Eating Disorders Associates

Phone (310) 325-4353 • Fax (310) 325-5732 • application@DrSchack.com
www.EatingDisordersAssociates.com
Linda Schack, MD • Lindsey Brucker, MD •
Lori Schur, RN, PhD • Sarah Wohn, PsyD • Lauren Warren, LMFT

MEDICAL STABILIZATION PROGRAM APPLICATION

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
Patients under the age of 18 may have a parent or other adult complete the patient portion for them.

- ☐ Patient Information Sheet *(complete by financially responsible party*) pages 2, 3
- ☐ Confidentiality Agreement *(patient completes; if under 18, parent sig. required)* page 4
- ☐ Patient Treatment Agreement *(to be completed by patient and parent),* page 5
- ☐ Communication Preferences *(to be completed by patients over 18),* page 6
- ☐ Current Treatment Professionals page 7
- ☐ Nutritional Supplements Info *(complete by financially responsible party), page 8*
- ☐ Essay Questions (*to be completed by patient*) page 9
- ☐ Treatment History *pages 10 – 12*
- ☐ Copy of front and back of Medical Insurance Card

IMPORTANT - Before returning, please double-check that you have filled out the admission packet as completely as possible, and have included a copy of front and back of your insurance card. Incomplete information will delay the admission process.

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PATIENT INFORMATION
Please print clearly.

Date _____

Patient Name_____

Age_____Birthdate _____Marital Status_____email _____

Height_____ Current Weight_____ Highest Previous Weight & Date_____

Occupation_____SSN_____

Home address _____

City, State, Zipcode _____

Home Phone _____Mobile Phone _____

FINANCIALLY RESPONSIBLE PARTY

Person financially responsible for cost of treatment.
☐ *If patient is responsible party, check this box and skip to EMPLOYMENT*

Responsible Party Name_____Birthdate_____
Last *First* *Middle Initial*
Email_____Relationship to Patient _____

Occupation_____SSN_____

Home address _____

City, State Zip _____

Home Phone_____Mobile Phone_____

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EMPLOYMENT

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

Employer_____ Job Title:_____

Business address _____

City, State Zip_____

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 _____

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CONFIDENTIALITY AGREEMENT

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

I understand that Lauren Warren, LMFT, and Doctors Schack, Brucker, Wohn 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.

I understand that Lauren Warren, LMFT and Doctors Schack, Brucker, Wohn 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 Lori Schur, RN, Ph.D. is a clinical psychologist, CA License PSY 14195.

I understand that Sarah Wohn, Psy.D. is a clinical psychologist, CA License PSY 29364.

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, Wohn 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 1-7.
*Family Member(s) to initial item 8. **
For patients under 18, parent to co-sign at bottom.

I,_____, agree to comply with all recommended treatment.
Patient's name

Specifically, I agree to:

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* _____
7. I understand that unhealthy behaviors are not permitted, including cigarette smoking. *Pt's Initials* _____
8. * Parent(s), caregivers, or significant other(s) agree to attend a minimum of two sessions of family education/support, once per week. (Can be done via phone/video conference if you are not local). *Family Member(s) Initials* _____

_____ _____
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 Doctors Schack, Brucker, Wohn 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 list at least one parent or other adult close friend, partner, or relative:

_____ _____
Name *Relationship*

_____ _____
Phone ☐*Home* ☐*Mobile* ☐*Work* *Alternate phone* ☐*Home* ☐*Mobile* ☐*Work*

_____
Email

_____ _____
Name *Relationship*

_____ _____
Phone ☐*Home* ☐*Mobile* ☐*Work* *Alternate phone* ☐*Home* ☐*Mobile* ☐*Work*

_____
Email

_____ _____
Name *Relationship*

_____ _____
Phone ☐*Home* ☐*Mobile* ☐*Work* *Alternate phone* ☐*Home* ☐*Mobile* ☐*Work*

_____
Email

_____ _____
Signature of Patient *Date*

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CURRENT TREATMENT PROFESSIONALS

To be completed by patient and/or parent.

Referring Program or Institution (ifapplicable) _____

Clinical Director _____

Phone_____ Fax _____

Please list all health professionals involved in the treatment of your eating disorder within the past 3 years:

Primary Care Physician_____

Phone_____Fax_____

Primary Therapist _____

Phone_____Fax_____

Dietitian_____

Phone_____Fax_____

Psychiatrist _____

Phone_____Fax_____

Other *(family therapist, recovery coach, alternative medicine provider, etc.)*

Name_____Specialty _____

Phone_____Fax_____

I agree to the release of information between Doctors Brucker, Schack, Schur, Wohn, Lauren Warren LMFT, Michele Manarino RD, or their designees, and my previous treatment professionals.

Patient Signature_____Date_____Date of Birth_____

Parent Signature_____Date_____

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Financial Information

Insurance

The hospital requires PPO insurance coverage.

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.

Nutritional Supplements *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 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 charges for recommended supplements._____*Initials*

☐ Visa ☐ MC ☐ Disc ☐ Amex Name on card_____

Card #_____Security code_____Exp. date _____

Billing address _____

City, State Zip _____

Signature_____Printed name_____

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Tell us a bit about yourself. 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?

_____

_____

_____

_____

What are your current medical problems?

_____

_____

_____

Signed_____ Relationship to Patient_____ Date_____

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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 the most recent (fill in as much information as you can.)

1. Name of Program/Facility_____

   Type of Program: (circle) Psychiatric Inpatient, Medical Stabilization, Residential, PHP, IOP, or other

   Location – City/State_____ Phone_____

   Primary Therapist_____

   Clinical Director_____

   Dates of Treatment_____to_____

2. Name of Program/Facility_____

   Type of Program: (circle) Psychiatric Inpatient, Medical Stabilization, Residential, PHP, IOP, or other

   Location – City/State_____ Phone_____

   Primary Therapist_____

   Clinical Director_____

   Dates of Treatment_____to_____

3. Name of Program/Facility_____

   Type of Program: (circle) Psychiatric Inpatient, Medical Stabilization, Residential, PHP, IOP, or other

   Location – City/State_____ Phone_____

   Primary Therapist_____

   Clinical Director_____

   Dates of Treatment_____to_____

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Name of Program/Facility_____

Type of Program: (circle) Psychiatric Inpatient, Medical Stabilization, Residential, PHP, IOP, or other

Location – City/State_____ Phone_____

Primary Therapist_____

Clinical Director_____

Dates of Treatment_____to_____

4. Name of Program/Facility_____

Type of Program: (circle) Psychiatric Inpatient, Medical Stabilization, Residential, PHP, IOP, or other

Location – City/State_____ Phone_____

Primary Therapist_____

Clinical Director_____

Dates of Treatment_____to_____

If more than 5, list names of additional programs and year of treatment.

Program_____ Year_____

Program_____ Year_____

Program_____ Year_____

Program_____ Year_____

Program_____ Year_____

Program_____ Year_____

I, _____ agree to the release of information between Doctors Brucker, Schack, Schur, Wohn, Lauren Warren LMFT, Michele Manarino RD, or their designees, and the above listed providers and their designees.

Signature_____ Date_____

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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.

☐ Specific week requested_____ (Admissions are generally scheduled in the mornings, Monday through Thursday.)

☐ Other: _____

Please attach a copy of the front and back of your insurance card to this page.