Thomas A. Davis, PhD, LPC, LMFT
700 Sunset Drive
Building 200, Suite 201
Athens, GA 30606

New Patient Information

Name_____DOB_____

Address_____

City _____ State _____ Zip _____

Home # _____ Cell #_____ Work #_____

Best place to reach you? Home _____ Cell _____ Work ____ OK to leave message? Home _____ Cell _____ Work _____

Email Address _____ How did you hear about us _____

Marital Status Married _____ Single _____ Divorced _____ Other _____ Gender M____ F _____ Other_____

Are you currently employed _____ Employers Name _____

Brief Description of why you are seeking therapy:

_____

_____

_____

Insurance Information

Primary Insurance _____ Authorization # (if needed) _____

Address _____ City _____State _____ Zip_____

Name of Insured _____ DOB _____

Member ID _____ Policy/Group # _____

Deductible amount? _____ Amount remaining? _____

If deductible has not been met, please be prepared to pay the full amount today.

Person Responsible for Payment (if other than patient)

Name _____ Relationship to Patient _____

DOB _____ Home # _____ Cell # _____

Address _____ City _____ State _____Zip_____

Employer _____

Emergency Contact

Name _____ Relationship to Patient _____

Home # _____ Cell # _____ DOB _____

May we contact them in case of emergency? _____ Yes _____No

CONSENT TO TREATMENT I understand treatment with Dr. Davis will involve discussing medical, relationship, psychological &/or emotional issues I may find distressing. I also understand this process is intended to assist me in improving my personal & interpersonal health & well-being. I further understand if I have questions concerning my therapy, Dr. Davis will answer them, or he will attempt to find answers for me. I understand I may leave therapy at any time, although I've been informed this is best accomplished in consultation with Dr. Davis.

_____ Initial _____Date

FILING OF CLAIMS & AUTHORIZED PAYMENT I understand & agree that when applicable, insurance claims for services rendered will be filed as a courtesy. I understand that I am fully responsible for payment of any deductible, co-payment & other costs that for whatever reason are not paid by my insurance company. I agree to promptly provide any information to this provider or to my insurance company required to process these claims and obtain any referrals and/or authorizations required prior to treatment. I understand that should I fail to provide such information as it is requested, and if the claims are not paid as a result, then I assume full responsibility for the entire cost of my therapy. I understand that it is my responsibility to verify that Dr. Davis is a participating provider with my insurance plan and obtain any referrals required prior to treatment. I understand that I am financially responsible for all charges whether they are paid by insurance or not. I authorize the release of any medical information necessary to secure the payment of benefits and that all benefits will be assigned directly to Dr. Davis. I authorize the use of my signature on all of my insurance submissions.

_____ Initial _____ Date

CANCELLATION POLICY I understand and agree that it is my responsibility to attend sessions that I've scheduled with Dr. Davis. If I cannot attend a therapy session, I must provide 24 hours notice of cancellation. I understand and agree that should I fail to provide 24 hour notice of cancellation, I assume full financial responsibility for payment of the entire fee for that session**. Please note, we maintain a 24/7 answering service in case of emergencies or cancellations. A text message will NOT be accepted in lieu of calling to cancel.**

_____ Initial _____Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES & PATIENT RIGHTS & RESPONSIBILITIES

Patient Name _____ DOB _____

Maiden Name or Other Name if applicable _____

I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices and Patient Rights & Responsibilities from Thomas A. Davis Ph.D., (effective April 15, 2003). I understand that my consent shall remain in force from this time forward.

Printed Name of Patient _____

Signature _____ Date _____

Relationship to Patient _____

Signature of Insured or Legal Guardian _____ Date _____

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tomdavis.phd@gmail.com
www.drtomdavis.com

PROBLEM WORKSHEET

PATIENT NAME: _____ **DATE:**_____

How can we best help you?

_____Individual Therapy
_____ Couple Therapy
_____ Family Therapy
_____ Behavioral
_____ Substance Abuse
_____ Addictions
_____ Other

If you had to choose ONE PROBLEM for which you most wanted help with, what would it be?

_____

_____

The problem that I/we have come to address today is best described as:

_____ An individual problem-who has the problem_____
_____ A couple problem (having to do with your relationship)
_____ A family problem (having to do with children/parents behavior)
_____ Another problem (please describe)
_____

Were you required to come to therapy as part of a court order or employer required attendance?

_____ YES _____NO

How pressured did you feel to come to therapy?

_____ Not pressured _____ A little _____ Somewhat _____ Quite pressured _____ Very

In the family in which you GREW UP, were there problems with

_____ Alcohol/Drug/Substance/Prescription Drug Use
_____ Physical Abuse or Violence
_____ Sexual Abuse
_____ Emotional Abuse
_____ Depression or other mental health issues
_____ Trouble with the law

Please briefly explain_____

_____

In the family in which you LIVE NOW, are there problems with

_____ Alcohol/Drug/Substance/Prescription Drug Use
_____ Physical Abuse or Violence
_____ Sexual Abuse
_____ Emotional Abuse
_____ Depression or other mental health issues
_____ Trouble with the law

Please briefly explain_____

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MEDICAL HISTORY QUESTIONNAIRE

Patient Name _____ DOB _____

Are you here for:

___Individual Therapy ___Couples Therapy ___Family Therapy

Reason for todays visit:_____

_____

Were you required to come here because of a court order or job related issue? _____ Yes _____ No

Did you feel pressured by someone else to come to therapy today? _____ Yes _____ No _____ Somewhat

Have you had prior Psychotherapy? _____ Yes _____ No If yes, when _____ and for what reason?

