Thank you for choosing Dr. Townsend and Associates, P.A. for your counseling and evaluation needs. We respect your time and would like to provide you with a full 45 minute session. In order for your therapist to spend the full 45 minutes scheduled for your appointment we ask that you follow the following steps.

**Arrive 15 minutes before your scheduled appointment time.**

To avoid delays when you arrive, please complete the enclosed forms in advance then email (drtownsendoffice@gmail.com), fax (904-797-2820) or bring them with you to our office.

Please have a photo id available.

If you plan to file insurance for your visits, you must have your insurance card with you at your first visit.

Your payment, co-payment or deductible is due at the time of your appointment.

Please note: We reserve the right to reschedule your appointment if the paperwork is not completed in advance.

Thank you,

Dr. Townsend and Associates, P.A.
**PATIENT INFORMATION**

**PLEASE FILL OUT ALL INFORMATION. PLEASE PRINT NEATLY**

NAME ____________________________________________ 
(Last) ___________ (First) ___________ (MI) ___________

ADDRESS __________________________________ CITY ___________ STATE _____ ZIP ________

HOME PHONE # ( )_________________ WORK PHONE # ( )_________________ CELL (____)__________________

EMAIL: _______________________________________________________________________________________________

DATE OF BIRTH ___/___/___     AGE: ___________            SEX: MALE __   FEMALE __

SOCIAL SECURITY: ____________________________ (REQUIRED)

MARITAL STATUS:  __SINGLE __MARRIED __DIVORCED __SEPARATED __WIDOWED __DOMESTIC PARTNERSHIP

EMPLOYED _____YES      ______NO       PLACE OF EMPLOYMENT ___________________________________________

ADDRESS ____________________________ CITY ____________________ STATE _____ ZIP ________

PATIENT’S EDUCATION:  ELE. SCH. ___   HIGH SCH. ___   COLLEGE ___   OTHER __

FULL TIME STUDENT _____YES    _____NO    IF YES WHERE?______________________________________

WHO IS YOUR PRIMARY CARE PHYSICIAN? ___________________________________________________________

DID HE/SHE REFER YOU TO OUR OFFICE? = YES = NO

IF NO, WHO REFERRED YOU? ________________________________________________________________

DATE OF LAST PHYSICIAN’S EXAM:  __/__/__.  PHYSICIAN’S NAME:____________________

LIST ANY MAJOR HEALTH PROBLEMS FOR WHICH YOU ARE CURRENTLY RECEIVING TREATMENT: _____________
_____________________________________________________________________________________________________

LIST ANY MEDICATION(S) CURRENTLY BEING USED:

<table>
<thead>
<tr>
<th>Name</th>
<th>MG</th>
<th>Frequency</th>
<th>Name</th>
<th>MG</th>
<th>Frequency</th>
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</tbody>
</table>
LIST FAMILY MEMBERS AND ANY OTHERS LIVING IN THE HOME WITH YOU:

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>BIRTHDATE</th>
<th>RELATIONSHIP</th>
<th>OCCUPATION</th>
</tr>
</thead>
<tbody>
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</table>

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

NAME ________________________________

ADDRESS __________________________ CITY ____ ZIP __________

HOME PHONE # (  ) __________________________ WORK PHONE # (  ) _______________________

RELATIONSHIP TO YOU: ____________________________________________________________

BRIEFLY DESCRIBE YOUR REASON FOR SEEKING HELP AT THIS TIME:

WHAT IS YOUR PRIMARY GOAL FOR SEEKING HELP FROM DR. TOWNSEND & ASSOCIATES, P.A.?

PLEASE CIRCLE ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU

NERVOUSNESS ANXIETY FEARS DEPRESSION
SHYNESS ANGER DIVORCE FRIENDS
SEXUAL PROBLEMS SUICIDE WORK SLEEP
RELAXATION FINANCES TENSION STRESS
HABITS EDUCATION HEALTH HEADACHES
MARITAL PROBLEMS PTSD MEMORY SADNESS
SELF-CONTROL INSOMNIA DELUSIONS TEMPER
OVER-ACTIVE HALLUCINATIONS ENERGY THOUGHTS
DRUG USE LONELINESS AMBITION APPETITE
CONCENTRATION ALCOHOL USE CAREER CHOICE INFERTILITY
LEGAL PROBLEMS UNHAPPINESS BEING A PARENT ADOPTION
MAKING DECISIONS BOWEL TROUBLE NIGHTMARES IDENTITY CONCERNS
STOMACH PROBLEMS CHILDREN GLBT CONCERNS AFFAIR
ADDITIONAL INFORMATION THAT MAY BE HELPFUL IN YOUR TREATMENT

