Dr Townsend & Associates

Comprehensive Counseling Services

Thank you for choosing Dr. Townsend and Associates, P.A. for your child's counseling and evaluation needs. We respect your time and would like to provide you with a full 45 minute session. Please note, we prefer to meet with the parent/guardian alone for the initial appointment. In order for your child's therapist to spend the full 45 minutes scheduled for your initial 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.

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

Thank you,

Dr. Townsend and Associates, P.A.

Dr Townsend & Associates

Comprehensive Counseling Services

PATIENT INFORMATION

PLEASE FILL OUT ALL INFORMATION. PLEASE PRINT NEATLY

NAME _____
(Last) (First) (MI)

ADDRESS _____ CITY _____ STATE ____ ZIP _____

HOME PHONE # ( )_____ WORK PHONE # ( )_____CELL (___)_____

PARENT'S EMAIL:_____

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

SOCIAL SECURITY: _____ **(REQUIRED)**

PARENT'S MARITAL STATUS: __SINGLE __MARRIED __DIVORCED __SEPARATED __WIDOWED __DOMESTIC PARTNERSHIP

PARENT'S 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 CHILD'S PEDICIATRICAN? _____

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:

Name	MG	Frequency	Name	MG	Frequency

LIST FAMILY MEMBERS AND ANY OTHERS LIVING IN THE HOME WITH PATIENT:

NAME	AGE	BIRTHDATE	RELATIONSHIP	OCCUPATION

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 FOR YOUR CHILD 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 YOUR CHILD

NERVOUSNESS	ANXIETY	FEARS	DEPRESSION
SHYNESS	ANGER	DIVORCE	FRIENDS
SUICIDE	PTSD	SLEEP	BOWEL TROUBLE
RELAXATION	POVERTY	TENSION	STRESS
HABITS	EDUCATION	HEALTH	HEADACHES
MEMORY	SADNESS	SELF-CONTROL	INSOMNIA
DELUSIONS	TEMPER	OVER-ACTIVE	HALLUCINATIONS
ENERGY	THOUGHTS	DRUG USE	LONELINESS
AMBITION	APPETITE	CONCENTRATION	ALCOHOL USE
UNHAPPINESS	ADOPTION	MAKING DECISIONS	
NIGHTMARES	IDENTITY CONCERNS	STOMACH PROBLEMS	

ADDITIONAL INFORMATION THAT MAY BE HELPFUL IN YOUR CHILD'S TREATMENT

PARENTS' MARITAL STATUS AND LENGTH OF RELATIONSHIP/MARRIAGE: PARENTS' OCCUPATION:

NUMBER OF SIBLINGS: MAJOR CHILDHOOD ILLNESSES/INJURIES:

PHYSICAL AND/OR SEXUAL ABUSE: EDUCATION PROBLEMS:

MEDICAL HISTORY

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

CONDITION	YOU	TREATING PHYSICIAN	CONDITION	YOU	TREATING PHYSICIAN
Diabetes			Cardiac		
Cancer			Stroke		
Dermatological			Asthma		
Migraine Headache			Gastrointestinal		
Neurological			Seizures		
Surgery			Broken Bones		
Traumatic Brain Injury			Other:		
Other:					

BEHAVIORAL HEALTH HISTORY

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

CONDITION	YOU	BLOOD RELATIVE	CONDITION	YOU	BLOOD RELATIVE
Depression			Psychotic Illness		
ADD/ADHD			Anxiety		
Bipolar Disorder			OCD		
Learning Disability			Mental Illness		
Addiction			Eating Disorder		
Suicide or Suicidal Thoughts			**Other:**		
PTSD					
		Note P:Paternal or M: Maternal			**Note P:Paternal or M: Maternal**

PLEASE MAKE A CHECK MARK NEXT TO ANY SERVICES YOUR CHILD IS CURENTLY RECEIVING OR HAS 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 treatment was received:

Did you find this Treatment helpful? ____ Yes ____ No

INSURANCE INFORMATION

Thank you for choosing us as you mental health provider. We are committed to your child's 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 _____

SIGNATURE ON FILE AND ASSIGNMENT OF BENEFITS AGREEMENT

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.

PARENT/GUARDIAN SIGNATURE_____

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.

PARENT/GUARDAIN SIGNATURE_____

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.

PARENT/GUARDIAN SIGNATURE_____

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.

PARENT/GUARDIAN SIGNATURE_____

RESPONSIBLE PARTY INFORMATION

NAME _____ _____
(Last) (First) (Mi) **Responsible party's S.S. number (for billing SJCSB only)**

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # ( ) _____ WORK PHONE # ( ) _____

PLACE OF EMPLOYMENT _____

PATIENT'S RELALTIONSHIP 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.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

CONSENT FOR TREATMENT OF MINORS WITH CONFIDENTIALY

Date: _____

Name of Parent/Guardian: _____

Telephone: ( ) _____ Can you be contacted at this number? _____

Can a message be left for you? _____

I, _____(Parent/Guardian) do authorize Dr. Townsend & Associates, P.A. to provide assessment, counseling, or any other requested services to _____(minor, under 18 years of age) and consent to the confidential relationship between the counselor and the named minor.

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 child's 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 your child/children will be utilized as part of their therapy. I recognize my child's/children's therapist will not render any type of forensic opinion.

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 of Parent/Guardian Date

DR. TOWNSEND & ASSOCIATES, P.A.

Child Developmental Milestone Questionnaire

Patient Name: _____ Date: _____

Person Completing Form: _____

Relationship to Patient: _____

Please write the age your child reached the following Developmental Skills (an estimation of the age is fine)

Motor

Age sat alone	_____	Age walked w/o holding on	_____
Age fed w/ fingers	_____	Age dressed torso/limbs	_____
Age fed w/ utensils	_____	Age tied shoelaces	_____
Age rode tricycle	_____	Age washed face/hands	_____
Age rode bicycle	_____	Age washed hair	_____

Language

Age spoke first word _____ Age spoke 2-3 word phrases _____

Names/sounds used to refer to mother _____

Names/sounds used to refer to father _____

Names/sounds used to refer to siblings _____

_____

Names/sounds used to refer to grandparents/other relatives _____

_____

Behavior

Stage of toilet training _____

Interactions w/ siblings _____

9 ST. JOHNS MEDICAL PARK DRIVE, ST. AUGUSTINE, FL 32086 (904)797-2705

6910 OLD WOLF BAY ROAD, PALATKA, FL 32177 (386)328-4955

Interactions w/ parents _____

Interactions w/ other children _____

Parental discipline style _____

_____

_____

Child's response to discipline _____

_____

_____

Primary disciplinarian _____

Responsibilities in home (chores, etc.) _____

_____

Please note any history of motor/language/behavioral delays or unusual development

_____

_____

_____

Please note any history of medical illnesses, surgeries, or hospitalizations

_____

_____

_____

Prenatal History:

Prenatal care received _____

Complications with pregnancy _____

_____

_____

Perinatal and Birth History:

Method of birth (vaginal birth, c-section, etc.) _____

Discharged from hospital in 3 days? _____ If no, please elaborate _____

_____

_____

APGAR Score (if known) _____ Birth weight _____

Education:

Attended Pre-K _____ Current grade level _____

Any history of academic delay _____

_____

Any exceptional student education services? _____ If yes, please elaborate _____

_____

_____