PATIENT INFORMATION

First Name: _____MI_____ Last : _____

Address: _____ City: _____St.____Zip_____
Birth Date: _____/_____/_____ Age: _____ Social Security #_____-_____-_____
Education Level:_____ **Email address:**_____

Home Phone: _____ Wk. Phone:_____ Cell: _____
Single ◉ Married ○ Divorced ○ Widow ○ Ethnic/Cultural Identity:_____
Career / Current Job_____
Employment Status: Full Time ◉ Part Time ○ Retired ○ Full Time Student ◉ Part-Time Student ○

PRIMARY INSURANCE _____ ID # _____ Group # _____
Policy Holder Name _____ Birth Date _____/_____/_____ Employer _____ _____
Work Phone _____ Home Phone _____ Cell _____

SECONDARY INSURANCE _____ID # _____ Group# _____
Policy Holder Name: _____ Birth Date _____/_____/_____ Employer:_____
Work Phone _____ Home Phone _____ Cell _____

RESPONSIBLE PARTY (if other than patient):
Name: _____ Address: _____ _____
City: _____St._____Zip_____
Home Phone: _____ Work Phone: _____ Cell _____
In emergency, contact: _____Phone #: _____

State the problem or concern for which you are seeking treatment:

What have you done to try to solve this problem?

What changes are you seeking?

Previous therapists? Yes ○ No ○ When?_____ Was it helpful? _____
Are there current suicidal thoughts? No Have you attempted Suicide? No
Have you had difficulty with anger? No Been violent? No Injured someone? No
Have you ever had work, relationship, health, or legal problems due to your use of alcohol or drugs? No

Date you last drank alcohol _____ How much typically?_____ How often?_____
What do you drink _____
Do you use tobacco/Nicotine? No How much? _____ How often_____
Do you use Marijuana? No How much? _____ How often _____
Date you last used drug(s) and type of drug used: _____
Previous drug use and what kind? Teens _____ 20's _____ 30's_____

How much coffee, colas, or teas do you drink per day? _____

Family history of mental health or substance abuse problems?_____

Check any that have happened: Emotional Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐

Have you had a head injury with loss of consciousness or caused you to see a doctor? No

Have you had any of the following:

Learning disabilities ☐ Hyperactivity ☐ Disciplinary problems ☐

Menstrual problems ☐ Possible PMS ☐ Premenopausal/Menopausal ☐

Any type of sleep problems: Falling asleep ☐ Staying asleep ☐ Early awakening ☐ Difficulty awakening ☐

Any appetite changes No Weight changes No Current weight: _____ lbs. Height: _____

Describe your worst nutritional habits _____

Legal Problems? Arrests? _____

Exercise? Frequency of physical activity? _____

Hobbies / Interests? _____

Describe your religious or spiritual beliefs _____

Check any of the following concerns - Make any additional comments

Shyness	☐	Panic	☐	Attention Deficit	☐	Anxiety	☐
Health	☐	Controlling	☐	Guilt	☐	Relaxation	☐
Inferiority	☐	Depression	☐	Over-Weight	☐	Compulstions	☐
Self-Injury	☐	Concentration	☐	Disorder Finances	☐	Phobias	☐
Memory Problems	☐	Self-Esteem	☐	Spending	☐	Fears	☐
Ambition	☐	Confusion	☐	Alcohol	☐	Worry	☐
Work	☐	Perfectionism	☐	Drug Use	☐	Stress	☐
Anger	☐	Relationship	☐	Low Energy	☐	Obsessions	☐
Jealousy	☐	Mood Swings	☐	Gambling	☐	Insecurity	☐
Nervousness	☐	Career	☐	Self Critical	☐	Parenting	☐
Making Decisions	☐	Physical Pain	☐	Sexual Problems	☐	Critical	☐

Comments:

Describe your health at present

List any medical problems you have

List any operations you have had

List any allergies you have, including allergies to medications

List any recently discontinued medications, psychiatric medications

List medications you are taking	Dosage	Number of times per day	Prescribed since when

If there is a need to call, may we leave a message on voice mail or with a family member? Yes
May we inform your physician of evaluation results? Yes
May we inform your psychiatrist of evaluation results? Yes

Primary physician: _____ Address:_____
Ph.:_____ Fax:_____ (Complete address is needed)

(Please fill out next page)

AUTHORIZATION FOR TREATMENT

I, _____ (Patient or Parent/Representative), authorize and consent to the treatment of patient named above. I understand that payment is required at time of service, and take full responsibility for all fees resulting from treatment. Medical/Mental Health treatment rendered cannot guarantee outcome.

