Smith
PSYCHOLOGICAL SERVICES
smithpsychologicalservices.com

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**

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Cancellation, No-Show, and Termination Policy

By signing below, I acknowledge and agree that if I must cancel an appointment, I will do so before the close of business on the day prior to my appointment (5 PM) by calling the office at 307-632-7771. I also agree to leave a message if no one answers and understand that voice message time stamps will be used to determine the cancellation time. I acknowledge and understand that if I miss an appointment without cancelling, either due to no-show or late cancellation, any future appointments will not be held until I contact the office, at which time appointments will be scheduled based on availability and at the discretion of the treating provider.

For therapy clients: I acknowledge and authorize the below credit card to be charged ***$30*** if I do not show for an appointment or do not cancel before close of business on the day prior to my appointment.

For testing clients: I acknowledge and authorize the below credit card to be charged ***$100*** if I do not show for an appointment or do not cancel before close of business on the day prior to my appointment. This fee applies to all scheduled interactions with assessment clients, including but not limited to scheduled calls, in person appointments, and telehealth appointments, regardless of scheduled length of appointment.

In the event that you do not show up to an appointment, and do not call to cancel, you may receive a call from the office within one week of your missed appointment to see if you would like to reschedule or terminate services. If we do not get ahold of you, we may send a letter via your home address to indicate your case has been terminated. These processes are subject to change based on your treating provider's discretion. You may call to reinitiate services should you desire, based on the availability and discretion of the treating provider.

In the event that you do not fill out the below credit/debit card information, by signing this agreement you are acknowledging and agreeing that the fee will be paid over the phone or in person before being able to schedule or attending an upcoming appointment.

Name on Card: _____

Credit Card on File: _____

Expiration Date: _____ CVV code: _____

Billing Address: _____

I hereby agree to the Cancellation, No-Show, and Termination policy. I am responsible for keeping my credit card information up to date and agree to inform Smith Psychological Services of any changes as soon as possible. Smith Psychology Services will also have full discretion for unpaid accounts and will take necessary actions to collect any unpaid balances.

_____ _____

Patient/Responsible Party Date

_____ _____

Witness – Smith Psychological Services Date

Jeremy Bay, MS, Provisional Professional Counselor
Professional Disclosure Statement

As a client of Smith Psychological Services, LLC, 1401 Airport Parkway, Ste 240, Cheyenne, WY 82001you are entitled to the following information regarding my education, experience and qualification and to the full disclosure of your rights as a client. Pursuit of LPC: A Licensed Professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one-year postdoctoral practice, and pass an exam in professional counseling.

Formal Professional Education

Master of Military and Emergency Responder Psychology from Colorado State University System, January 2024
Bachelor of Science, Human Services, Colorado State University System, 2020
Associates of Science, Military Studies, Hawaii Pacific University, 2008

Licensure Status

Provisional Professional Counselor, WY #1445
Supervised by Shaina Smith, PhD, Clinical Psychologist, WY #694, 1401 Airport Parkway, Ste 240, Cheyenne, WY, 82001, 307-632-7771

Areas of Specialization

You are entitled to receive information from me about my methods of therapy or approach to assessment, the duration of your treatment, and our fee structure. Please ask if you would like to receive this information. You also may seek a second opinion or terminate your therapy/assessment at any time.

Clients Rights and Responsibilities

1. Sexual intimacy with a client is never appropriate.
2. I will adhere to the Code of Ethics of the American Counseling Association.
3. I will always follow appropriate guidelines to ensure the confidentiality of your records with a note of the following exceptions:
    a. As of March 1, 1999 Wyoming has implemented a privileged communication statute. This law states that, when involved in legal proceedings (civil, criminal or juvenile) clients retain the right to privacy, unless these specific circumstances exist:

        1) abuse or harmful neglect of children, the elderly or disabled or incompetent individuals is known or reasonably suspected
        2) the validity of a will of a former client is contested
        3) information related to counseling is necessary to defend against a malpractice action brought by a client
        4) an immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor
        5) in the context of civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed to the counselor
        6) the client alleges mental or emotional damages in civil litigation, or his/her mental or emotional state becomes an issue in any court proceeding concerning

child custody or visitation
7) the patient or client is examined pursuant to a court order
8) in the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue.

4. I will be working with you under the license of my supervisor listed above. I will consult with my supervisor and team about your counseling/assessment. Sessions can be recorded and observed for my training purposes. These recordings will be erased after consultation and supervision is completed.

5. If you require any additional information about me or feel you need to register a complaint you can contact the Wyoming Board of Mental Health professionals at 2001 Capitol Ave, Room 127, Cheyenne, Wyoming 82001.

This disclosure statement is required by the Mental Health Professions Licensing Act, administered by the Wyoming Mental Health Professions Licensing Board, 2001 Capitol Avenue Room 127 Cheyenne, WY, 82002, Phone 307-777-7788.

I have read and understand the information in this document.

_____

Client Signature Date

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	