



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

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 read 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** _____

I have read and consent to the **Supervision Disclosure Statement** provided. **Initial** _____

Do you consent to email communication, recognizing that email is not HIPAA protected?	Yes	No
May we phone you to confirm appointments?	Yes	No
May we leave a voicemail message?	Primary Phone	Yes
	Alternate Phone	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

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 your 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

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version – Lifetime/Recent

	Past Month		Lifetime (Worst Point)	
	YES	NO	YES	NO
Ask questions that are bolded and <u>underlined</u>.				
Ask Questions 1 and 2				
1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) <u>Have you actually had any thoughts of killing yourself?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.				
3) <u>Have you been thinking about how you might do this?</u> <i>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."</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) <u>Have you had these thoughts and had some intention of acting on them?</u> <i>As opposed to "I have the thoughts but I definitely will not do anything about them."</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) <u>Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How long ago did the Worst Point Ideation occur?

6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u>	YES	NO
<i>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.</i>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, ask: <u>Was this within the past three months?</u>	<input type="checkbox"/>	<input type="checkbox"/>

- Low Risk
- Moderate Risk
- High Risk

Adverse Childhood Experience (ACE) Questionnaire

Name: _____ Date: _____

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

Attempt or actually have oral, anal, or vaginal intercourse 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 _____

Adverse Childhood Experience (ACE) Questionnaire

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

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. Were any of your parents or other adult caregivers:

Often pushed, grabbed, slapped, or had something thrown at them?

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 _____

ACE SCORE (Total "Yes" Answers): _____

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

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)



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Policy to Read

Notice of Privacy Practice

Effective Date: March 2, 2022

Introduction

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires mental health professionals to issue this official Notice of Privacy Practices. This notice describes how information about you is protected, the circumstances under which it may be used or disclosed and how you may gain access to this information. Please review it carefully. For psychotherapy to be beneficial, it is important that you feel free to speak about personal matters, security in the knowledge that the information you share will remain confidential. You have the right to the confidentiality of your medical and psychological information, and this practice is required by law to maintain the privacy of that information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health and psychological information. If you have any questions about this Notice, please contact the office.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g., a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, the only minimum necessary information needed to accomplish the task will be shared.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes. The following should help clarify these terms:

- PHI refers to information in your health record that could identify you. For example, it may include your name, the fact you are receiving treatment here, and other basic information pertaining to your treatment.
- Use applies only to activities *within* my office and practice group, such as sharing, employing, applying, utilizing, and analyzing information that identifies you.
- Disclosure applies to activities outside my office or practice group, such as releasing, transferring, or providing access to information about you to other parties.
- Authorization is your written permission to disclose confidential health information. All authorizations to disclose must be made on a specific and required form.
- Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. For example, with your written authorization I may provide your information to your physician to ensure the physician has the necessary information to diagnose or treat you.
- Payment Your PHI may be used, as needed, in activities related to obtaining payment for your health care services. This may include the use of a billing service or providing you documentation of your care so that you may obtain reimbursement from your insurer.
- Health Care Operations are activities that relate to the performance and operation of my practice. I may use or disclose, as needed, your protected health information in support of business activities.

For example, when I review an administrative assistant's performance, I may need to review what that employee has documented in your record.

Written Authorizations to Release PHI

Any other uses and disclosures of your PHI beyond those listed above will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization at any time, in writing.

Uses and Disclosures without Authorization

The ethics code to the American Psychological Association, Wyoming State law, and the federal HIPAA regulations all protect the privacy of all communications between a client and a mental health professional. In most situations, I can only release information about your treatment to others if you sign a written authorization. This Authorization will remain in effect for a length of time you and I determine. You may revoke the authorization at any time, unless I have taken action in reliance on it. However, there are some disclosures that do you require your Authorization. I may use or disclose PHI without your consent in the following circumstances:

- Child Abuse – If I have reasonable cause to believe a child may be abused or neglected, I must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – If I have reason to believe that an individual such as an elderly or disabled person protected by state law has been abused, neglected, or financially exploited, I must report this to the appropriate authorities.
- Health Oversight Activities – I may disclose your PHI to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions. If a client file a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your treatment and the records thereof, such information is privileged under state law, and is not to be released without a court order. Information about all other psychological services (e.g., psychological evaluation) is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.
- Serious Threat to Health or Safety – If you communicate to me a specific threat of imminent harm against another individual or I believe that there is a clear, imminent risk of injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.
- Worker's Compensation – I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to a worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Special Authorizations

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

- Psychotherapy Notes – I will obtain a special authorization before releasing your Psychotherapy notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection from PHI.
- HIV Information – Special legal protections apply to HIV/AIDS related information. I will obtain a special written authorization from you before releasing information related to HIV/AIDS.
- Alcohol and Drug Use Information – Special legal protections apply to information related to alcohol and drug use and treatment. I will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment. You may revoke all such authorizations (of PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses/disclosures of PHI. However, I am not required to agree to the request.
- Right to Receive Confidential Communications by Alternative Means – You have the right to request and receive confidential communications by alternative means and locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy of PHI in my records as these records are maintained. In such cases I will discuss with you the process involved.
- Right to Amend – You have the right to request an amendment of PHI for as long as it is maintained in the record. I may deny your request. If so, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of all disclosures of PHI. I can discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the Notice of Privacy Practices from me upon request.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you at our next session, or by mail at the address you provided me.