PARENTS’ MARITAL STATUS AND LENGTH OF RELATIONSHIP/MARRIAGE:  

PARENTS’ OCCUPATION:

NUMBER OF SIBLINGS:  

MAJOR CHILDHOOD ILLNESSES/INJURIES:

PHYSICAL AND/OR SEXUAL ABUSE:  

OCCUPATIONAL AND/OR EDUCATION PROBLEMS:

MEDICAL HISTORY

PLEASE CHECK THE APPROPRIATE BOX IF YOU HAVE EVER HAD ANY OF THE LISTED CONDITIONS. PLEASE LIST YOUR TREATING PHYSICIAN FOR ANY CHECKED CONDITION:

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>YOU</th>
<th>TREATING PHYSICIAN</th>
<th>CONDITION</th>
<th>YOU</th>
<th>TREATING PHYSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Heart Attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td>Stroke</td>
<td></td>
<td></td>
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<tr>
<td>Dermatological</td>
<td></td>
<td></td>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine Headache</td>
<td></td>
<td></td>
<td>Post-Partum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

BEHAVIORAL HEALTH HISTORY

PLEASE PLACE A CHECK IN THE APPROPRIATE BOX IF YOU OR A BLOOD RELATIVE HAVE EVER HAD ANY OF THE LISTED CONDITIONS. IF CONDITION IS CHECKED FOR BLOOD RELATIVE, PLEASE INDICATE THEIR RELATION TO YOU:

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>YOU</th>
<th>BLOOD RELATIVE</th>
<th>CONDITION</th>
<th>YOU</th>
<th>BLOOD RELATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td></td>
<td>Psychotic Illness</td>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADD/ADHD</td>
<td></td>
<td>OCD</td>
<td>Mental Illness</td>
<td></td>
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<tr>
<td>Bipolar Disorder</td>
<td></td>
<td></td>
<td>Eating Disorder</td>
<td></td>
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<tr>
<td>Learning Disability</td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
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<tr>
<td>Addiction</td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Suicide or Suicidal Thoughts</td>
<td></td>
<td>Note P:Paternal or M: Maternal</td>
<td>Note P:Paternal or M: Maternal</td>
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<td></td>
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<tr>
<td>PTSD</td>
<td></td>
<td>Note P:Paternal or M: Maternal</td>
<td>Note P:Paternal or M: Maternal</td>
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</tr>
</tbody>
</table>

PLEASE MAKE A CHECK MARK NEXT TO ANY SERVICES YOU ARE CURRENTLY RECEIVING OR HAVE RECEIVED IN THE PAST:

- Inpatient Hospitalization
- Intensive outpatient treatment (IOP)
- Partial Hospitalization Program (PH)
- Intensive outpatient treatment (MH)
- 12 Step Program/Self Help
- Outpatient Counseling
- Group Counseling
- Community Support
- Psychiatric/Medication Management

If you checked any of the above treatment(s), please briefly describe below when and why you received this treatment:


Did you find this Treatment helpful?  

- Yes
- No
Thank you for choosing us as your mental health provider. We are committed to your treatment. Please understand that payment of your bill is considered part of your treatment.

We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, as a courtesy we can bill your company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we have billed your insurance company and they have not paid your account in full within 90 days, the balance may be automatically transferred and billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. If at anytime you are interested in signing up for our monthly payment plan, please see our receptionist.

Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed and payment is due upon receipt of bill.

**PLEASE FILL OUT ALL REQUESTED INFORMATION**

*Please note, a copy of your insurance card does not replace the following information.*

*Please fill out the below information thoroughly.*

**PRIMARY INSURANCE CARRIER:** COMPANY NAME ________________________________________________________________

ADDRESS __________________________ CITY __________________ STATE ______ ZIP ______________

GROUP NAME/NUMBER ______________________________ CONTRACT/I.D. NUMBER ______________________________

NAME OF INSURED ______________________________________ RELATIONSHIP TO INSURED S = SELF, P = SPOUSE, C = CHILD, O = OTHER

