insurance carriers. This will be charged to your credit card by Spectracell. If your insurance is not contracted with Spectracell, the fee is $290.

Nutritional Supplements and Testing Information *To be completed by financially responsible party.*

Most patients who are admitted for medical stabilization related to an eating disorder benefit from nutritional supplementation. The choice of supplements is individualized; examples of frequently used supplements include fish oil, calcium, potassium, magnesium, phosphorus, multivitamins, vitamin B-12, B-complex, and probiotics (beneficial bacteria used to improve intestinal health).

Our hospital formulary is somewhat limited in this area. Therefore, our practice is to stock our own supplements and provide them when there is no equivalent hospital formulary product. We have most supplements on hand and can provide them to patients immediately. No sales tax is collected since physician-provided supplements are considered medical treatment.

Patients will be billed for supplements at the suggested retail price.

☐ I am providing my credit card information to cover the $650 program fee, the $190 (or $290) micronutrient testing, and recommended supplements._____*Initials*

☐ Visa ☐ MC ☐ Disc ☐ Amex Name on card_____

Card #_____Security code_____Exp. date _____

Billing address _____

City, State Zip _____

Signature_____Printed name_____

If you are registered for our program and subsequently cancel your admission plans, your program fee will be refunded less $150 administration fe

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Treatment Goals

Please answer the following questions *as comprehensively as possible,* so that we can best help you.
(for the patient)

Why have you decided to seek help at this time?

_____

_____

_____

_____

What made you choose TMMC Medical Stabilization Program, as opposed to other treatment programs?

_____

_____

_____

_____

What are your goals for this hospital stay?

_____

_____

_____

_____

Please summarize any previous treatment you have received for your eating disorder.

_____

_____

_____

_____

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Treatment History

I have been in one or more intensive outpatient (IOP), partial hospital (PHP), Residential, Inpatient, or Medical Stabilization Programs.

☐ No. *Please skip this page.*
☐ Yes. *Please complete this page.*

Please list previous treatment programs, starting with most recent. (fill in as much information as you can).

1. Name of Program/Facility_____
   Location (City/State)_____phone_____
   Primary Therapist_____
   Clinical Director_____
   Dates of Treatment_____to _____

2. Name of Program/Facility_____
   Location (City/State)_____phone_____
   Primary Therapist_____
   Clinical Director_____
   Dates of Treatment_____to _____

3. Name of Program/Facility_____
   Location (City/State)_____phone_____
   Primary Therapist_____
   Clinical Director_____
   Dates of Treatment_____to _____

4. Name of Program/Facility_____
   Location (City/State)_____phone_____
   Primary Therapist_____
   Clinical Director_____
   Dates of Treatment_____to _____

5. Name of Program/Facility_____
   Location (City/State)_____phone_____
   Primary Therapist_____
   Clinical Director_____
   Dates of Treatment_____to _____

If more than 5, list only names of programs and year (if known). Use next sheet if necessary.

Program_____ Year_____

Program_____ Year_____

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Treatment History *continued*

Program_____ Year_____

Program_____ Year_____

Program_____ Year_____

Program_____ Year_____

Have you ever left a program against medical or professional advice? ☐ Yes. ☐ No.

If yes, please describe what happened, and your reason for leaving.

_____
_____
_____
_____
_____
_____

Admission preference:

☐ As soon as possible, when a bed is available.
☐ Contingent upon travel plans/need lead time.
☐ Other. _____

Anything else you would like us to know:

_____
_____
_____
_____
_____
_____
_____

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Lauren Warren, M.S., LMFT #94034
23440 Hawthorne Blvd, Suite 220
Torrance, CA 90505
(562) 852-6122

As part of your family member's stay at Torrance Memorial Medical Center's Medical Stabilization Program for Patients with Eating Disorders, you are required to attend weekly family psycho-education sessions with me. Your Program Fee, for the first few weeks of your loved one's stay, covers three (3) sessions under my care. After those three sessions, it will be your responsibility to schedule and make payments to me directly for further sessions. Though sessions after the initial three are not required, they are highly encouraged to help you and your loved one through the process and the transition from the hospital stay.

By making this important decision to participate in family therapy, you are committing to understanding more about your loved one's eating disorder and the interpersonal relationships helping or hindering recovery. You are paying for the services and time of a licensed mental health professional with years of clinical experience, trained to assist you and your loved one through recovery.

Therapy is both a confidential and professional relationship. As part of the treatment team process, your loved one's therapist, doctor, dietitian and I will share information pertaining to your loved one's recovery process. Additionally, your participation, and what is revealed in the course of treatment is protected by legal, professional and ethical standards. Information gathered in the course of treatment will not be released without your written consent, with the following (legal) exceptions:

1. when you represent a potential danger to yourself;
2. when you represent a potential danger to others;
3. when there is reasonable suspicion of child abuse, elder abuse, neglect or sexual abuse presently or in the past.

Financial responsibilities are part of this process. The fee for services is $190 a session. This can be paid on your session date before or after services are rendered. If you cannot keep your scheduled appointment time, it is required you provide advance notice. Your session is reserved time for you; late cancellations make it difficult to reschedule the time in order for someone else to benefit. It is my policy to charge the full session fee for all sessions missed, unless medically necessary, without at least 24-hour notice.

There are both benefits and risks associated with professional therapy. Benefits include: a greater understanding of yourself, improved communication and increased sense of self-worth and hope; resolution of internal and external conflicts that are negatively affecting your life; development of skills in order to cope better with life's challenges. Risks include: feeling more depressed or sad as difficult issues are being dealt with and lack of resolution of issues, especially if therapy is ended prematurely. There can be no guarantee of results with therapy, but clients who participate fully generally find the experience worth their investment. Time, energy, and commitment are the keys to the successful completion of therapy. I encourage you to discuss any concerns you have regarding this process as they arise.

By signing below, you are stating your understanding and agreement with the policies outlined above.

Patient Name (Print)	Patient Signature	Date
Therapist Signature		Date
Parent/Significant Other Signature		Date