Date:__________ Time:____

Intake information:

____

Last Name First Name

Parent Name (If applicable):____

Address:

____

____

____

Email: ____________________________

Home phone number________________

Cell number _______________________

Work number______________________

____

DOB Driver's license/State ID/or Social Security Number

How did you hear about us?____________________________________

___ **Private Pay.**

Insurance information:

Name of insured____

Insurance Holder____

Last Name First Name Relationship

____

DOB Social Security number

Insurance ID number______________ Group number____________

Insured place of employment__ _________________________________

Name and phone of insurance_ _________________________________

Insurance Address____

Comments:____

City State Zip____

Please check all services of interest:

- ☐ Adult Development Workshops/Events
- ☐ Relationship groups
- ☐ Youth groups
- ☐ Relationship Camps
- ☐ Youth camps
- ☐ Relationship Workshops
- ☐ Youth/Parenting Workshops
- ☐ Local Relationship Events
- ☐ Local Youth/Parent Events

HIPPA NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATIION. PLEASE REVIEW IT CAREFULLY.

Effective date: February 28, 2010
Calvin Smith, LBP has been and will always be totally committed to maintaining clients confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.
This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and
collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent
There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Oklahoma State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

INSURANCE INFORMATION AND VERIFICATION OF BENEFITS
Client's name D.O.B.
****
Insurance Company
Mental Health Outpatient Company
Number to verify benefits
Information from: Date
****
Primary Insured
Employer
I.D.# or Soc.Sec.#
Policy #
Group #
Birth Date
****
Effective Date of Policy LBP
accepted
Max Payable Per Session Dr.'s Referral
needed
Percent Coverage
Max Payable per calendar year
****
Number for Precert
Precertification ID #
Certified by
Managed Care Company
# of Sessions Authorized
Patient Co-pay
****
CLAIMS SENT TO; Insurance
Forms:
Company Forms
Standard HCFA 1500

INFORMED CONSENT

Thank you for choosing Calvin L. Smith, MS, LPC. Today's appointment will take approximately 45 — 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Calvin L. Smith, MS, LPC has earned a Masters Degree in Christian Counseling from Oral Roberts University, a Masters Degree in rehabilitation counseling from the University of Wisconsin Madison, and a Masters Degree in Industrial/Organizational Psychology from Tulsa University. He is licensed by the State of Oklahoma as a Therapist. He has over 10 years of clinical experience in treating adolescents, adults and families using individual and couples therapy. Calvin practices standard cognitive-behavior therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

I understand and consent to receive counseling services from Calvin Smith, LPC. I am aware that he is a Christian Counselor and consent to the use of Biblical references and principles in counseling sessions.

I consent to receiving text messages and being contacted by phone.

I understand that non-compliance with recommendations can result in a referral or discharge from services. You have the right to discontinue services at any time and counselor reserves the right to discontinue services if he feels that your care may be better serviced through another option.

I understand and consent to counselor coordinating with his private and confidential team to discuss appropriate medical care as deemed necessary.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information shared with our staff psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Oklahoma State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others, information necessary for case supervision or consultation and h) or when required by law If an emergency situation for which the client or their guardian feels immediate attention is necessary and I am unable to return your call within 15 minutes, the client or guardian understands that they are to contact the emergency in the community (911) for those services. Calvin L Smith will follow those emergency services with standard counseling and support to the client or the client's family.*

Signature(s) ___________________________________ ***Date:***_____________

Signature(s) ___________________________________ ***Date:***_____________

FINANCIAL/INSURANCE ISSUES: To schedule each appointment a fee will be held against your account to hold your appointment. This holding fee will be applied to your co-pay if applicable or private session. If you do not show for your appointment, this holding fee will be forfeit in application to your session hour.

After a missed appointment the appointment fee will be deducted from the standard rate of an appointment stated in your fee schedule. Without a cancellation notice of 3 business days in advance, a cancelled appointment will be charged the appointment fee (not the copay).

Asa courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay.

We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask You may have a copy of this form if requested.

We ask that every client authorize payment of medical benefits directly to the Calvin Smith.
I have received a copy of my fee schedule.

