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

Provisional Profession Counselor Disclosure Statement

Susan Schilt, Provisional Professional Counselor
Smith Psychological Services
1401 Airport Parkway, Ste. 240
Cheyenne, WY 82001
Office: 307-632-7771
E-mail: susan.schilt@gmail.com

Informed Consent

I am a Provisionally Licensed Professional Counselor. I have a Bachelor of Science in Business from the University of Wyoming and a Master of Arts in Clinical Mental Health Counseling from Colorado Christian University. My counseling experience consists of my practicum and internship at Volunteers of America in Cheyenne, Wyoming and women's and recovery ministry over the last ten years. I am under the supervision of Shaina Smith, PhD of Smith Psychological Services.

Services Provided

Counseling therapy is a partnership between counselor and client to set and work to accomplish personal healing and growth goals. It is impossible to guarantee results regarding counseling goals; however, we will work together to help you achieve the best possible results. We will review your goals regularly to ensure they are still accurate. Counseling can be difficult as current life patterns are examined and changed or replaced with healthier life patterns. The concerns discussed in counseling can cause an increase in fear, anxiety, negative thoughts, or other physical, mental, or emotional impacts. These impacts are a common aspect of therapy. I am not a medical doctor and will not provide medical advice or prescribe medication. You have the right to ask about methods or assessments used in your therapy. You have the right to refuse service; however, you acknowledge the potential negative psychological consequences of refusing services.

Counselor – Client Relationship

The communication between a counselor and a client can be very personal and intimate. However, this relationship is always professional. Therefore, sexual intimacy with a client is never appropriate. Clients should report all violations to the Wyoming Mental Health Professionals Board.

I will adhere to the Code of Ethics of the American Counseling Association.

This disclosure statement is required by the Mental Health Professions Licensing Act. Questions or concerns can be directed to the Mental Health Professions Licensing Board located at 2001 Capitol Ave, Room 127, Cheyenne, WY 82001.

Use of Technology

Communication via e-mail, text, or fax is not encrypted; therefore, I cannot guarantee confidentiality. If you communicate via any of these methods, you acknowledge and assume all risk of the potential breach of confidentiality, and you will have a place within our initial intake forms to communicate your preferences and allowances. Our office will call or send text appointment reminders based on client preferences.

I do not communicate or connect with clients on social media, such as Facebook, Twitter, or Instagram. My relationship with clients is professional only.

Use of Diagnosis

Diagnoses guide therapists and clients to the best treatment path in the most cost-effective manner. Diagnoses protect clients from poor therapy practices and ensure therapists focus on the client and improving their quality of life. Insurance companies also use diagnoses for reimbursement. However, not all diagnoses are reimbursable.. All diagnoses become a part of your permanent health record.

Statement of Confidentiality

All communication between the client and the counselor will become part of the client's treatment, and appropriate records will be kept in a safe and confidential filing system. Generally, all information shared between you and the counselor during therapy sessions is legally confidential and cannot be released without your consent. However, there are some exceptions to this confidentiality:

- Suspected abuse or neglect of children, the elderly, disabled, or vulnerable
- An immediate threat of physical violence against a readily identifiable victim is disclosed to the clinician
- An immediate threat of suicide
- A client alleges mental or emotional damages in civil litigation
- A client's mental/emotional state becomes an issue in any child custody/visitation court proceeding
- A court-ordered examination of the client
- For billing purposes, the billing agent will send client demographics, diagnosis codes, dates of service, and fees to the insurance company.
- The validity of a former client's will is contested
- Information related to counseling is necessary to defend against a malpractice action brought by a client

Complaints and Grievances

I strive to meet the needs of all clients in a respectful, compassionate, and professional manner. You are encouraged to discuss any grievances or concerns directly with me. However, you have

the right to file a complaint to address the situation. You should file you grievance through the Wyoming Mental Health Professions Licensing Board located at 2001 Capitol Avenue, Room 127, Cheyenne, WY 82001. You can also find additional information on the Board's website: https://mentalhealth.wyo.gov.

Termination of Services

Clients have the right to terminate services at any time. Please notify me of your intent to end therapy. I may request a final session to discuss therapy aftercare. In addition, services may be terminated for other reasons, including but not limited to:

- A mutual agreement between the client and counselor to end counseling
- The client does not return to counseling, does not call to cancel or reschedule within a reasonable amount of time, as outlined in the practice's policies
- The counselor terminates counseling due to the client no longer needing counseling
- The counselor determines another counselor is better equipped to meet the client's needs.
- The client begins inpatient or residential treatment and is not expected to return to counseling.

Should I be unable to continue therapy with the client, I or my designee will work with you to continue treatment with another counselor or provide you available and appropriate referrals.

Acceptance of Terms

I agree that I have read and understood the preceding information by signing below. My questions have been answered, and I understand my rights as a client or as the client's responsible party.

_____ _____

Client Signature / Client Responsible Party Date

_____ _____

Susan Schilt, Provisional Professional Counselor Date

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version – Lifetime/Recent

	Past Month		Lifetime (Worst Point)	
Ask questions that are bolded and underlined.	**YES**	**NO**	**YES**	**NO**
Ask Questions 1 and 2				
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*				
2) *Have you actually had any thoughts of killing yourself?*				
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.				
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"				
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"				
5) *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*				

How long ago did the Worst Point Ideation occur?

	YES	NO
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

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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