Haydon-Davis Counseling, Inc

Wendy H. Davis, LCSW

Licensed Clinical Social Worker

305 Kingsley Lake Drive Suite 702
St. Augustine, FL 32092

Telephone: (904) 716-5619
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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Financial Policies

Please carefully read the information found below detailing our financial policies. It is important to us that you have a complete understanding of these policies. We reserve the right to amend or make changes to these policies and will notify you in writing. If you have any questions or concerns, please let us know.

List of Fees & Services

Initial Evaluation:…………………………….**$110**
Therapy session 45 minutes: ………………**$90**
Therapy session 60 minutes: ……………..**$110**

Missed appointment Fee: ……………………………**$75**
Letters/Forms completed:………………………….**$80**
Phone Support past 10mn:………………**$25** per 15mn

Cancellation/Rescheduling & Arrival Time Policy

If you are unable to make your scheduled appointment, please contact the office **24** hours in advance. If you do not show for an appointment or do not give proper notice of cancellation or need for rescheduling, you will be charged a **$75 fee**. This is a fee to you as insurance companies do not pay for missed appointments. Also, note that if you arrive late for your appointment, you are forfeiting that time.

Court Services- Court services are **not** part of mental health treatment. If you require involvement in any court proceedings, additional fees will apply. Court related fees are not covered by insurance. Court appearances and depositions 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 accepted in Cash, as a Money Order or by Credit Card. There are no refunds. Report writing is billed at $110 per hour and requires 2 hours be paid in advance. A charge of $1 per page will be made for coping of any records.

Insurance and Payment Agreement

- ✓ I acknowledge that it is my responsibility to know and understand my insurance plan benefits.
- ✓ I will notify Haydon-Davis Counseling, Inc. of any changes in my insurance coverage or participation and provide proper documentation.
- ✓ I understand that all fees for services, co-pays, co-insurance amounts and deductibles are due at the time of the service.
- ✓ I understand that there is a **$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 by credit/debit.
- ✓ I understand an account is considered delinquent if there has not been a payment made 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 past due will be submitted to a collection agency and continue to accrue interest.** I also agree **to pay all collection costs** on any unpaid balance on my account, generally 50% of balance.
- ✓ **I acknowledge responsibility for any payments due to Haydon-Davis Counseling, Inc. for services provided or fees as previously outlined above.**

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

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Parental Consent and Treatment Agreement For a Child or Adolescent

You or your son or daughter is requesting counseling services at the Haydon-Davis Counseling, Inc. Because (s)he is under 18 years of age, parental consent is necessary for her/him to receive counseling and psychological services. The purpose of this form is to inform you about the counseling process and you and your child's rights and responsibilities regarding clinical services.

The process for arranging counseling involves your child's scheduling an appointment to meet with a counselor. Before the appointment, you and your child will be asked to complete forms. The forms (s)he will be asked to complete are extensive, but provide the counselor with important information about the child's background. However, a counselor-client relationship is not created until your child has visited with a counselor in person.

Your child's first meeting with one of our counselors will be an initial assessment. In the initial assessment, the counselor will help your child clarify her/his concerns and discuss services that are most likely to be helpful. At each session, we ask that the parent participates by meeting with the counselor individually or with the child.

CONFIDENTIALITY

Haydon-Davis, Counseling, Inc. adheres to strict confidentiality standards according to Florida Law. While your child is a minor, you have rights to discuss your child's counseling with her/his counselor. After your child becomes 18, you can have her/him give the counselor written permission to allow two-way communication between yourself and the counselor. If your child does not sign such a release at that time, you can communicate information to the counselor, but the counselor will not be able to confirm whether or not your child is continuing in counseling or talk to you about your child's counseling experience. Please note that although you have rights to your child's counseling information until they become 18, it is often in the best interest of college-aged clients if their parents are only involved when requested by the client and/or counselor

Haydon-Davis Counseling, Inc. will maintain confidentiality about the fact that your child is in counseling, the information your child discloses in counseling, and your child's counseling records. If you or your child wants us to provide information about your child's counseling to your pediatrician or other professional, we will do so with your child's written authorization. Until your child is 18 years old, your written permission is also necessary.
There are several instances when information may be released. First, in an effort to provide her/him with the best service, the counselor may share information about her/him with a licensed colleague for the purpose of clinical consultation.

