Dr Townsend & Associates

Comprehensive Counseling Services

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 session. In order for your therapist to spend the full time scheduled for your appointment we ask that you follow the following steps.

Arrive 15 minutes before your scheduled appointment time.

Please complete the attached paperwork and return it to our new patient coordinator by mail, secure or encrypted email to drtownsendoffice@gmail.com, fax (904-797-2820) or by dropping off to our practice.

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.

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 (____)_____

EMAIL: _____

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

LAST 4 OF SOCIAL SECURITY: _____**(REQUIRED)**

MARITAL STATUS: __SINGLE __MARRIED __DIVORCED __SEPARATED __WIDOWED __LONG TERM RELATIONSHIP

EMPLOYED _____YES _____NO PLACE OF EMPLOYMENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

FULL TIME STUDENT _____YES _____NO IF YES WHERE? _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

DID THEY REFER YOU TO OUR OFFICE? • YES • NO

IF NO, WHO REFERRED YOU? _____

DATE OF LAST PHYSICIAN'S EXAM: __/__/__. PHYSICIAN'S NAME: _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? NAME _____

ADDRESS _____ CITY _____ ZIP _____

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

RELATIONSHIP TO YOU: _____

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

NAME	AGE	BIRTHDATE	RELATIONSHIP	OCCUPATION

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	LGBTIA+ CONCERNS	AFFAIR
ATTENTION PROBLEMS			

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:

CONDITION	YOU	TREATING PHYSICIAN	CONDITION	YOU	TREATING PHYSICIAN
Diabetes			Heart Attack		
Cancer			Stroke		
Dermatological			Asthma		
Migraine Headache			Post-Partum		
Neurological			Seizures		
Surgery			High Blood Pressure		
Traumatic Brain Injury			Other:		
Other:					

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:

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 YOU ARE CURENTLY 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

INSURANCE INFORMATION

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 any time 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 _____ ZIP _____ 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.

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

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.

_____ _____
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

Consent for Treatment and Client Information

Thank you for choosing Dr. Townsend & Associates, P.A. for your counseling and evaluation needs. We have listed below some helpful information regarding services with our practice. Please review the following information. Please sign at the bottom of the last page to indicate that you have reviewed this information.

Length of Treatment

Psychotherapy typically involves regular sessions, 45 minutes in length. Duration of treatment varies depending on the nature of the problem and your individual needs.

Confidentiality

Information shared with a mental health professional is kept strictly confidential and is not disclosed without your written permission.

Confidentiality is **not guaranteed** in cases of: (a) danger to yourself or others (e.g., planning to hurt others or yourself); (b) situations in which either children under the age of 18, disabled persons or elderly persons who are under the care of others are endangered (examples of endangerment are sexual or physical abuse, or neglect) or (c) when you are going to violate a major law.

If you wish for your insurance company to pay for your visits, they will require information regarding your diagnosis, and possibly additional information such as psychological history and the treatment plan and goals of therapy. Your therapist can provide you with the information that is typically requested from your insurance provider.

Should, during your treatment at Dr. Townsend & Associates, PA, you ever be involved in a legal situation your signature below acknowledges that you have been informed that there will be no one sided conferences with an opposing attorney without written confirmation from yourself, by court order or as required by law or Florida Regulations.

Should psychological testing be conducted during your treatment at Dr. Townsend & Associates, PA, please note that by signing below you acknowledge that raw test data will not be released to anyone other than a licensed clinical psychologist, an appropriately licensed & trained individual or by court order.

Fee Policies

The ordinary charge for an individual or joint therapy session is $200.00. Charges for psychological evaluation may require a deposit that will be discussed with clients prior to the evaluation. **If you need to cancel an appointment, 24 hours' notice is appreciated**. **Otherwise, a cancellation fee of $75.00 will apply**. Please be aware that insurance carriers will not cover cancellation charges.

If you have mental health insurance coverage, our office will bill your carrier if appropriate and/or assist with insurance reimbursement. Please be aware that charges are the client's responsibility. In addition, any co-payment necessary should be made at the time of the session.

Our office reserves the right to engage the services of a collection agency in the event of unpaid balances. Charges for collection efforts also become the client's responsibility.

_____
Initials

Court/Forensic Requests

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. By signing below, 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.