INSURED’S SOCIAL SECURITY NUMBER ___________________________ INSURED’S BIRTHDAY ______________

ADDRESS ____________________________________________________________________________________________

CITY __________________________, STATE ______ HOME PHONE (________) __________________

INSURED’S EMPLOYER _____________________________________________

**SECONDARY INSURANCE CARRIER:** COMPANY NAME ________________________________________________________

ADDRESS __________________________ CITY __________________ STATE ______ ZIP ______________

GROUP NAME/NUMBER ______________________________ CONTRACT/I.D. NUMBER ______________________________

NAME OF INSURED ______________________________________ RELATIONSHIP TO INSURED S = SELF, P = SPOUSE, C = CHILD, O = OTHER

INSURED’S SOCIAL SECURITY NUMBER ___________________________ INSURED’S BIRTHDAY ______________

ADDRESS ____________________________________________________________________________________________

CITY __________________________, STATE ______ ZIP ___________ HOME PHONE (________) __________________

INSURED’S EMPLOYER _____________________________________________
Kindly accept a photocopy of this authorization as if it were an original executed authorization. I understand that Dr. Townsend & Associates, P.A. utilizes computerized billing, therefore, my signature below acts as a signature on file. I authorize the release of any payment and medical information necessary to process my or my family member’s claim and related claims.

SIGNED ___________________________

I hereby authorize payment directly to Dr. Townsend & Associates, P.A. of the insurance benefits otherwise payable to me or my family member for their professional services. I understand that I am financially responsible to Dr. Townsend & Associates, P.A. for all charges not covered by this agreement.

SIGNED ___________________________

In the event that my insurance company fails to meet its obligations with respect to payment of my or my family member’s claim, I give my permission to Dr. Townsend & Associates, P.A. to send a complaint to the State Insurance Commissioner using my name as a complainant. I also understand that I will be informed, in writing, if this occurs.

SIGNED ___________________________

I understand that if I do not meet my financial obligations in regard to payments due Dr. Townsend & Associates, P.A., the account will be turned over to a collection agency. If the account is turned over to a collection agency I understand that I am responsible for all collection charges.

SIGNED ___________________________

**RESPONSIBLE PARTY INFORMATION**

<table>
<thead>
<tr>
<th>NAME</th>
<th>(Last)</th>
<th>(First)</th>
<th>(Mi)</th>
<th>Responsible party’s S.S. number (for billing SJCSB only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td></td>
<td></td>
<td></td>
<td>CITY</td>
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<tr>
<td>HOME PHONE # ( )</td>
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<td>WORK PHONE # ( )</td>
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</tr>
<tr>
<td>PLACE OF EMPLOYMENT</td>
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PATIENT’S RELATIONSHIP TO RESPONSIBLE PARTY: (CIRCLE ONE)  S — SELF,  P — SPOUSE,  C — CHILD,  O — OTHER

BY SIGNING BELOW I AGREE THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. MY SIGNATURE BELOW REFLECTS THAT I HAVE READ AND REVIEWED THE INSURANCE INFORMATION SECTION AND I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES AND I ALSO UNDERSTAND THAT IT IS NECESSARY TO PAY FOR SERVICES WHEN RENDERED.

CANCELATIONS NOT MADE 24 HOURS IN ADVANCE WILL BE CHARGED TO THE RESPONSIBLE PARTY.

PATIENT SIGNATURE ________________ DATE ____________________
CONSENT FOR TREATMENT

I, ________________________________ (Patient) do authorize Dr. Townsend & Associates, P.A. to provide assessment, counseling, or any other requested services.

INFORMED CONSENT

I understand that it is the policy of Dr. Townsend & Associates, P.A. to not provide opinion, letters or reports for forensic or court related purposes. This includes child custody cases. I agree to cooperate with this policy by making every effort to keep my therapy with Dr. Townsend & Associates, P.A. out of the forensic arena.

I understand that it is the policy of Dr. Townsend & Associates, P.A. that all information is held in the strictest confidence. I understand that the information disclosed to the counselor during individual or family sessions is to be kept confidential. All information obtained relevant to my treatment will be utilized as part of my therapy.

Exceptions include:

1. Reporting abuse of children, elderly or handicapped individuals to self or others.
2. Reporting of reasonable belief that a person poses a threat or danger to self or others.
3. Cooperation with any state or federal court order.
4. Case Review for supervision/staffing at Dr. Townsend & Associates, P.A.

I acknowledge my responsibility to maintain the confidentiality of all persons that I see, hear or meet with at Dr. Townsend & Associates, P.A.

My signature below reflects that I have read, understand and will adhere to the above policies of Dr. Townsend & Associates, P.A.

____________________________________________  _______________
Signature                                           Date