Dr. Daphne Timmons, PhD.

Last Name:________________________ ☐ Mr. ☐ Mrs. ☐ Miss ☐ other:___________ Sex: Male_____ Female_____

First Name:________________________ Date of Birth:_____/___/______ Age:_____ SSN -------------------_______

Middle Name:______________________ Preferred Name: ______________________________________

Address:__________________________ City:_________________ State:_____ Zip:__________ County: ___________

Referred by: ____

Education Level: ____

May we send a message to you via email? ☐ Yes ☐ No
Email address:____
(Please note that most standard email does not provide a secure means of communication. There is some risk that protected health information (PHI) contained in an email may be disclosed to, or intercepted by, unauthorized third parties).

☐ Home Phone: ( )_________________ ☐ Cell Phone: ( )_______________ Work Phone: ( ) _______________
Please check the box where we may leave you a message about appointments.

If applicable may we communicate with you via text message? Yes_____ No_____ (If yes, we will use the cell phone number listed above unless you want us to use another number) Cell Phone: ( )______________________________
(Please note that "Text messages are generally not secure because they lack encryption, and the sender does not know with certainty the message is received by the intended recipient. Also, the telecommunication vendor/wireless carrier may store the text messages.")

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ other: __________________________

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Other: ________________________________

Student Status: ☐ Not a Student ☐ Full ☐ Part-time

Employment Status: ☐ Full ☐ Part ☐ N/A Employer: ____

Emergency Contact Name:____ Relationship:______________________

Previous counseling: Yes ☐ No ☐ Name of counselor _______________________________________

What brings you to counseling at this time? ____

____

Primary Physician____ Office Phone ____________________________

Current medical conditions ____

Current medications ____

____

If on psychotropic medications, who prescribes? Name: ____

Contact Information of prescriber of psychotropic medications: ______________________________

Guarantor/Financially Responsible Person (if different from patient)

Last Name:________________________ ☐ Mr. ☐ Mrs. ☐ Miss ☐ other:___________Sex: Male_____Female_____

First Name:________________________Date of Birth:_____/___/_______Age:______SSN ------------------_______

Middle Name:______________________Relationship to Patient: ____

Address:__________________________City:__________________State: _____Zip:___________County:_____________

Home Phone: ( )_________________Cell Phone: ( )_______________Work Phone: ( ) _______________

If this person is financially responsible for payments on your account, may we contact them on one of the telephone numbers listed above? Yes________No_________. If they request a receipt in the mail or via email, may we send them information regarding their payments to your account? If insurance should deny your claim for any reason can we contact them regarding your insurance? Yes_______No_______.

Primary Insurance	**Secondary Insurance**
Insurance Company:______________________________	Insurance Company: __________________________________
Policyholder Name:_______________________________	Policyholder Name: ___________________________________
Member or Policyholder ID#:_______________________	Member or Policyholder ID#:____________________________
Policyholder Date of Birth:_________________________	Policyholder Date of Birth: ______________________________
Insurance Co. Phone#:____________________________	Member or Policyholder ID#:____________________________
Group#:_______________________________________	Group#:____
Relationship to Patient:_____________________________	Relationship to Patient: _______________________________

Consent for Treatment, Authorization, Assignment of Benefits, and Release

CONSENT FOR TREATMENT: I consent and authorize Dr. Daphne Timmons to provide me therapy and to use and release my protected health information (PHI) for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the South Carolina Privacy Notice Form, a copy of which has been made available to me.

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION: I understand that my mental health information, including complete records and billing information, may be released to my insurance company and to other mental health professional and/or mental health institutions for treatment and payment purposes.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all of my rights and allow payment to be made directly to Dr. Daphne Timmons for all therapy otherwise payable to me under terms of my insurance.

PAYMENT GUARANTEE: I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered Dr. Daphne Timmons, including charges for services not covered by my insurance. I consent and authorize Dr. Daphne Timmons to contact me by telephone at any number associated with me, including a wireless number and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account if applicable.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep Dr. Daphne Timmons informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my mental health.

Print Patient's Name: ____

Patient's Signature:____Date: ____/_____/_________

Print Legal Guardian's Name: ____

Legal Guardian's Signature:____Date: ____/_____/_________

Dr. Daphne Timmons, PhD.

Ongoing Communication Regarding Your Mental Health

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM DR. DAPHNE TIMMONS MAY DISCUSS YOUR MENTAL HEALTH CONDITION? IF YES, WHOM? (Please provide the information below)

For ongoing communication regarding your mental health and for your privacy, you must complete this section to authorize Dr. Daphne Timmons to release and/or discuss your mental health information with the following people or organizations. Any revocation or modification to your authorization with regard to an individual or organization must be submitted in writing.

PLEASE NOTE: By listing an individual(s)/entity(s) below, you authorize Dr. Daphne Timmons to release and/or discuss your mental health information with the individual(s)/entity(s).

From Date:________________________________ To Date: ________________________________

Name of Individual/Entity	Phone Number	Relationship

Print Patient's Name: ____

Patient's Signature:____ Date:____/____/________

Print Legal Guardian's Name: ____

Legal Guardian's Signature:____ Date:____/____/________