Laura Smith, MSW, LCSW-C, LLC
Psychotherapist

CLIENT INFORMATION FORM

Today's Date: _____

CLIENT INFORMATION

Last Name	First Name	Primary Phone			OK to leave a message?
Email Address	OK to email?	Birth Date / /	Age	Gender	Ethnicity
Street Address	City	State	Zip		
Relationship Status (please circle) Single Married Divorced Separated Widowed/Widowered	Social Security Number	Alternative Phone	OK to leave a message?		
Occupation	Employer	Work Phone	OK to leave a message?		
How were you referred? Doctor Family Friend Website/other (please list): _____					

IN CASE OF EMERGENCY

Name of Local Friend/Relative	Relationship	Primary Phone	Alternative Phone

MEDICAL INFORMATION

Primary Care Physician /Clinic Name	Address	Phone	Date of last physical exam

Please list any current medications you are taking:	Prescribing Physician(s)
Have you had any recent hospitalizations? If so, for what condition?	Please list any allergies you may have:

Please explain your primary reason(s) for deciding to begin therapy:

Have you ever received therapy or psychiatric treatment in the past? With whom and for how long?

Laura Smith, MSW, LCSW-C, LLC
LauraSmithLCSWC@gmail.com
(301)639-3418
1005 Motter Avenue, Office Suite
Frederick, MD 21701

Insurance Information Form

Patient Name: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Policy Holder's Address: _____

Insurance Company Name: _____

Member or Identification Number: _____

Group Number: _____

Policy Holder's Employer: _____

Deductible Amount (if applicable): _____

Copayment Amount (if applicable): _____

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Treatment Contract

Confidentiality: Everyone who seeks psychotherapy has a basic right to privacy. This means that in our professional relationship, all information disclosed in our sessions and the written records of those sessions are confidential and generally require your written permission to disclose. Exceptions to confidentiality include the following:

- If you consent in writing
- If I have evidence suggesting that you are a danger to yourself or others
- If there is a suspicion of child abuse or neglect
- If the disclosure of information is allowed by a valid court order
- If the disclosure is made to medical personnel in a medical emergency

Phone Availability: I can be available to take and return phone calls and text messages on my confidential phone number (301)639-3418. Phone calls received outside of my normal office hours may be returned during my next business day. If the matter that you need to discuss will take longer than 15 minutes, a prorated professional cost will be charged.

Emergencies: Should you experience a psychological emergency and feel that you may harm yourself or others, call 911, or proceed to your nearest emergency room for assistance. You may also call the Crisis Hotline, which is available 24 hours per day at **1-800-273-TALK**.

Communication via Email: If you communicate confidential or private information via e-mail, then I will assume you have made an informed decision to do so, and will view it as your decision to take the risk that such information may be intercepted. Furthermore, you should be aware that all e-mails I receive from you and send to you become a part of your legal record.

Cancellations: If you wish to cancel a previously scheduled session, you must do so within 24 hours of your scheduled appointment time. Failure to do so will result in a charge of the full session fee ($160). It is your responsibility to assure that I have received your cancellation request.

Inclement Weather Policy: If weather conditions make it unsafe to travel, we will continue to have our appointment at your scheduled time via telephone or internet session if possible.

Personal Property and Accidents: Laura Smith, MSW, LCSW-C, LLC is not responsible for any personal property or valuables that you bring into the facilities. This includes loss or damage. Laura Smith, MSW, LCSW-C, LLC is not liable for any accidents or physical injuries sustained while on the property.

I have read and understood the guidelines specified in this statement. I have had the opportunity for verbal clarification about this document.

_____ _____

Client Signature **Date**

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Payment Policy

Professional Fees: The fee for a 45-60 minute individual, couple, or family therapy session is $160.00. Longer sessions may be arranged, if desired, for a prorated amount. For other professional services such as phone consultations lasting longer than 15 minutes, legal proceedings requiring my participation, letter writing, or preparation of treatment records, my hourly fee is $160 which will be prorated as well. Payment schedules for these and other professional services will be agreed upon when they are requested. Please allow for 7 business days for letters and forms to be completed.

Billing and Payments: Payment is due at the time of service, NO EXCEPTIONS. You may pay with a credit/debit card, check, or cash. Payment via credit/debit card may cause my business name to show up on your statements and could provide a breach in confidentiality if your statement is received by an individual other than yourself.

Insurance Reimbursement: I am currently paneled with BlueCross BlueShield PPO and Federal health care insurance and Cigna only. I am happy to submit these claims to your insurance company on your behalf if you choose to use your insurance. However, it is your responsibility to contact your insurance carrier to be informed of copayment amounts, deductibles, etc. Additionally, you are responsible for obtaining any referrals of preauthorization. If your insurance does not provide the coverage you anticipated or if a charge is not covered due to a failure on your part to provide me with the documents required to secure insurance coverage, please be aware that you will be responsible for the balance. If you are not using insurance for services, you are responsible for paying your full session fee at the time of service. If you decide to submit claims to your insurance company for reimbursement you may do so at any time. However, be aware that **the services provided will still be charged to you, not your insurance company, and you are responsible for payment at the time of service and I cannot guarantee payment from your insurance provider**.

Cancellations: If you wish to cancel a previously scheduled session, you must do so within 24 hours of your scheduled appointment time. Failure to do so will result in a charge of the full session fee ($160). It is your responsibility to assure that I have received your cancellation request.

Your signature below indicates that you have read and understood the above listed information. In addition, you assign payment of all medical insurance benefits payable for services rendered by Laura Smith, MSW, LCSW-C, LLC if we agree I will submit to your insurance company. Furthermore, you authorize release of information of any information needed for processing of insurance claims.

_____ _____

Signature of Patient, Guardian, or Representative **Date**

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Consent to Treatment

I/We understand my/our rights and responsibilities as a client, and my therapist's responsibilities to me. I/We request and authorize Laura Smith, LCSW-C to provide psychotherapy services and consent to participate in this treatment.

Please initial below:

_____ I/We have read, understand, and agree to comply with all terms in the Treatment Contract.

_____ I/We understand that there is an expectation that I/we will benefit from these services, but there is no guarantee that this will occur.

_____ I/We have read, understand, and agree to the late policy.

_____ I/We have read, understand, and agree to the limits to confidentiality.

_____ I/We agree to make all payments at the time of service.

_____ I/We agree to pay the fee of $_____ per session.

_____ I/We have read, understand, and agree to the cancellation policy and agree to pay the full session fee if I/We cancel an appointment with less than 24 hours notice or miss an appointment. I/We also understand it is my/our responsibility to ensure that Laura Smith has received my/our cancellation request.

_____ I/We agree to contact via email even though this may not be secure (**please do not initial if you do not wish to communicate via email**).

I/We understand that I/We have the right to receive a copy of this Consent to Treatment form.

_____ _____
Client names Signature & Date

_____ _____
Laura Smith, LCSW-C Signature & Date

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I,_____, declare I have read and received a copy of the Notice of Privacy Practices and the Patient Rights and Responsibilities for the office of Laura Smith, MSW, LCSW-C, LLC.

_____
Printed Name

_____
Signature (parent or legal guardian if client is a minor)

_____
Date