You should be aware that Haydon-Davis Counseling, Inc. staff may be required to disclose client information, even without consent, in the following situations:

1 When doing so is necessary to protect the client or someone else from imminent physical and/or life-threatening harm.
2 When a client lacks the capacity or refuses to care for him/herself and such lack of self care presents substantial threat to his or her well-being.
3 When the abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected. Examples of abuse, neglect, or exploitation include, but are not limited to, violence towards a minor, a minor witnessing violence or being in the presence of violence, drug use in front of or while caring for a minor, or financial exploitation of an elder adult. Examples also include incidents of past abuse, including those described above, if the alleged perpetrator of abuse is currently in a caretaker capacity with any minor or is still present in the home of a minor.
4 When a client is involved in a legal proceeding and there is a court order for the release of the client's records.
5 When a release is otherwise required by law (e.g., Patriot Act).

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Informed Consent and Treatment Agreement for a Child or Adolescent (continued)

BENEFITS AND RISKS
Counseling is an active and cooperative effort involving both the patient and the counselor. Counseling may result in better emotional and mental health and positive changes in behaviors and coping ability. However, through the normal process of counseling and discussing your child's personal concerns, your child may experience greater emotional distress at times. Your child also may find that the positive changes that (s)he makes may result in changes in the relationships in her/his life (e.g., gaining relationships, becoming closer in relationships, losing relationships, or relationships feeling more distant). If you or your child has any concerns about your child's progress or the results of her/his counseling, we encourage you or your child to discuss them with her/his counselor at any time.

PATIENT RESPONSIBILITIES

Patients are expected to behave in a respectful manner. Failure to do so may also result in termination of services.

Parental Informed Consent for Child's Counseling Services at Haydon-Davis Counseling, Inc.

I am the parent or legal guardian of ____.
Minor Child's Name

I have full, partial, or rotating custody of the above child/adolescent. I have received a copy of the Haydon-Davis Counseling, Inc. Parental Consent for Counseling form. I have read and fully understand the information contained in this form. I hereby give my permission to Wendy H. Davis, LCSW to engage in counseling/psychotherapy with my daughter/son.

______________________________ ______________________
Student's Name (Print) Student's Date of Birth

______________________________ ______________________
Name of Parent/Legal Guardian (Print) Date

______________________________ ______________________
Parent/Legal Guardian's Signature Date

______________________________ ______________________
Wendy H. Davis, LCSW Date

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LIFE HISTORY QUESTIONNAIRE

Child/Adolescent

The purpose of this questionnaire is to obtain an understanding of your life experience and background. Then we can begin to develop a comprehensive treatment program suited to your specific needs. Please return this questionnaire when completed, or at your scheduled appointment.

Name: ____ Circle: M / F Date:__________________________

Birth Date: __________________ Age:_________ Place of Birth:________________________________

By who were you referred? ____

Chief Complaint:

____

____

____

Presenting Problem: (check all that apply)

______Very unhappy
______Irritable
______Temper Outbursts
______Withdrawn
______Daydreaming
______Fearful
______Clumsy
______Overactive
______Slow
______Short attention span
______Distractible
______Lacks initiative
______Undependable
______Peer conflict
______Phobic

_______Impulsive
_______Stubborn
_______Disobedient
_______Infantile
_______Mean to others
_______Destructive
_______Trouble with the law
_______Running away
_______Self-mutilating
_______Head banging
_______Shy
_______Rocking
_______Strange behavior
_______Strange thoughts

_______Fire setting
_______Stealing
_______Lying
_______Sexual trouble
_______School performance
_______Truancy
_______Bed wetting
_______Soiled pants
_______Eating problems
_______Sleeping problems
_______Drug use
_______Sickly
_______Alcohol use
_______Suicide talk

Explain:____

____

How long have these problems occurred? (number of weeks, months, years)?________________________________

What made you seek help at this time? ____

Any previous mental health contact? Please explain.

____

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Pt Name:_________________

Problems perceived to be: _______very serious ________serious ________not serious

What changes would you like to see in your child?

____

What changes would you like to see in your family?

