Dr. Jacquelyn Hall-Davis, M.D.

Phone:(618)622-9240
Fax: (618)622-9241

INITIAL CLIENT INFORMATION

Date:_____ Client's SSN:_____

Client's First Name:_____ Last Name:_____ MI: ___

Address:_____ City:_____ State:_____ Zip:_____

Phone: (Home) _____ (Work)_____ (Cell) _____

Birthdate:_____ Age:_____ Gender: **M** **F** Email: _____

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*Mother's Name:*_____ Phone: _____

Address: _____ City:_____ State:_____ Zip: _____

Employer:_____ Phone:_____

*Father's Name:*_____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

EMERGENCY INFORMATION

In case of emergency, contact:

Name (1): _____ Relationship: _____

Phone:_____

Address: _____ City:_____ State:_____ Zip:_____

*Name (2):*_____ Relationship:_____

Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Physician: _____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

*Therapist/Counselor:*_____ Phone: _____

Address:_____ City:_____ State:_____ Zip:_____

REFERRAL SOURCE

Name_____

Address_____ City_____ State_____ Zip_____

May we thank your referral source: YES NO

TRICARE ONLY INFORMATION

Tricare: Prime Standard Retired Active Duty

Subscriber Name_____ Relationship_____

Sponsor's SS#_____ Sponsor's DOB_____

OTHER INFORMATION

All efforts will be attempted to give a courtesy call a day or two in advance to remind you of your upcoming appointment. Ultimately, it will be your responsibility to remember your appointment date and time.

Okay to e-mail for confirmations: YES NO E-mail address_____

_____YES. A courtesy call is okay. Call me at this number_____

Can we talk to anyone else at that number? YES NO If yes, who?_____

Okay

Can we leave a message on an answering machine or voicemail? YES NO

_____NO. I DO NOT WANT A REMINDER CALL.

If you are unable to keep your scheduled appointment, you must give 24 hours advance notice of cancellation. If 24 hours notice is not given you will be charged $25. If you NO SHOW for a scheduled appointment time you will be charged $50. This amount must be paid and is not billable to your insurance company.

I understand the 24 hour cancellation/NO SHOW policy: YES NO

_____ _____

Signature ***Date***

MEDICAL HISTORY
REVIEW OF SYSTEM FORM

DATE:_____

NAME:_____

DATE OF BIRTH:_____

- *If no changes in the below information, please skip to page 2*

___Married ____Single___ Divorced____ Widowed_____ NO. of Children:_____

Occupation:_____

Tobacco Use: YES/NO How much?_____ How Long?_____ Date Quit:_____

Alcohol Use: YES/NO How much per day?_____

Caffeine (coffee, tea, cola) Per day?_____

PAST ILLNESSES OF YOURSELF AND FAMILY:

You/Family	You/Family	You/Family
☐ ☐ Alcoholism	☐ ☐ High Blood Pressure	☐ ☐ Stroke
☐ ☐ Anemia	☐ ☐ Kidney Disease	☐ ☐ Suicide Attempt
☐ ☐ Asthma	☐ ☐ Liver Disease	☐ ☐ Thyroid Disease
☐ ☐ Cancer/Tumor	☐ ☐ Hepatitis	☐ ☐ Tuberculosis, TB
☐ ☐ Diabetes	☐ ☐ Lung Disease	☐ ☐ Ulcer in GI Tract
☐ ☐ Drug Abuse	☐ ☐ Mental Illness	☐ ☐ Venereal Disease
☐ ☐ Depression	☐ ☐ Osteoarthritis	☐ ☐ High Cholesterol
☐ ☐ Epilepsy/Seizures	☐ ☐ Osteoporosis	☐ ☐ HIV/ Immune DX
☐ ☐ Glaucoma	☐ ☐ Phlebitis	☐ ☐ Other_____
☐ ☐ Heart Disease	☐ ☐ Rheumatic Arthritis	_____

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS- PLEASECHECK EACH ITEM "YES" or "NO" AS THEY RELATE TO YOUR HEALTH

ALLERGIC/IMMUNOLOGIC:	Yes	No
Hives/Eczema	☐	☐
Hay Fever	☐	☐
CARDIOVASCULAR:		
Murmur	☐	☐
Chest Pain	☐	☐
Palpitations	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Difficulty Lying Flat	☐	☐
Swelling Ankles	☐	☐
CONSTITUTIONAL:		
Weight Loss	☐	☐
Fatigue	☐	☐
Fever	☐	☐
EAR,NOSE,THROAT:		
Difficulty Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus Trouble	☐	☐
Nasal Stuffiness	☐	☐
Frequent Sore Throat	☐	☐
ENDOCRINE:		
Loss of Hair	☐	☐
Heat/Cold Tolerance	☐	☐
EYES:		
Glasses/Contacts	☐	☐
Eye Pain	☐	☐
Double Vision	☐	☐
Cataracts	☐	☐
GASTROINTESTINAL:		
Heartburn/Reflux	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Change in BMs	☐	☐
Diarrhea	☐	☐
Jaundice	☐	☐
Abdominal Pain	☐	☐
Black or Bloody BM	☐	☐
GENITOURINARY:		
Burning/Frequency	☐	☐
Nighttime	☐	☐
Blood in Urine	☐	☐
Erectile Dysfunction	☐	☐
Abnormal Discharge	☐	☐
Bladder Leakage	☐	☐
HEMATOLOGY/LYMPH:		
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐

MUSCULOSKELETAL:	YES	NO
Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐
NEUROLOGICAL:		
Loss of Strength	☐	☐
Numbness	☐	☐
Headaches	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐
PSYCHIATRIC:		
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficulty Sleeping	☐	☐
RESPIRATORY:		
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Chills	☐	☐
SKIN:		
Rash/Sores	☐	☐
Lesions	☐	☐
Itching/Burning	☐	☐