Telephone consultations, preparation of records, and correspondence for court/forensic requests are billed pro-rated at $500.00 per hour. Court testimony charges are $750.00 per hour, portal to portal. In addition, patient will be responsible for preparation time charges.

Disability/FMLA Requests

Completion of Disability/FMLA forms will be considered for patients, if appropriate, and only after 3 counseling sessions have been completed with the patient. This allows for adequate assessment of patient's symptoms. There is a fee of $25.00 for form completion.

Quarterly Assessments

Our office provides quarterly assessments. These assessments consist of the Beck Anxiety Inventory and a Beck Depression Inventory. These assessments aide our clinicians in providing patients with the most appropriate care and it is our office policy that each patient participate in these quarterly assessments. Most insurance plans cover the cost of the assessments, however if you are unsure of your insurance coverage of the assessment, please speak to our front office staff and they will be happy to help you determine the cost, if any to you.

Emergencies

When a client's therapist is unavailable, arrangements can be made for coverage or telephone contact as necessary. In case of life-threatening emergencies please go to your local hospital emergency room or call 911. During the normal workday (Monday - Friday, 9:00 a.m. to 5:00 p.m.) please call the office and discuss your emergency with our receptionists.

Accompaniment of Guardians for all Minor Children

It is the policy of Dr. Townsend & Associates, PA that all minor children be accompanied by a parent or legal guardian at all times while on the premises and that said parent or guardian, or designated adult remain on the premises at all times whether the child is with them in the lobby area or in session. Children who are over the age of 16 may attend therapy sessions without the accompaniment of a parent or guardian if said parent or guardian signs a release giving their permission for the child to attend therapy without their being present.

As a parent or guardian your signature below allows Dr. Townsend & Associates, PA to obtain emergency medical care for your child, at your expense, if this becomes necessary based on staff decision. The latter applies if a legal guardian/parent is not present at the time of the crisis/emergency.

Physician Contact

Physical and psychological symptoms often interact. We encourage you to seek medical consultation, if warranted. In addition, medication may sometimes be helpful for psychological disorders. When appropriate, referral for medical/psychiatric consultation can be arranged.

We may ask a client's permission to contact their primary care or specialist physician regarding treatment, in order to coordinate your psychological and medical care.

_____

Freedom to Withdraw

You have the right to end therapy at any time and are obligated only to pay for completed sessions or fees incurred by not canceling 24 hours in advance. If requested, a therapist may provide a client with names of other qualified psychotherapists, either in this office or in another practice.

We appreciate clients informing their therapist if they do want to discontinue their therapy, although this not a requirement. Your therapist also has the right to terminate outpatient care.

Electronic Communication

By circling YES below, I formally request that I receive reminder calls/texts and/or emails for appointment reminders, workshop availability or other clinical activities. The number I would prefer to be called/texted is:
( )_____ The email I would prefer to receive office communications to is:
_____
Please note that no HIPAA protected PHI will be sent via texts or emails without specific written consent. All documents or messages containing HIPAA protected PHI will be available through your Patient Portal only. If you have voice mail please indicate your desire as to whether staff should leave a message by circling the appropriate answer below.

YES - Please leave a message NO - I would prefer no message be left

Patient Portal

Protecting our patients' confidential data is our priority. The best way for our Practice to communicate with you in a secure and encrypted manner is via your Patient Portal. We ask all patients to log in to their Patient Portal within 30 days of their initial appointment. Should you need help in creating your Patient Portal account, please speak to the front office staff for guidance.

30 Day No Contact Policy

It is our office policy that after 30 days of no contact with our office, your file will be considered closed. Should you wish to reinitiate services after 30 or more days have passed, you may call our office to discuss availability.

Privacy Practices Statement

Dr. Townsend & Associates, P.A. adheres to stringent HIPPA guidelines. Should you wish to receive a copy of our Privacy Practices, please request a copy from the front office staff. By signing below, I acknowledge that I have been informed that I may receive a copy of the Privacy Practices at my request.

Informed Consent

By signing below, I acknowledge that I have reviewed the Consent for Treatment and Client Information Form. Should I wish to receive a copy, I can request a copy from the front office staff.

By signing below, I acknowledge I have read and understand the preceding statements, have had the opportunity to ask questions about them and agree to begin treatment with Dr. Townsend & Associates, P.A.

_____ _____
Patient Signature Date

Revised 2023