____

PSYCHOSOCIAL HISTORY

Mother-Relationship to child: _________Natural parent ___________Relative
_________Step-parent ___________Adoptive parent

Occupation: ____Education:__________________________________

Religion: ______________________ Birthplace:__________________________ Birth date:____________________

Father-Relationship to child _________Natural parent ___________Relative
_________Step-parent ___________Adoptive parent

Occupation:____Education:__________________________________

Religion:______________________ Birthplace:_______________________ Birth date:________________________

Marital History of Parents: Natural Parents: _____married when________
_____separated when________
_____divorced when________
_____deceased when________
Step-Parents _____married when________

Pt's religious/spiritual upbringing? ____

If child is adopted: Adoption source ____

LIVING ARRANGEMENTS: Number of moves in child's life:_____
Places Dates

____

____

____

____

Was the child ever placed, boarded, or lived away from the family? ____Yes ____No

Explain: ____

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Pt Name:________________

What are the major family stressors at the present time, if any? ____

____

BROTHERS and SISTERS: (indicate if step-brothers and sisters)

Name Age Sex Any Mental Health or substance abuse problems

1.____

2.____

3.____

4.____

5.____

List all extended family members by their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

____

____

Others living in the home (and their relationship):

____

Are there any family members with chronic or severe medical problems? If yes, please indicate relative and illness.

____

____

CHILD HEALTH INFORMATION:

	AGE		AGE		AGE
____ High fevers	_____	____ Dental Problem	_____	_____ Unconsciousness	_____
____ Pneumonia	_____	____ Weight Problems	_____	_____ Stomach Problems	_____
____ Flu	_____	____ Allergies	_____	_____ Concussions	_____
____ Encephalitis	_____	____ Skin Problems	_____	_____ Accident Prone	_____
____ Meningitis	_____	____ Asthma	_____	_____ Anemia	_____
____ Convulsions	_____	____ Headaches	_____	_____ Head Injury	_____
____ Fainting	_____	____ Blood Pressure	_____	_____ Dizziness	_____
_____Sinus Problems	_____	____ Tonsils Out	_____	____ Heart Problems	_____
____ Visions Prob.	_____	____ Hyperactivity	_____	_____Hearing Prob.	_____
_____Earaches	_____	_____Other Illnesses, etc.	_____	(Explain) ______________________	

Has the child ever been hospitalized? ____ No ____ If yes, at what age and for what reason?

____

Has the child ever taken, or is he/she taking presently any prescribed medications? If yes, please explain.

____

____

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Pt Name:_________________

Allergies- please list:____

Primary Care Physician or Pediatrician:________________________________Phone: _________________________

DEVELOPMENTAL HISTORY: _____ Child wanted? Yes / No Planned for: Yes / No

Normal Pregnancy: ___ Yes ___ If No- Please Explain ____
BIRTH: Were there any complications during birth? ____No If yes, please explain.___________________________
____
Did mother use or abuse alcohol or drugs during pregnancy? _____ No _____ Yes – What? ___________________

NEWBORN PERIOD: Please circle any of the below issues you had with your child.

irritability vomiting difficulty breathing difficulty sleeping convulsions/twitching colic

DEVELOPMENTAL MILESTONES: Met at appropriate ages: ______yes ________no
If no, explain: ____

EARLY SOCIAL DEVELOPMENT:

Relationship to siblings and peers: ______ individual play _______ group play ______ competitive
_______ cooperative ______ leadership role _______ a follower

Describe special habits, fears, or idiosyncrasies of the child:

____

EDUCATIONAL HISTORY:

What school does your child attend and what grade? ____

Types of classes: ______ regular _____ learning disability _____ emotionally handicapped

Did child skip a grade? ___No ___ If yes, grade______ Repeat grade? ___ No ____If yes, grade _______

Does child attend school on a regular basis? ___ Yes ___ No Does child appear motivated for school? Yes / No

Has child ever been suspended or expelled? ___ No ___ If yes, for what?

____
Any school issues I should be aware of, but not mentioned?
____

Highest grade on last report card?____________________ Lowest grade on last report card?___________________

Favorite subject?__________________________________ Least favorite subject?___________________________

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Pt Name:_________________

ACADEMIC PERFORMANCE:
Does child participate in extracurricular activities? _______Yes _____ No (Explain)

____

In school, how many friends does child have: _____a lot _____ a few ____none

What are child's educational aspirations? ___ quit school ___ graduate high school ___ go to college

List child's special interests, hobbies, skills:
____

____

Has the child ever been involved with the legal system? ____ No ____ Yes (if yes, explain)

____

Has child every used any drugs or alcohol? If yes, please indicate type and whether use is past or present.

____

____

Has child ever been employed? _____ No _____ Yes - Explain

____

ADDITIONAL COMMENTS: ____

____

____

____

____ ____________________
Signature of parent of guardian **Date**

____ ____________________
Signature of client if age 14 or older **Date**