PATIENT INFORMATION

First Name: _____MI_____ Last : _____

Address: _____ City: _____St.____Zip_____

Birth Date: _____/_____/_____ Age: _____ Educational Level:_____

Home Phone: _____ Wk Phone:_____ Cell: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widow
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? _____ When? _____ Was it helpful? _____

Are there current suicidal thoughts? ____YES ____ NO Attempted suicide? ____YES ____ NO

Have you ever had difficulty with your anger? ___ YES ___ NO, been violent? ___ YES ___ NO
or injured someone?___ YES ___ NO

Have you ever had work, relationship, health, or legal problems due to your use of alcohol or drugs? ___YES ___NO

Date you last drank alcohol. _____How much typically?_____ What do you drink?_____

Do you smoke? ___ How much_____

Date you last used drug(s) and type of drug used: _____

(Fill out back side of this sheet)

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

Family history of mental health or substance abuse problems?_____

Circle 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? _____ YES _____ NO

Have you had _____learning disabilities, _____hyperactivity or _____disciplinary problems?

Menstrual problems? ____Possible PMS?____ Premenopausal? _____

Any type of sleep problems?_____

Any appetite changes? _____or weight changes?_____

Legal Problems? Arrests? _____

Exercise? Frequency of physical activity ? _____

Hobbies / Interests? _____

Circle any of the following concerns - Make any additional comments

Attention Deficit	Guilt
Over-Weight	Eating Disorder
Finances	Spending
Alcohol	Drug use
Low energy	Gambling
Self Critical	Critical
Sexual Problems	Marriage
Anxiety	Relaxation
Compulsions	Phobias
Fears	Worry
Stress	Obsessions
Insecurity	Parenting
Shyness	Health
Inferiority	Self Injury
Memory Problems	Ambition

Work	Anger
Jealousy	Panic
Controlling	Depression
Concentration	Self Esteem
Confusion	Perfectionism
Relationship	Mood Swings
Career	Nervousness
Making Decisions	Physical pain

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 ____ NO
May we inform your physician of evaluation results? _____ YES _____ NO or psychiatrist? _____ YES _____ NO

Primary physician: _____ Address:_____

Ph.:_____ (Complete address is needed) _____
_____ ____

_____ _____
SIGNATURE **DATE**

(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.

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 clearly understand that it is still 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 90 days of filing, I am responsible for the full amount.

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 3pm the day prior to cancel your appointment. Workplace demands that you cancel your medical appointments are not acceptable.
Late Cancellation: **$50.00** fee for cancellation the day of your appointment.
Missed Appointments: $50.00 will be charged for a missed appointment.
Returned Checks: $35.00 fee for returned checks.

_____ _____
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.

CREDIT CARD GUARANTEE FOR COPAY & BALANCE

Our insurance assignment program is designed for convenience and keeping your out of pocket expenses to a minimum. We will auto debit your card for copayment at the time of service so you do not waste time at our office before your session.

We will bill your health insurance on your behalf and wait up to 90 days for payment. On day 90, if the bill is not paid by your insurance company, we will charge your card below for the negotiated amount of claim. Any payments made afterward will immediately be refunded to you.

Please check the agreements below:

[ ] **Private Patient / Self Pay:** I agree to authorize debit $_____ from my account at the time of my scheduled session. My therapy is completely confidential. No commercial insurance company will obtain my information.

[ ] Copayments: I agree to authorize copayment debit from my account at the time of service.

[ ] Insurance Assignment: I agree to authorize debit from my account ninety days post session pending denial by insurance.

Name_____

Billing Address_____

Circle : Visa MasterCard Discover

_____ - _____ -_____ - _____ Expiration ____ / ____

CV Code: _____ (three numbers on back right side)