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

CLIENT RIGHTS DISCLOSURE STATEMENT

Client's Name: _____ **Date of Birth**: _____

LPCC Holder: Stevie (Stephanie) White **Supervisee Licensure Number:** LPCC.0021447

Supervisor: Dr. Shaina Smith **Supervisor's Licensure Number**: PSY.0005177

REGULATION OF PSYCHOTHERAPISTS: The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations and can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800.

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.

CLIENT RIGHTS AND IMPORTANT INFORMATION

a. I am a practitioner with an LPCC licensure pursuing LPC certification. 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.

b. 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.

c. In a professional relationship such as ours, sexual intimacy between a clinician and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Regulatory Agencies at the address and/or telephone number stated in Section 1 above.

d. Generally speaking, information provided by and to a client in a professional relationship with a clinician is legally confidential, and the information cannot be disclosed without the client's consent. There are several exceptions to confidentiality, some are described in C.R.S. § 12-245-220 and in the Notice of Privacy Practices that you were provided. If legal exceptions to confidentiality arise during our professional relationship, when necessary and appropriate, I will identify them to you. Some exceptions to confidentiality include:

(1) I am required to report any suspected incident of child abuse or neglect to law enforcement. I am not required to report past abuse if the victim is over 18, unless the alleged abuser currently has access to children;

(2) I am required to report any suspected incident of abuse or neglect for protected populations, including elderly, persons with disabilities and other vulnerable adults to law enforcement, which may include contacting law enforcement to perform a wellness check for the person of concern;

(3) I am required to report any threat of imminent physical harm by a client to a specific person, including those identifiable by their association with a specific location or entity, to law enforcement, the person(s) threatened, and/or the person(s) responsible for the specific location or entity threatened;

(4) I am required to initiate a mental health evaluation of a client who is imminently dangerous to themselves or to others, or who is gravely disabled, as a result of a mental disorder;

(5) I am required to report any suspected threat to national security to federal officials; and

(6) I may be required by Court Order to disclose treatment information.

e. Under Colorado law, C.R.S. § 14-10-123.8, parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information. If you request treatment information from me, I may provide you with a treatment summary in compliance with

Colorado law and HIPAA Standards.

I have read the preceding information. I understand my rights as a client/patient. I also acknowledge that I have received a copy of this Disclosure Statement and have reviewed the Notice of Privacy Practices.

_____ _____

Client Signature/Legal Representative Date

_____ _____

Therapist Date

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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