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: _____

Guardian Name/s (if minor): _____

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

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

SSN # _____ DOB: _____

Email Address: _____

Responsible Party Place of Employment: _____

Contact Number: _____

Primary Insurance

Insurance Company: _____

Insurance Policy #: _____ Group #: _____

Guarantor Name: _____ Guarantor's DOB: _____

Relationship to patient: _____

Place of Employment: _____ Contact Number: _____

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 acknowledge the receipt of the **Notice of No-Show & Late Cancellation Policy** for my review? 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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Voluntary Credit Card on File Authorization & Consent

Patient Name: _____

DOB: _____

To simplify payments, clients have the option to keep a credit or debit card securely on file with Smith Psychological Services. This is a **voluntary authorization,** and you may choose to opt in or out at any time.

Credit Card Information (Optional)

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Card Number: _____

Expiration Date (MM/YY): _____

Security Code (CVV): _____

I **voluntarily authorize** Smith Psychological Services to securely store the above card and charge it for the following:

☐ _____ Insurance CoPays at the time of service
initial

☐ _____ Late cancellation or missed appointment fees in accordance with practice policy
initial

I understand that :

- This consent is optional and can be withdrawn in writing at any time.
- I may use another method of payment at any time, if preferred.
- My information will be stored securely in compliance with HIPAA and PCI regulations.
- I will receive a receipt upon request for any charges made.

Signature of Cardholder: _____ **Date:** _____

☐ *I decline to store a card on file at this time* _____
initial

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Notice of No-Show & Late Cancellation Policy

We value your time and are committed to providing quality care. To help ensure availability for all clients and support consistent scheduling, we have implemented the following No-Show and Late Cancellation Policy. Please review the information below carefully. You will be asked to acknowledge this policy as part of your general consent to treatment.

Cancellation Requirements

If you need to cancel or reschedule an appointment, we ask that you notify our office **no later than 5:00 PM the business day prior** to your scheduled appointment. You may cancel by calling our office at **307-632-7771**. If no one is available to take your call, please leave a voicemail—**voicemail timestamps will be used to verify the time of your cancellation.**

Missed Appointment Policy

If you miss an appointment (including late cancellations), the following will apply:

- **Your future appointments will not be held** until you contact the office to reschedule.
- Appointments will be rescheduled **based on provider availability** and at the **discretion of the treating provider**.

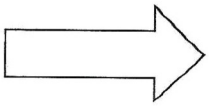
Fee Structure

Fees for no-shows or late cancellations will be charged based on the type of service scheduled:

- **Therapy Clients:**
  A $30 fee will be charged to the **credit/debit card on file**. If no card is on file, an invoice will be sent.
- **Testing/Assessment Clients:**
  A $100 fee will be charged to the **credit/debit card on file**. This applies to **all scheduled interactions**, including phone consultations, in-person appointments, and telehealth sessions, regardless of appointment length. If no card is on file, an invoice will be sent.

Re-engagement After a Missed Appointment

If you do not show up for an appointment and do not call to cancel, our office may attempt to contact you within one week to determine if you wish to continue services. If we are unable to reach you, a letter may be mailed to your home address notifying you of service termination. These procedures may vary depending on your provider's discretion.



Should you wish to resume services in the future, you may contact the office to request re-initiation, which will be considered based on scheduling availability and provider discretion.

Payment Without a Card on File

If you choose not to keep a credit/debit card on file, please be aware that payment for **any no-show or late cancellation fee may be required to be paid in full by phone or in person prior to rescheduling or attending any future appointments**.

Licensed Professional Counselor Disclosure Statement

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

Informed Consent

I am a 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 will video-record sessions with clients on occasion. The recordings are via video camera and never connected to the internet. The videos are stored briefly in your client folder and then deleted once they are reviewed.

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, changed, or replaced with healthier ones. 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

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

E-mail, text, or fax communication 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. You 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 the insurance company client demographics, diagnosis codes, dates of service, and fees.
- 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, Licensed Professional Counselor 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**

UHS Rev 4/2020

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

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ____

2. Did a parent or other adult in the household **often** ...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ____

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ____

4. Did you **often** feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ____

5. Did you **often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ____

10. Did a household member go to prison?
    Yes No If yes enter 1 ____

Now add up your "Yes" answers: This is your ACE Score TOTAL ____

Building Character to Develop Talent – David McMillan, Durango High School
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Resilience

This questionnaire was developed by the early childhood service providers, pediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and updated in February 2013. Two psychologists in the group, Mark Rains and Kate McClinn, came up with the 14 statements with editing suggestions by the other members of the group. The scoring system was modeled after the ACE Study questions. The content of the questions was based on a number of research studies from the literature over the past 40 years including that of Emmy Werner and others. Its purpose is limited to parenting education. It was not developed for research.

RESILIENCE Questionnaire

Please circle the most accurate answer under each statement:

1. **I believe that my mother loved me when I was little.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

2. **I believe that my father loved me when I was little.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

3. **When I was little, other people helped my mother and father take care of me and they seemed to love me.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

4. **I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

5. **When I was a child, there were relatives in my family who made me feel better if I was sad or worried.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

6. **When I was a child, neighbors or my friends' parents seemed to like me.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

7. **When I was a child, teachers, coaches, youth leaders or ministers were there to help me.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

8. **Someone in my family cared about how I was doing in school.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

9. **My family, neighbors and friends talked often about making our lives better.**
   Definitely true Probably true Not sure Probably Not True Definitely Not True

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10. We had rules in our house and were expected to keep them.

Definitely true Probably true Not sure Probably Not True Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to.

Definitely true Probably true Not sure Probably Not True Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.

Definitely true Probably true Not sure Probably Not True Definitely Not True

13. I was independent and a go-getter.

Definitely true Probably true Not sure Probably Not True Definitely Not True

14. I believed that life is what you make it.

Definitely true Probably true Not sure Probably Not True Definitely Not True

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled "Definitely True" or "Probably True"?) _____

Of these circled, how many are still true for me?_____

Any positive memories that you feel has increased your ability to handle adversity? (Please explain)