

# Haydon-Davis Counseling, Inc

Wendy H. Davis, LCSW

Licensed Clinical Social Worker

305 Kingsley Lake Drive Suite 702  
St. Augustine, FL 32092

Telephone: (904) 716-5619

Fax: (248) 751-5913

## PATIENT REGISTRATION FORM

Patient's Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_

City State Zip Home Phone

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Sex: \_\_\_\_\_ S/M/D/O DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Responsible Billing Name: \_\_\_\_\_ Check here if same as above: \_\_\_\_\_

Last First Middle Initial

Address: \_\_\_\_\_  
Street City State

Zip Code Home Phone Work Phone

**Please Note:** Payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills this is a matter between you and your insurance carrier.

### PRIMARY INSURANCE

Insured's Name: \_\_\_\_\_  
Last First Middle

Relationship to Patient: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

Insured's Home Phone: \_\_\_\_\_ Insured Work Phone: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

I certify that the information I have reported with regard to my insurance coverage is correct and permit a copy of this authorization to be used in place of the original. This authorization may be revoked either by me or the above name carrier at anytime in writing.

Signature of Subscriber: \_\_\_\_\_ Date: \_\_\_\_\_

### ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION:

I authorize payment of medical benefits to the Provider named above for professional services. I also authorize the release of any psychiatric, medical or other information including protected health information (PHI) and/or medical records necessary to process claims. I also request payment of government benefits either to myself or to the provider above who accepts assignment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# Haydon-Davis Counseling, Inc

Wendy H. Davis, LCSW

Licensed Clinical Social Worker

305 Kingsley Lake Drive Suite 702  
St. Augustine, FL 32092

Telephone: (904) 716-5619  
Fax: (248) 751-5913

---

## List of Charges

Initial Evaluation 60mn .....	\$135	Individual Therapy 45mn.....	\$115
Family/Couples Therapy 60/90mn.....	\$135/200	Letter/Forms to Employer, School, Etc: .....	\$120
Lack of Notice to Change Appointment/Missed appointment Fee: .....		\$85	

---

## Cancellation/Rescheduling & Arrival Time Policy

If you are unable to make your scheduled appointment, please contact my office **24** hours in advance. Missed appointments, those without proper notice of cancellation or need for rescheduling, will be assessed a **\$85** fee. Please be aware that insurance companies will **not** reimburse for missed appointments. Also note that if you arrive late for your appointment, you are forfeiting that time. Your appointment starts at the time on your appointment card, not when you arrive.

---

## In Case of Emergency

**If you feel you are at danger to yourself or someone else, call 911 immediately.**

If you need to speak with me about an urgent matter and it cannot wait until normal business hours, you may leave a voice mail on my main number and I will return your call promptly. I will also leave a message on my voice mail that will indicate who to contact should I be unavailable. I will make reasonable attempts to inform you ahead of time when I will be unavailable, i.e. emergencies, vacation or attending a workshop.

---

## Court Appearances

Court appearances are billed to the individual requesting the testimony. The fee for these services is \$250/hour with a required minimum fee of \$750 paid 24 hours in advance. Payment is expected in Cash or Money Order. There are no refunds. Report writing is billed at \$120 per hour and requires one hour be paid in advance. In the event that records or other materials are subpoenaed, a charge of \$1 per page will be made for copying and file preparation.

---

## Payment Agreement

- I authorize Haydon-Davis Counseling, Inc to release information to my insurance carrier for the purpose of processing insurance claims for the patient indicated below.
- I understand that all co-pays and deductibles are due at the time of the patient's appointment.
- I understand that I will be charge \$25 fee for a returned check. I understand checks may no longer be accepted if a check is returned for insufficient funds - payment will need to be cash or Money Order.
- I understand an account is considered delinquent if the patient has not paid the balance within 30 days following written notification of the balance due. I understand that the unpaid balance will then be subject to a monthly finance charge of 15%. **Any portion of the account balance over 30 days old will be submitted to a collection agency and continue to accrue interest.**
- I am responsible to pay all collection costs on any unpaid balance on my account, generally 50% of balance.
- I understand that for each counseling session, I am responsible for payment of \$ \_\_\_\_\_.
- **I acknowledge responsibility for my account and guarantee payment of all charges against it.**

Patient's Name: \_\_\_\_\_  
Last First Middle

Responsible Party: \_\_\_\_\_  
Last First Middle

**Your signature below indicates that you have read, understand and agree to comply with all the terms and conditions explained above.**

**Signature of Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Pt Name:**

**MR#:**

---

**Haydon-Davis Counseling, Inc**

**Wendy H. Davis, LCSW**

*Licensed Clinical Social Worker*

305 Kingsley Lake Drive Suite 702  
St. Augustine, FL 32092

Telephone: (904) 716-5619  
Fax: (248) 751-5913

---

**Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**For Treatment:** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment:** We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations:** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law:** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Without Authorization:** Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

**Child Abuse or Neglect:** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect. Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Patients:** We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person’s estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Medical Emergencies:** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

**Family Involvement in Care:** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Pt Name:

MR#:

---

**Haydon-Davis Counseling, Inc**

**Wendy H. Davis, LCSW**

*Licensed Clinical Social Worker*

305 Kingsley Lake Drive Suite 702  
St. Augustine, FL 32092

Telephone: (904) 716-5619  
Fax: (248) 751-5913

---

**Notice of Privacy Practices (continued)**

**Health Oversight:** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

**Law Enforcement:** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions:** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**Public Health:** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Public Safety:** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Research:** PHI may only be disclosed after a special approval process or with your authorization.