Although I may have insurance or a financial agreement with a third party, I am aware that I am ultimately responsible for fees incurred as a result of services rendered. I also accept financial responsibility as outlined below, even though that may be discrepant from the policies of my insurance carrier.

I authorize Davis Sound Mind to utilize my debit / credit card to process my copayment at the time of service, process my deductible, and process my late cancellation, missed appointment.

Insurance Assignment:
I authorize the release of medical information necessary to process my claims. I authorize payment of medical benefits to DAVIS SOUND MIND, MARK DAVIS, LCSW, NICOLE DAVIS, LCSW for services rendered. I acknowledge and understand that I am responsible for all charges for all services rendered to me or any member of my family. Although I have requested my insurance company to be billed directly by this office, I understand that it is my responsibility to make sure the bill is paid within a reasonable time period. If any portion of my bill is not paid by my insurance for any reason, including failure to obtain authorization, within 30 days of response to office filing, I am responsible for the full amount. Unless otherwise amended, my balance shall be processed by the card on file with Davis Sound Mind.

The practice of DAVIS SOUND MIND does implement periodic rate increases, usually at times of six to twelve months.

Appointment Cancellation Policy:
Please call twenty-four hours before, or by 4 pm the day prior to cancel your appointment. Workplace demands that you cancel your medical appointments are not acceptable.
Late Cancellation: **$110.00** Less than 24 hours cancellation. This will be processed on you card on file.
Missed Appointments: $110.00 will be charged for a missed appointment. This will be processed on you card on file.
Returned Checks: $35.00 fee for returned checks.
Forms: There is a $75.00 charge for all forms from external agencies. FMLA, Disability, etc. We do require you to submit all forms with five days advance to any deadline**.**
Document Fax/Copy $1.00 per page.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
Legally Authorized Representative Signature DATE

Notice of HIPPA
This office is permitted to disclose
1. Personal Health Information (PHI) to federal and state agencies that regulate or investigate the health care industry.
2. PHI to accreditation organizations, insurance companies, and care management companies.
3. Law enforcement officials, subject to applicable state and federal laws for purposes of complying with court subpoenas or other legal process.

Davis Sound Mind

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Employee Assistance Programs

12960 North Dale Mabry Hwy. Counseling 813-968-3417

Tampa, FL 33618 **DavisSoundMind.com** Toll Free 866-968-3417

NEW PATIENT INFORMATION

As a new client in our practice we hope that you find the relief and answers that you have come to discuss. This is a commitment on your part and my part to resolve problems and to begin engagement in solutions to your concerns. We will use years of experience and expertise for your benefit. Whether we are engaged in individual therapy, marital therapy, or family therapy, rest assured that when your appointment time is here, we will be here for you. Bring in all journal writings, therapy assignments, questions, and notes when arriving. Reviewing your progress this way will help us most successfully determine your next step. It is likely that we will be utilizing various techniques that you may already have heard about. We count on your involvement as this often has a major impact on the pace of progress. Avoidance of excess alcohol and drug use is recommended. The surgeon general recommends that patients with depression remove firearms from the household.

Journaling *is very helpful regarding tracking the changes you are looking to make as result of therapy. When opportunities are present for change please write an analysis of how well you handled the new change in your behavior.*

Positive Attitude is *the active use of positive comments that you make aloud to others and about yourself. Achieving these positive comments while reducing negative comments to a zero will help you feel better.*

Health *Resolve to engage in healthy lifestyle.*

Regular Physical Activity *is a major stimulant to improve scores on depression and anxiety. Personal wellbeing, sexual activity, self-esteem does improve as a result of as little as 30 minutes walking a day. Medicine & Science Sports and Exercise Dec. 2005 Therefore, commitment to consistent activity is one of two priorities to get on board with for yourself.*

Healthy Food Choices *are important as nearly one third of us is overweight and half of those overweight are obese. Rates are even higher among those with depression and rates of depression with people who are overweight is even more alarming. Therefore, consistent nutritional good choices is one of two priorities to get on board with for yourself.*

Appointment Cancellation Policy:

Appointment Cancellation Policy: Please call twenty-four hours before, or by 3pm the day prior to cancel your appointment. Workplace or school demands that you cancel your medical appointments are not an acceptable waiver.

Late Cancellation: **$110.00** fee for cancellation the day of your appointment. This will be processed on your card on file.

Missed Appointments: $110.00 will be charged for a missed appointment. This will be processed on your card on file.

Returned Checks: $35.00 fee for returned checks.

Forms Policy: There is a $75.00 charge for all forms from external agencies. We do require you to submit all forms with five days advance to any deadline.

Document Fax/Copy $1.00 per page.

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