Dr Townsend & Associates

Comprehensive Counseling Services

Thank you for choosing Dr. Townsend and Associates, P.A. for your evaluation needs. We respect your time and ask that you review the following steps to ensure that your scheduled evaluation process is as efficient and easy as possible.

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.

Please allow a minimum of 3 hours for the full evaluation process. Your appointment will consist of approximately 1 ½ hours of psychological testing and a 1 hour session with a licensed psychologist.

Please bring a list of all current medication and their dosages.

Should you require reading glasses, please have them available during your evaluation appointment.

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 __

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:

Name	MG	Frequency	Name	MG	Frequency

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

NAME	AGE	BIRTHDATE	RELATIONSHIP	OCCUPATION

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

ADDRESS ______________________________ CITY ______ ZIP __________

HOME PHONE # (   ) ____________________ WORK PHONE # (   ) ____________________

RELATIONSHIP TO YOU: ______________________________

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

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

Pre-Surgical Psychosocial Evaluation

FAMILY CONSTELLATION:

Please Describe Your Marital History (dates and lengths of marriage(s), quality of relationship(s), reason(s) for divorce, etc.):

____

____

____

If you are married/have a significant other, please describe their health, eating, and exercise habits, height and weight:

____

____

____

If you have children, please list their names, ages, occupations, and place of residency:

____

____

____

FAMILY OF ORIGIN:

Where were you born and raised? ____

Did your parents remain married or divorce? _____________________________________

How many siblings do you have? ___ Please list: ___________________________________

How would you describe your upbringing? ______________________________________

How would you describe your relationship with your family now? ______________________

____

Was your childhood stable? Yes_______ No_______

Were your parents supportive and caring? Yes______ No_______

Is there any history of mental health problems or substance abuse in your family? ____________

If so, please list: ____

Have any members of your family struggled with medical issues (spouse, parents, children)? _____

If so, please list: ____

Please list all health issues in family: ____

____

EMPLOYMENT / EDUCATIONAL HISTORY:

Please list the highest grade that you completed:___________________________
Please list your high-school GPA:_____ / College GPA:_____
Please list any degrees that you completed:____
Did you graduate with your high-school class: yes____ no____
If no, please describe why:____

Please describe any academic or behavioral difficulties you experienced during your education:
____

____

If you are employed outside your home, what is your job title?___________________________
How long have you been at this job?___________

Please list your prior job ____
How long were you at this job? ___________

SOCIAL/PERSONAL FUNCTIONING:

Please describe how your medical condition has impacted your daily functioning (e.g. health, work, lifestyle, relationships):____

____

____

STRESS FACTORS:

What stressors exist in your life (e.g. physical, emotional, financial)?_______________________

____

____

COPING MECHANISMS:

What methods do you use to cope with your stressors? ______________________________

____

____

SUBSTANCE USE HISTORY:

How often do you drink alcohol (average per week)?______________________________
How old were you when you had your first alcoholic drink?__________________________
How old were you when you first became intoxicated/drunk?__________________________
When were you last drunk?____
Do you have a history of alcohol abuse?___________________________________
Have you ever received treatment for substance abuse?______________________________
Have you ever attended AA or NA?______________ If yes, when______________
Have you ever had a DUI?__________________ If yes, when______________

Please describe any illegal substance use (current or historical)__________________________

____

____

Do you smoke or use smokeless tobacco?_________ If yes, for how long?______________

CURRENT BEHAVIORAL HEATH:

Are you currently experiencing any psychological problems or difficulties?_______________

If yes, please describe:____

How many hours do you typically sleep at night: ___________________________________

Please list any difficulties you have with sleeping:

____

____

Please list any difficulties you have with attention/concentration:

____

____

Please list any difficulties you have with memory:

____

____

Are you currently thinking of suicide? ______________________

Have you ever considered suicide in the past or made such an attempt?______________

If so when?______________________________

Have any members of your family committed suicide or homicide?______________

If so when?______________________________

Have you ever seen or heard things that others did not see or hear? ______________

If so when, what, and how often?______________________

Have you ever experienced physical, sexual, or verbal abuse?______________

Please list your primary strengths:______________________

____

Please list your primary areas of weakness:______________________

____

DAILY ROUTINE:

Describe your daily routine (activities, household chores, meal preparation, etc….)

____

____

____

How often do go outside of the home each week? ______________________

Do you regularly exercise? Yes________ No________

If yes, what type and how often? ______________________

MEDICAL CONDITION HISTORY:

When did you first experience or were diagnosed with your medical condition(s)?______________

____

What pain management programs have you utilized? ____________________

____

Were these programs successful? Yes _____ No _______

REASONS FOR SEEKING SURGERY:

What problems does your medical condition cause for you? ____________________

____

____

Why are you seeking surgery at this point in time?____________________

____

Who is in your present support system and will they continue after your surgical procedure?

____

____

Which procedure are you considering? ____________________

Have you researched this procedure and if so where and how? ____________________

____

____

Who have you discussed your surgery with as of today?

____

____

____

Do you understand the surgical procedure you are considering? Yes______ No______

Please describe it briefly. ____________________

____

____

What motivates you to comply with the procedure you are considering and the aftercare which is part of the program? ____

____

____

What changes have you made in preparation for surgery?____________________________

____

What changes will be necessary post surgery? ____________________________________

____

Are you willing to attend a support group? Yes _____ No _____

Are there any factors that would prevent compliance with the surgical procedure/program?

Yes ______ No______. If yes please describe them________________________________

____

____

____

If we interviewed you 3 years after the surgery and you told us it was the best 3 years of your life – what would have happened??

____

____

____

INSURANCE INFORMATION

Thank you for choosing us as you 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 (   ) ____________

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 Evaluation and General Information

The pages below provide some basic information about your evaluation at our office. Please read and sign at the bottom of the last page to indicate that you have reviewed this information.

Confidentiality

Information shared with a mental health professional is kept strictly confidential and is not disclosed without your written permission. One exception at our office is that the therapists here at Dr. Townsend & Associates, PA do staff clients so as to provide quality of care. 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.

Should, during your evaluation 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 evaluation 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.

Physician Contact

We may ask you for permission to contact your primary care or specialist physician regarding your past care or treatment.

Freedom to Withdraw

You have the right to end the evaluation at any time and are obligated to pay for completed portions or fees incurred by not canceling 24 hours in advance.

By signing below, I acknowledge that I have reviewed and received a copy of the Consent for evaluation and General Information Form.

Privacy Practices Statement

By signing below, I acknowledge that I have reviewed the Privacy Practices posted in the office of Dr. Townsend & Associates, PA. I recognize that I have 72 hours to remove my approval to proceed with the requirements outlined in HIPAA.

I hereby authorize Dr. Townsend & Associates, PA to release the results of this evaluation to:

____

I hereby agree that should I choose to seek a copy of the completed report or any data collected regarding my evaluation, it will be obtained from my physician.

I have read and understand the preceding statements, have had the opportunity to ask questions about them and agree to this evaluation and the release thereof.

______________________________ ______________

Signature Date