Haydon-Davis Counseling, Inc

Wendy H. Davis, LCSW

Licensed Clinical Social Worker

305 Kingsley Lake Drive Suite 702 Telephone: (904) 716-5619

St. Augustine, FL 32092 Fax: (248) 751-5913

PATIENT REGISTRATION FORM

Patient's Name:_____
Last First Middle Initial

Address:_____

_____
City State Zip Home Phone

Cell Phone:_____ E-mail:_____

Sex:_____ S/M/D/O DOB:_____ SSN:_____

Responsible Billing Name: **Check here if same as above:** _____

_____
Last First Middle Initial

Address:_____
Street City State

Zip Code_____ Home Phone_____ Work Phone_____

Please Note: **Payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills this is a matter between you and your insurance carrier.**

PRIMARY INSURANCE

Insured's Name:_____
Last First Middle

Relationship to Patient: _____ Insured's DOB: _____Insured's SSN:_____

Insured's Home Phone:_____ Insured Work Phone:_____

Name of Insurance Carrier:_____ Employer:_____

Policy Number: _____Group Number:_____

I certify that the information I have reported with regard to my insurance coverage is correct and permit a copy of this authorization to be used in place of the original. This authorization may be revoked either by me or the above name carrier at anytime in writing.

Signature of Subscriber: _____ **Date:** _____

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION:

I authorize payment of medical benefits to the Provider named above for professional services. I also authorize the release of any psychiatric, medical or other information including protected health information (PHI) and/or medical records necessary to process claims. I also request payment of government benefits either to myself or to the provider above who accepts assignment.

Signed: _____ **Date:** _____

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List of Charges

Initial Evaluation 60mn .....$110 Individual Therapy 45mn.....$90

Family Therapy 45/90mn.....$110/150 Letter/Forms to Employer, School, Etc: $80

Lack of Notice to Change Appointment/Missed appointment Fee: $75

Cancellation/Rescheduling & Arrival Time Policy

If you are unable to make your scheduled appointment, please contact my office **24** hours in advance. Missed appointments, those without proper notice of cancellation or need for rescheduling, will be assessed a **$75** fee. Please be aware that insurance companies will **not** reimburse for missed appointments. Also note that if you arrive late for your appointment, you are forfeiting that time. Your appointment starts at the time on your appointment card, not when you arrive.

In Case of Emergency

If you feel you are at danger to yourself or someone else, call 911 immediately.

If you need to speak with me about an urgent matter and it cannot wait until normal business hours, you may leave a voice mail on my main number and I will return your call promptly. I will also leave a message on my voice mail that will indicate who to contact should I be unavailable. I will make reasonable attempts to inform you ahead of time when I will be unavailable, i.e. emergencies, vacation or attending a workshop.

Court Appearances

Court appearances and custody evaluations are billed to the individual requesting the testimony. The fee for these services is $250/hour with a required minimum fee of $750 paid 24 hours in advance. Payment is expected in Cash or Money Order. There are no refunds. Report writing is billed at $100 per hour and requires one hour be paid in advance. In the event that records or other materials are subpoenaed, a charge of $1 per page will be made for coping and file preparation.

Payment Agreement

- I authorize Haydon-Davis Counseling, Inc to release information to my insurance carrier for the purpose of processing insurance claims for the patient indicated below.
- I understand that all co-pays and deductibles are due at the time of the patient's appointment.
- I understand that I will be charge $25 fee for a returned check. I understand checks may no longer be accepted if a check is returned for insufficient funds - payment will need to be cash or Money Order.
- I understand an account is considered delinquent if the patient has not paid the balance within 30 days following written notification of the balance due. I understand that the unpaid balance will then be subject to a monthly finance charge of 15%. **Any portion of the account balance over 30 days old will be submitted to a collection agency and continue to accrue interest.**
- I am responsible to pay all collection costs on any unpaid balance on my account, generally 50% of balance.
- I understand that for each counseling session, I am responsible for payment of $ _____.
- **I acknowledge responsibility for my account and guarantee payment of all charges against it.**

Patient's Name: _____

Last First Middle

Responsible Party:_____

Last First Middle

Your signature below indicates that you have read, understand and agree to comply with all the terms and conditions explained above.

Signature of Responsible Party: _____Date:_____

Pt Name: **MR#:**

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Wendy H. Davis, LCSW of Haydon-Davis Counseling, Inc. keeps medical information about you. This protected health information (PHI) includes but is not limited to medical records and other health information describing your health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. This information will be treated as private and confidential and will not be released without your written permission, our discussion or as dictated by the law.

There are several ways I may need to or request to use this information. First, the information is used when I treat you or refer you for treatment. For example, I might ask permission to discuss aspects of your care with your family or significant other. If a physician referred you, I may ask to thank them for the referral or discuss aspects of your treatment. All requests will be discussed with you first and you have every right to refuse with the following exceptions: I am legally and ethically bound to break confidentiality if I believe that you are in imminent danger to yourself and/or someone else (i.e. suicidal, child abuse, sexual abuse, homicidal threats, etc.) Secondly, I may use or share your PHI to obtain payment for your health care services, including to a collection agency or credit bureau. This includes information required by your insurance company to secure authorizations for treatment and submissions of claims for mental health services. Finally, I use this information to conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).

Under the law, each patient has certain rights to the medical information kept by Haydon-Davis Counseling, Inc. The rights are briefly summarized below.

- **Access.** You can ask to look at your record.
- **Restriction**. You can ask to limit who sees your information. You can ask to limit what information is sent out.
- **Accounting**. You can ask to see the list of places where your information has been sent.
- **Amending**. You can ask to change medical information if it is incorrect.

A complete notice with explanations of uses, disclosures, rights and information on how to file a privacy complaint is available at the following: In person at the office or by phone at 904-716-5619.

A patient also has the right to file a complaint regarding privacy with the Secretary of Health and Human Services, toll free at 1-877-696-6775.

Florida Statutes: Florida statutorily grants patients the right of access to medical records maintained by health care practitioners. The disclosure of patient information by providers is generally prohibited without the patient's consent, subject to specified exceptions. Florida has numerous laws protecting the confidentiality of health information held by a variety of entities and government agencies.

Signature of Patient or Representative Date

Wendy H. Davis, LCSW Date

Pt Name: **MR#:**

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Informed Consent and Treatment Agreement

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As patient in psychotherapy, you have certain rights and responsibilities that are important for you to understand. Foremost, you have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You also have the right to ask questions about any aspects of psychotherapy and about my specific training and experience. More detail about these rights and responsibilities are described below.

Psychotherapy/therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems.

The first 2-3 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. We will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. I may ask you to do "homework" in terms of reading, writing and/or to attempt making changes in your thinking or behavior. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. There are no guarantees about success of therapy as it is not an exact science, but I can promise that I will work with you actively to facilitate the achievement of your goals.

If at any time, you are unhappy with what is happening in therapy or have questions about my procedures, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. It would be greatly appreciated if you would share verbally or in writing the reason for early termination of treatment, as this may be help me to improve my services.

1- I have been given information regarding my rights to privacy and confidentiality including the limits of confidentiality of my record and personal health information.
2- I am aware that a complete copy of the Notice of Privacy Practices for protected private health information (HIPPA) is available for review upon my request.
3- I have been informed of my financial responsibilities upon entering into psychotherapy services.

Given all the information above, I give my authorization and consent to participate in psychotherapy evaluation and treatment with Wendy H. Davis, LCSW of Haydon-Davis Counseling, Inc.

_____ _____

Patient's Signature Date

_____ _____

Wendy H. Davis, LCSW Date