FEMALES ONLY:

Date of last mammogram:_____

Normal_____ Abnormal_____

Date of last PAP_____

Normal_____ Abnormal_____

Age Onset Periods:_____

Age Onset Menopause_____

Periods Regular? Yes____ No_____

Number of Pregnancies_____

SIGNATURE/REVIEWING PHYSICIAN:_____

Dr. Jacquelyn Hall-Davis, M.D.
1669 Windham Way, Suite B
O'Fallon, IL 62269
Phone: (618) 622-9240
Fax: (618) 622-9241

We do our best to provide quality services to our clients. In order to preserve that mutually trusting and respectful relationship, the client needs to assure that payment for services is made in a timely manor.

PLEASE READ CAREFULLY
FORM MUST BE FILLED OUT COMPLETELY TO RECEIVE SERVICES

1. **Standard insurance co-payments/ co-insurances are required at the time of service. All cash accounts are expected to be paid at time services are rendered.**
2. **There is a $25 fee for returned checks.**
3. **There is a $25 fee for late cancellations (less than 24 hours notice) and a $50 fee for no show appointments. Payment of these fees will be charged to your credit card on the date of the missed appointment.**
4. **To secure payment for our services, we require that your credit card information be kept on file for uncovered expenses or fees due to missed appointments with less than 24 hours notice.**
5. **We will file with Tricare. However, if we have not received payment within 90 days, it becomes your responsibility and we will charge the balance to your credit card.**
6. **If you have a balance on your account, you will receive two bills in the mail. If after those two bills we don't receive a payment you will then receive a red letter which will be a final notice. If you receive a final notice, please contact the office to pay the balance or to set up a payment plan.**

I _____, have read, understood, and agree to
(Print Name)
the terms and conditions as stated. Furthermore, I authorize Counseling Associates of Southern Illinois to charge my credit card for any of the aforementioned fees, services not covered by insurance, or charges that are in excess of what aforementioned covers (e.g. co-pays) if applicable. All balances are due at the time services are rendered. If the balance of your bill is in excess of $100 by the end of 3 months, we will charge your credit card. **You will be contacted by us 24 hours prior to charging your credit card.**

Credit card: Visa Mastercard Discover

Credit card # _____ Expiration Date _____

CVV (3 or 4 digit code)_____ Zip code _____

Signature _____ Date _____

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Dr. Jackie Hall-Davis requests:

24 HOUR NOTICE POLICY

When canceling your scheduled appointment

If you are unable to keep your scheduled appointment, please kindly give 24hours notice of cancellation.

A $25 fee will be assessed to your account should you cancel within 24 hours. If you NO-SHOW for a scheduled appointment time a $50 fee will be assessed. Payment of these fees will be due upon receipt of a bill/ billed to your card on file and is not billable to your insurance carrier..

**We appreciate your efforts in keeping your appointments or cancelling them within 24 hours so that we are able to offer this time to another client that may be waiting for an immediate appointment.

Notice of Privacy Practices and Patient Rights

Receipt and Acknowledgement of Notice

Patient Name: _____

I hereby acknowledge that I have received and understand Jacquelyn Hall-Davis M.D.'s *Privacy Practices and Patient Rights.* I understand that if any questions regarding the Privacy Practices or my rights, Dr. Hall-Davis will explain them.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent, Guardian or Personal Representative Date

- If you are signing as a personal representative of a Patient, please describe your legal authority to act for this individual (power of attorney, health care surrogate, etc.):

_____

☐ **Patient Refuses to Acknowledge Receipt**

I acknowledge that I provided the patient with a copy of their Patient Rights and informed them of the Notice of Privacy Practice.

_____ _____

Signature of Staff Member if Patient Refuses to Sign Date

CONSENT TO TREAT

I am voluntarily seeking services from Jacquelyn Hall-Davis, M.D. for the purposes of diagnosis and treatment and do hereby consent to such diagnostic procedures and treatment as may be deemed necessary for myself or, in my capacity as guardian, for the minor. I am aware that mental health and substance abuse counseling is not an exact science and acknowledge that no guarantees have been made as to the result of diagnosis, treatments, test, or examination. The undersigned certify as agent or as patient, the foregoing has been read and agrees to execute the above and accept its terms.

Authorization to Release Information to Third Party

I authorize Dr. Hall-Davis to release to my private insurance carrier(s), other third party payer(s), and to relevant funding sources any medical information acquired in the course of my examination or treatment which are necessary to file claims for reimbursement, and for the discharge of the legal or contractual obligations of the insurance carrier(s), other third party payer(s) or relevant funding source(s). Such information may include, but is not limited to, any information or diagnosis pertaining to psychiatric, alcohol, or substance abuse history, or any disability I may have had. This is a continuing disclosure and is effective for the entire treatment episode and until all claims are filed or processed. This consent is subject to written revocation at any time except to the extent that action has been taken in reliance thereon.

Assignment of Interests

I hereby assign to Jacquelyn Hall-Davis, M.D. any and all benefits payable up to the amount of my bill accruing to me in connection with my treatment, beginning with the date of admission. IN the even that payment is received from more than one source causing overpayment for this period of treatment, I authorize application of the overpayment to any bill for which I am legally responsible that has not been paid in full at the time of the receipt of the overpayment.

The undersigned hereby acknowledges understanding and receipt of this instrument.

Signature of Consumer	Signature of Guardian (if needed)	Signature of Insured
Signature of Guarantor	Witness	Date