Elizabeth Ann Smith, L.C.S.W. A.C.S.W.
Elizabeth33@msn.com
Phone: 480-294-4581
Elizabethannsmith.com

INTAKE FORM

CLIENT INFORMATION (Please Print)

First Name_____ Middle Initial_____ Gender [ ] M [ ] F
Last Name_____ Birth date_____ Age_____
Address_____
City_____ State_____ Zip_____
Email_____
Home Phone_____ Okay to call [ ] Yes [ ] No
Work Phone_____ Okay to call [ ] Yes [ ] No
Cell Phone_____ Okay to call [ ] Yes [ ] No
Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Living Together [ ] Separated [ ] Widowed
Employer/School_____ Occupation_____
Primary Care MD_____ Primary Care Phone_____
Emergency Contact Name_____ Relationship_____
Home Phone_____ Cell Phone_____

INSURANCE INFORMATION (Please Print)

Medical Health Plan_____ Benefits Info Phone_____
Insurance To Be Billed_____ I.D. Number_____
Is this an Employee Assistance Program Benefit? [ ] Yes [ ] No
Subscriber First Name_____ Group Number_____
Subscriber Last Name_____ Authorization #_____
Subscriber SSN_____ Gender [ ] M [ ] F
Subscriber Birth date_____ Relationship to Client_____
Employer_____ Referred by_____

Secondary Insurance_____ Benefits Info Phone_____
Subscriber Name_____ Subscriber SSN_____
Subscriber Birth date_____ Employer_____
Relationship to Client_____ Referred by_____

I authorize my insurance company to directly pay Elizabeth Smith L.C.S.W. A.C.S.W. for services rendered to me, my children or spouse. I authorize the release of any information pertinent to my case to any insurance company or adjuster involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original. This is a direct assignment of my rights and benefits under the policy. I also authorize this behavioral health professional to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I understand that the filing of a claim to my insurance company is a courtesy to patients.

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE _____ DATE _____

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Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name: _____
Birth date: _____
Social Security Number: _____

I hereby acknowledge that I have received and have been given the opportunity to read a copy of Elizabeth A. Smith's Notice of Privacy and Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Elizabeth A. Smith, L.C.S.W. A.C.S.W.

_____ _____

SIGNATURE OF PATIENT/CLIENT DATE

_____ _____

SIGNATURE OF LEGAL GUARDIAN DATE

If you are signing as a personal representative or legal guardian of an individual, please describe your legal authority to act for this individual. (Power of Attorney, healthcare surrogate, etc.)

- Patient/Client Refuses to Acknowledge Receipt

_____ _____

SIGNATURE OF STAFF MEMBER DATE

Elizabeth Ann Smith, L.C.S.W., A.C.S.W.

Email: Elizbeth33@msn.com

Phone 480 294-4581

Fax 480 659-0904

Elizabethannsmith.com

TREATMENT AGREEMENT

Please read and sign before starting treatment

BENEFITS AND EMOTIONAL RISKS:

The purpose of a therapeutic relationship is the assessment and treatment of mental health relationship or behavioral health problems. There are no guarantees this will be successful. If the therapist, or you, decides at any time to terminate the relationship, the therapist may give you three referrals.

Generally, I use an individual, couple or family modality in assessment and treatment face to face. I also do telephonic EAP or treatment sessions if the clients insurance benefits allow it, or if private pay.

I am a trained clinical social worker with a background in psychotherapy, but I am also eclectic when using treatment theories and modalities in which to treat patients.

I keep up to date by attending continuing education seminars to maintain the State license requirements.

Growth in understanding one's own development, or insight into what has been bothering one, are other benefits to therapy. I believe and try to subscribe to the philosophy of helping people help themselves. I have seen many who have improved due to guidance in reading and applying tools that they have learned in therapy. Length of treatment varies but this can be discussed in the treatment plan and process. The potential risks are that there are no guarantees, in which case the client is free to seek other treatment specialists.

PAYMENTS AND FEES. All insurance and EAP clients will be billed according to the individual contracts and benefits of the client. The insurance company has a contract with the therapist according to their fee schedule and guidelines. Private pay clients pay the therapist according to a fee schedule for services rendered. This will be provided upon request. Credit card payments or pay pal arrangements can be arranged. Payment for copays is due at the beginning of each session. Coinsurance is due upon receipt of the Explanation of Benefits (EOB) from the insurance company. If your insurance company says you did not pay your deductible, then you must pay me in cash, check, credit card or money order for the patient responsibility amount due for services rendered. This is when money owed me will be going toward your deductible by the insurance company. IF you do not do this a collection agency will be

contacted and this may lead to more fees such as attorney fees. Any returned check for insufficient funds will be charged an additional $35.00.

If payment for private pay clients is not paid, you will be expected to pay or answer to a collections agency with possible additional costs such as attorney fees. Clients have a right to be informed of all fees they are required to pay.

CONFIDENTIALITY

All federal HIPPA privacy and state laws of confidentiality laws apply. Storage of files of all clients will be held in locked cabinets in the therapist's possession. As a client you have a right to a copy of your file. Should you want a copy of your file, tell the therapist. You will be charged for the mailing and copying costs of this request.

All information regarding files will be kept confidential except to insurance company representatives, and EAP panel representatives, or to the client themselves. You will be notified if I seek consultation with other colleagues or supervision or with a team of treatment professionals. Clients have a right to participate in treatment decisions and in the development and periodic review and revision of the client's treatment plan.

CANCELLATIONS: If an emergency occurs, please call 911 or go to your local hospital emergency room. Please give at least 24 hours' notice for appointment cancellations. If you have any questions about these standard policies and procedures please ask the therapist before signing or dating this.

Thank you.

Elizabeth A. Smith

Licensed Clinical Social Worker

SIGNATURE OF CLIENT OR CLIENT'S LEGAL REPRESENTATIVE_____

DATE _____

Elizabeth Ann Smith LCSW, ACSW

Elizbeth33@msn.com

Phone 480 294-4581

Fax 480 6590904

As your therapist, I can provide the following services:

Assessment and treatment for your psychological disorder

Inform your employer, with your written release, what if you attended sessions, what your diagnosis is, that you are continuing in treatment and your current status.

It is outside our scope of our professional role to:

Comment on your ability or inability to engage in your work functions, estimate prognosis related to work functioning, make comments related to your habitation or potential for rehabilitation related to work functioning. This would include releasing you for return to work.

This can be done by the therapist in some exceptions such as work short term disability forms only if the psychotherapist agrees to do this and you sign a release of information to do this. The EAP Company that made the referral in these situations must also agree the psychotherapist can do this if wants to.

Child custody evaluations or recommendations

Forensic or legal work

Represent you in court

Fill out any type of lawsuit paperwork.

We can offer you to a specialist for these needs. These needs are usually not covered on an insurance plan however.

If you agree any questions about this policy statement, please ask your therapist before you sign an agreement to receive treatment.

Sincerely,

Elizabeth A. Smith LCSW, ACSW

I have read this Legal Issues Policy Statement.

Signature_____ Date_____