Home Office
1401 Airport Pkwy, Suite 240
Cheyenne, WY 82001

Branch Office
1635 Foxtrail Dr.
Loveland, CO 80538

Tel: 307-632-7771
Fax: 307-632-9697

Consent for Evaluation

Identifying Information

Name: ____

Ethnicity: ______________________________ Pronouns: He/Him; She/Her; They/Them

Address: ____

City: ________________ State: ________ Zip: ____________________

Primary Phone: ________________ Alternate Phone: ____________________

SSN # ____________________ DOB: ____________________

Email Address: ____

Preferred Contact Method: ____

Primary Insurance

Insurance Company: ____

Insurance Policy #: ________________ Group #:____________________

Guarantor Name: ________________ Guarantor's DOB:____________________

Relationship to patient: ____

I understand that it is my responsibility to obtain any prior authorization that may be required by my insurance carrier and provide the details of said authorization to Smith Psychological Services. I further agree that charges incurred regardless of insurance coverage are my responsibility and subject to insurance plan benefits and limitations. Initial ________

I acknowledge the receipt of the Notice of Privacy Practices for my review and I have received and consent to the Notice of Privacy Practices? Initial ________

I have read and consent to the telemedicine consent form provided? Initial ______

Do you consent to email communication, recognizing that email is not HIPPA protected? **Yes** **No**

May we phone you to confirm appointments? **Yes** **No**

May we leave a voicemail message? **Primary Phone** **Yes** **No**
Alternate Phone **Yes** **No**

May we send you information via mail? **Yes** **No**

I have read, understood, and agree with the consent form and the conditions stated above.

______________________________ ______________________
Signature **Date**