Signature(s) ___________________________________ ***Date:***_____________

Signature(s) ___________________________________ ***Date:***_____________

COORDINATION OF TREAMENT: ***It*** *is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no inform will be shared.*

____You may inform my physician(s)

PHYSICIAN NAME:_________________________________
CLINIC: :_________________________________
ADDRESS: :_________________________________
PHONE: :_________________________________
_____I decline to inform my physician

Signature(s) ___________________________________ ***Date:***_____________
Signature(s) ___________________________________ ***Date:***_____________

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*

Signature(s) ___________________________________ Date:_____________

Signature(s) ___________________________________ Date:_____________

May we contact you at home (circle one) ***yes no?*** *May we contact you at work* ***yes no?*** *May we contact you by cell phone* ***yes no?*** *Where may we contact you_________________________________*

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CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: *I/We consent that*

maybe treated as a client at the Calvin Smith. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.

Signature(s) ___________________________________ Date:_____________

Signature(s) ___________________________________ Date:_____________

FEE SCHEDULE:

EFFECTIVE September 5, 2016 Calvin Smith, LPC, SCHEDULE IS AS FOLLOWS:

Initial consultation $145.00 (up to 2 hours)
Individual counseling $120.00
Family or couples counseling $120.00
Divorce Mediation- Court ordered $375.00
Three hours
Review of records $75.00 per hour
Minimal phone consultation or correspondence no charge
Extensive phone consultation
or correspondence more than 5 minutes $2.00 per minute
Missed appointment- hourly rate $120.00
Based on information provided by your insurance company and your portion of the fee at the time of service is estimated to be deductible met/not met/unknown

Insurance may not reimburse for mediation, review of records, extensive phone consultation or missed appointments.

This is merely an estimate and we cannot guarantee this is the final amount due.
Thank you

CLIENT RIGHTS

Right to request how we contact you
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc.
Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way. May we contact you at home (circle one) **yes no?** May we contact you at work **yes no?.** May we contact you by cell phone **yes no?** Where may we contact you

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure **made for** a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.
Right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

What are your challenges Lately?

Please Mark the Symptoms that best describe what you are experiencing?

☐ Loss of Sleep ☐ Angry ☐ Irritable lately

☐ Pressure to talk/Talkative ☐ Racing Thoughts ☐ Increase in Goals

☐ Tired/Fatigue ☐ Problems at work/family/social ☐ Drugs/Substance
Use

☐ Poor Appetite ☐ Low self-esteem ☐ Poor Concentration

☐ Feelings of Hopelessness ☐ Suicidal Thoughts ☐ Homicidal Thoughts

☐ Extreme Pleasure seeking ☐ Decreased need for sleep ☐ Powerful

☐ Excessive Fear ☐ Avoidant of Social Situations ☐ Exposed to a Fearful
Situation

☐ Anxiety ☐ Dizzy/Light Headed ☐ Nausea

☐ Fear of Losing Control ☐ Fear of Dying ☐ Chills/Hot Flashes

☐ Trembling/Shaking ☐ Chest Pain ☐ Pounding Heart

☐ Feeling of Choking ☐ Loss of Pleasure in all ☐ Lack of Reactivity to Pleasurable Stimuli

☐ Depressed in the Morning ☐ Weight loss ☐ Excessive Guilt

☐ Extreme Negativism ☐ Fidgety ☐ Feelings of
Worthlessness

☐ Delusions ☐ Disorganized Speech ☐ Hand Tremors

☐ Seizures ☐ Trouble Walking ☐ Slurred Speech

☐ Loss of Memory ☐ Restlessness ☐ Weight Gain

☐ Loss of Coordination ☐ Blurred Vision ☐ Dry Mouth

☐ Racing Heart Beat ☐ Hallucinations

☐ Past Diagnosis> What was the Diagnosis?____________________

Have you experienced any symptoms in the past two weeks? Yes or No
Number of Years you have experiences these challenges:
☐ 2 Weeks ☐ 0-6 months ☐ 1 – 2 years ☐ 2-5 years ☐ 5-10 years

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I certify the above information is true and correct to the best of my knowledge.

____

Client Signature: Date

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