_____

_____

Are you currently having any thoughts of harming yourself or anyone else? _____ Yes _____ No

Present Medications Dosage & Frequency Prescribing Doctor

_____

_____

Current or Recent Medical Conditions Treating Doctor

_____

_____

Hospitalizations or Surgeries

Date_____Type of Surgery _____

Date_____Type of Surgery _____

Date_____Type of Surgery _____

Do you have any allergies? _____ Yes _____ No

Please list_____

Any known developmental problems or disabilities?

_____

Primary Care Physician _____ Phone _____

May we contact your PCP to discuss treatment? _____ Yes _____ No

Are you working with or have you recently worked with a Psychiatrist? _____ Yes _____ No

Name _____ City _____ State _____

Phone_____

May we contact your Psychiatrist to discuss your treatment? _____ Yes _____ No

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Have YOU ever had any of the following:

	Y /N			Y/ N			Y/N	
Depressed mood			Relationship Issues			Forgetfulness		
Anxiety			Thoughts of harming self or others			Impulsivity		
Mood Swings			Loss of Interest in Activities			Increase/Decrease in Libido		
Stress			Hopelessness			Suspiciousness		
Problems with Attention/Focus			Feeling Overwhelmed			Increased Irritability		
Traumatic Experiences			Fatigue			Excessive Energy		
Eating Disorders			Excessive Guilt			Avoidance		
Alcohol/Drug Abuse			Crying Spells			Hallucinations		
Sleep Disturbance			Panic Attacks					
Anger/Violence Issues			Excessive Worry					

Have any of your blood relatives ever had any of the following

Depression		Suicide	
Anxiety		PTSD	
Alcohol Abuse		High Blood Pressure	
Other Substance Abuse		Stroke	
Bipolar Disorder		Cancer	
Schizophrenia		Thyroid Problems	
Anger/Violence Issues		Diabetes	

Do you smoke? _____ Yes _____ No _____ Cigarettes per DAY / WEEK / MONTH

Do you drink? _____ Yes _____ No _____ Drinks per DAY / WEEK / MONTH

Have you ever been abused emotionally, sexually, physically or by neglect? _____ Yes _____ No

In the home you **GREW UP** in were there problems with any of the following:

Alcohol Abuse Physical Abuse Sexual Abuse Emotional Abuse Mental Health Issues Addictions Issues with the Law

In the home you live in **NOW** are there problems with any of the following:

Alcohol Abuse Physical Abuse Sexual Abuse Emotional Abuse Mental Health Issues Addictions Issues with the Law

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NO SHOW and/or LATE CANCELLATION POLICY

I understand and agree to the following:

1.It is my responsibility to notify Thomas A. Davis Ph.D. by telephone (706-548-9850) at least 24 hours prior to the scheduled appointment if I am unable to keep my appointment time.

2. Should I fail to provide at least 24 hour notice of cancellation or no show for the scheduled appointment, I assume full financial responsibility for payment of the entire fee for that session.

3. I understand that a 24 hour/7 day a week answering service is maintained for this reason, and that emails and text messages will NOT be accepted in lieu of calling to cancel.

Signed_____
Date_____

Please let us know if you would like a copy of this for your records.

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HIPAA Information and Consent Form Patient

Name: _____DOB:_____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request. I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy.

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Assumption of the Risk & Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19 has been declared a worldwide pandemic by the World Health Organization. ***COVID-19 is extremely contagious*** and is believed to spread mainly from person-to-person contact. As a result, federal, state and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Thomas A. Davis, PhD, LPC, LMFT has put in place preventative measures to reduce the spread of CVID-19; however Dr. Davis ***cannot guarantee*** that you or your child[ren] will not become infected with COVID-19. Further, attending in-person appointments with Dr. Davis ***could increase*** your risk and your child's risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself and/or my child and family may be exposed to or infected by COVID-19 by attending in-person appointments with Dr. Davis and such exposure or infection may result in personal injury, illness, permanent disability and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Dr. Davis' office may result from the actions, omissions, or negligence of myself and others, including, but not limited to Dr. Davis, his employees, volunteers and other participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my children [including, but not limited to, personal injury, disability and death] illness, damage, loss, claim, liability or expense, of any kind that I or my child may experience or incur in connection with my attendance or my child's attendance at in-person appointments with Dr. Davis. On my behalf and/or on behalf of my child I hereby release, covenant not to sue, discharge and hold harmless Dr. Davis, his employees, agents and representatives of and from the claims, including all liabilities, claims, actions, damages, costs of expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions or negligence of Dr. Davis, his employees, agents and representatives, whether a COVID-19 infection occurs before, during or after participation in any in-person appointments with Dr. Davis.

Print Name_____ Date _____

Signature of Patient/Parent _____

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