No Surprises Act “Good Faith Estimate”

You have the right to receive a “Good Faith Estimate” explaining how much your medical and mental health care will cost. Under the law, healthcare providers need to give clients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a Good Faith Estimate for the total expected cost of your healthcare services, including psychotherapy services. You can ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service. The Good Faith Estimate shows the costs of items and services that are reasonably expected for your healthcare needs for an item or service. The estimate is based on information known at the time the estimate is created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during the course of care. You could be charged more if special circumstances occur. In non-emergency circumstances, you will be provided with an updated Good Faith Estimate for any new expected charges. If you are billed for more than your Good Faith Estimate, you have the right to dispute the bill under federal law. Specifically, if you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill. You may contact the healthcare provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute within 120 calendar days (about 4 months) of the date of the original bill. There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on the Good Faith Estimate. If the agency disagrees with you and agrees with the healthcare provider or facility, you will have to pay the higher amount. To learn more or to get a form to start the dispute resolution process, call HHS' toll free number: 1-877-696-6775.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint. Complaints

may be filed to the Wyoming Board of Psychology, address 2001 Capitol Ave, Room 127, Cheyenne WY 82002, or by email at JoAnn.Reid@wyo.gov.

If you have any questions about this Notice please contact me:

Smith Psychological Services, LLC
Shaina Smith, PhD
1401 Airport Parkway, Suite 240
Cheyenne, WY 82001
307-632-7771
admin@smithpsychological.com

Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on March 3, 2022



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Policy to Read

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**.

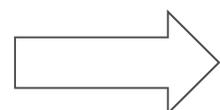
Fee Structure

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.**



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Policy to Read

Consent for Telemedicine

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.

I understand that the telemedicine visit will be done through a two-way video. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the health care provider as well.

I understand that the laws protecting privacy and confidentiality (HIPAA) also apply to telemedicine.

I understand that email correspondence must take place to arrange telemedicine services.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without effect my right to future care.

I understand that email correspondence must take place to arrange telemedicine services.

I understand that no recording shall take place, from both the psychologist and client.

I understand that by initialing the main consent form, I am consenting to receive psychological services via telemedicine.



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SUPERVISION DISCLOSURE STATEMENT

Some clinical services provided at this clinic are delivered by clinicians, trainees, or support staff who are practicing under the supervision of Shaina Smith, PhD, a licensed psychologist. Supervision is conducted in accordance with applicable state laws, professional standards, and ethical guidelines.

Shaina Smith, PhD
Licensed Psychologist
License Numbers: WY 694 ; CO PSY.0005177 ; MT 5429 ; AK 191664 ; PsyPact 21003

The following individuals are currently practicing under the supervision of Dr. Smith:

- Kaitlin Dent, M.S.Ed., M.Phil.Ed.
- Sadonia Garner, MS
- Jessica Lewis, MS
- Stephanie White, M.Ed., LPCC, NCC
- Kaydei Murphy, AA (Psychology), Psychometrician

IMPORTANT INFORMATION REGARDING SUPERVISION

a. I understand that the provider I am seeing is practicing under supervision and that Shaina Smith, PhD maintains clinical oversight and professional responsibility for the services provided.

b. I understand that my case may be discussed with the supervisor and/or supervision team for the purposes of consultation, training, and ensuring quality of care. These discussions are conducted in a professional and confidential manner that are consistent with HIPAA requirements.

c. I understand that sessions may be observed or recorded when clinically appropriate and/or required for supervision or training purposes. Any recordings will be stored securely and erased after supervision and training requirements are met.

d. I understand that I may ask questions at any time regarding supervision, my provider's credentials, or the role of the supervising psychologist, and have access to the supervising psychologist at my request within an appropriate timeframe.

e. I understand that I have the right to request services from a different provider or to discontinue services at any time, consistent with clinical policies.

REGULATION OF PSYCHOLOGICAL SERVICES AND COMPLAINTS

The practice of psychology and related mental health services is regulated by state licensing boards. If you have a concern or wish to file a complaint regarding the services you receive, you may contact the appropriate regulatory agency based on the state in which services are provided.

Wyoming:

Wyoming Board of Psychology
2001 Capitol Ave
Cheyenne, WY 82001
Phone: (307) 777-7788

Colorado:

Department of Regulatory Agencies
Division of Professions and Occupations
1560 Broadway, Suite 1350
Denver, CO 80202