**Fundraising:** We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

**Verbal Permission:** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization:** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at \_\_\_\_\_:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Pt Name:

MR#:

**Haydon-Davis Counseling, Inc**

**Wendy H. Davis, LCSW**

*Licensed Clinical Social Worker*

305 Kingsley Lake Drive Suite 702  
St. Augustine, FL 32092

Telephone: (904) 716-5619  
Fax: (248) 751-5913

**Notice of Privacy Practices (continued)**

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Wendy H. Davis, LCSW or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint. The effective date of this Notice is September 2013.

**Florida Statutes:** Florida statutorily grants patients the right of access to medical records maintained by health care practitioners. The disclosure of patient information by providers is generally prohibited without the patient's consent, subject to specified exceptions. Florida has numerous laws protecting the confidentiality of health information held by a variety of entities and government agencies.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Haydon-Davis Counseling, Inc.'s **Notice of Privacy Practices**. A complete notice with explanations of uses, disclosures, rights and information on how to file a privacy complaint is available at the following: In person at the office or by phone at 904-716-5619.

\_\_\_\_\_  
Signature of Patient/Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature or Parent, Guardian or Personal Representative \*    Date

\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

\_\_\_\_\_ Patient/Client Refuses to Acknowledge Receipt:

\_\_\_\_\_  
Signature of Staff Member

**Pt Name:**

**MR#:**

**Haydon-Davis Counseling, Inc**

**Wendy H. Davis, LCSW**

*Licensed Clinical Social Worker*

305 Kingsley Lake Drive Suite 702  
St. Augustine, FL 32092

Telephone: (904) 716-5619  
Fax: (248) 751-5913

---

**Informed Consent and Treatment Agreement**

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As patient in psychotherapy, you have certain rights and responsibilities that are important for you to understand. Foremost, you have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You also have the right to ask questions about any aspects of psychotherapy and about my specific training and experience. More detail about these rights and responsibilities are described below.

Psychotherapy/therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems.

The first 2-3 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. We will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. I may ask you to do "homework" in terms of reading, writing and/or to attempt making changes in your thinking or behavior. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. There are no guarantees about success of therapy as it is not an exact science, but I can promise that I will work with you actively to facilitate the achievement of your goals.

If at any time, you are unhappy with what is happening in therapy or have questions about my procedures, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. It would be greatly appreciated if you would share verbally or in writing the reason for early termination of treatment, as this may help me to improve my services.

- 1- I have been given information regarding my rights to privacy and confidentiality including the limits of confidentiality of my record and personal health information.
- 2- I am aware that a complete copy of the Notice of Privacy Practices for protected private health information (HIPPA) is available for review upon my request.
- 3- I have been informed of my financial responsibilities upon entering into psychotherapy services.

**Given all the information above, I give my authorization and consent to participate in psychotherapy evaluation and treatment with Wendy H. Davis, LCSW of Haydon-Davis Counseling, Inc.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Wendy H. Davis, LCSW

\_\_\_\_\_  
Date

**Pt Name:** \_\_\_\_\_

**MR#:** \_\_\_\_\_

**Haydon-Davis Counseling, Inc**

**Wendy H. Davis, LCSW**

*Licensed Clinical Social Worker*

305 Kingsley Lake Drive Suite 702  
St. Augustine, FL 32092

Telephone: (904) 716-5619  
Fax: (248) 751-5913

**Authorization for Electronic Communication**

As a convenience to me, I hereby request that Haydon-Davis Counseling, Inc. communicate with me regarding my treatment by Haydon-Davis Counseling, Inc. via electronic communications (e-mail or text message). I understand that this means Haydon-Davis Counseling, Inc and/or my treating providers will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications. I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Haydon-Davis Counseling, Inc. shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Haydon-Davis Counseling, Inc. to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Haydon-Davis Counseling, Inc. to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Haydon-Davis Counseling, Inc., I may revoke this authorization by providing written notice to Haydon-Davis Counseling, Inc. at P.O. Box 600003 Jacksonville, FL 32260-0003 or fax at 248-751-5913.

I agree that Haydon-Davis Counseling, Inc. may communicate with me electronically unless and until I revoke this authorization by submitting notice to Haydon-Davis Counseling, Inc. in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_  
for minor