ELIZABETH A. SMITH, LCSW, ACSW

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PHONE 480 294-4581

ELIZABETHANNSMITH.COM

INTAKE FORM

CLIENT INFORMATION

FIRST NAME ________________________-MIDDLE INITIAL _____________-

LAST NAME______________-

GENDER ________________--(M) (F) _______-OTHER____________

BIRTHDATE ____________AGE________--

ADDRESS ____________(STREET) CITY___________STATE_______---ZIPCODE_________--

EMAIL_____________-

HOME PHONE____________ OK TO CALL YES _ NO__

WORK PHONE____________OK TO CALL I yes __NO___

CELL PHONE _______-

MARITAL STATUS ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) LIVING TOGETHER ( ) SEPARATED ( )

WIDOWED ( )

EMPLOYER /SCHOOL _______________-OCCUPATION____________

PRIMARY CARE PHYSCIAN ________________-

EMERGENCY CONTACT NAME ____________----RELATIONSHIP _____________---

HOME PHONE ____________ CELL PHONE _____________

INSURANCE INFORMATION (PLEASE PRINT)

MEDICAL HEALTH PLAN __________________ BENEFITS INFO PHONE _____________

INSURANCE TO BE BILLED _______________ID NO. ______________

IS THIS AN EAP EMPLOYEE ASSISTANCE BENEFIT? _________

--IS THIS FOR A VIRTUAL TELEHEALTH SERVICES OR FACE TO FACE___________________________

SUBCRIBER FIRST NAME ___________-GROUP NO. --------

SUBCRIBER LAST NAME _________-----AUTHORIZATION NO. _________

SUBSCRIBER SSN ___________---GENDER M ____--F______OTHER______---

SUBSCRIBER BIRTH DATE ----------------

REALTIONSHIP TO CLIENT________---

EMPLOYER_____________---REFERRED BY ________---

SECONDARY INSURANCE ________-----

BENEFITS INFO PHONE ____________SUBSCRIBER NAME _____-SUBSCRIBER SSN_________-SUBSCRIBER BIRTHDATE-----------RELATIONSHIP TO CLIIENT------------------REFERRED BY______________---

I AUTHORIZE MY INSURANCE COMPOANY TO DIRECTLY PAY ELIZABETH A SMITH LCSW, ACSW FOR SERVICES RENDERED TO M MY CHILDREN OR SPOUSE . I AUTHORIZE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY OR ADJUSTER INVOLVED IN THIS CASE. A PHOTOCOPY OF THE ASSIGNMENT SHALL BE CONSIDERED OF MY RIGHTS AND BENEFITS UNDER THE POLICY.I ALSO AUTHORIZE THIS BEHAVIORAL HEALTH PROFESSIONAL TO INITIATE A OMPLAINT TO THE INSURANCE COMPANY 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 ____________________----

ELIZABETH A. SMITH LCSW, ACSW

PHONE 480 2944581

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. It 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 also do telehealth services using HIPPA compliant platform.

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 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 can be arranged. Payments for copays is due at the beginning of each session Coinsurance is due upon receipt off the explanation of benefits (EOB) from the insurance company. If the 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 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.

CANCELLATIONS, LATE CANCELLATIONS, NO SHOWS FEES

If you do not give 24-hour notice to cancel an appointment or do not show up for the scheduled appointment, then I charge you for the missed clinical session at the same fee.

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, If 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 clients 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.

IN CASES OF EMERGENCY

Please call 911 or go to your local hospital emergency room.

If you have any questions about these standard policies and procedures (Treatment Agreement), please ask the therapist before signing.

Elizabeth A. Smith

Licensed clinical social worker

SIGNATURE OF CLIENT (OR CLIENT'S LEGAL REPRESENTATIVE) ______________Date_____

ELIZABETH ANN SMITH, LCSW, ACSW

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Legal Issues Policy Statement

As a psychotherapist, I can provide the following services:

Assessment and treatment for your diagnosed issue.

Inform your employer with your written release (HIPPA)

what dates you attended sessions that you attended sessions.

It is outside the scope of treatment to

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

Child custody evaluations or recommendations

Forensic or legal work

Represent you in court

Fill out any type of lawsuit paperwork

We can offer a specialist for these needs.

Please ask any question you may have

If you can agree about this policy statement, please sign below as an agreement to receive treatment.

I have read the Legal Issues Policy Statement

Signature ______________________-Date_________________