Deborah L Smith, Ed.M./LMHC ~ Adult Biopsychosocial Assessment Date/Time _____

Personal Information

Name: _____ DOB: _____ Age: _____ _____

Presenting Situation

Presenting Problem: Why are you seeking counseling *now*? What's going on now? If there are major life issues which are currently impacting you at this time (*pregnancy, recent or pending incarceration, probation, a terminal illness, parental divorce, death of a parent or sib or other close relationship*)

_____

_____

_____

_____

_____

Medical

Primary Care Provider: _____ Phone: _____

Medical history and current medical symptoms or issues: _____

_____

_____

Medication:

Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)

Name	Dose	Schedule	Physician
1.			
2.			
3.			

Recent medication change? Yes No Date_____ Describe change: _____

Medication history: Over the counter meds? Vitamins? Supplements? _____

Allergies (including food) or adverse side effects to medications: Describe: _____

Symptoms of Depression

Sleep disturbance (increased/decreased, hours per night, DFA, MNA, restlessness, nightmares)

_____

Appetite problems

_____

Loss of energy, concentration, motivation, etc.

_____

Excessive guilt / Self-blame

_____

Irritability

Isolating / withdrawing from family or friends

Feelings of helplessness or hopelessness

Does the client have difficulties caring for self? (Deteriorating hygiene or grooming)

Symptoms of Anxiety

Chronic worry / fear / uncertainty (If "Yes" describe below with frequency and reason for worry)

Panic attacks (If "Yes" describe below) Last panic attack

Last panic attack

Obsessive thoughts / compulsive behaviors (If "Yes" describe below)

Specific fears (social phobia / agoraphobia / simple phobias)

Symptoms of Mood Instability

Severe mood fluctuations

Anger outbursts / tantrums / reactions disproportionate to stressor

Frequent crying spells for no apparent reason

Manic or hypo-manic symptoms (racing thoughts, decreased sleep, spending splurges, difficulty concentrating)

Suicide Risk

Have you ever thought about hurting yourself?

Have you ever thought of suicide? ☐ Yes ☐ No

Have you ever attempted suicide ☐ Yes ☐ No

Have you ever cut / hurt yourself deliberately?

Thinking about it currently? Yes No Plan: _____ Means_____ Intent: _____

Access to a weapon? _____

Has anyone in your family or a close friend ever attempted or committed suicide? _____

Homicide Risk:

Have you ever thought of hurting or threatened or attempted to hurt others? Yes No_____

Have you ever actually physically hurt anyone? Yes No _____

Abuse-Addiction-Behavioral

	Age first used	Pattern of Use: when, how much, where…	Date last used
Alcohol			
Cannabis			
Cocaine			
Stimulants (crystal, speed, amphetamines, etc.)			
Benzodiazepines – Ativan, Xanax			
Inhalants (paint, glue, gas, etc.)			
Hallucinogens (LSD, PCP, Mushrooms)			
Opioids (heroin, pain pills, narcotics, methadone) IV?			
Designer drugs, (herbal, steroids, cough syrup, anything else)			
Tobacco (Smoke, chew)			
Caffeine			
Longest period of sobriety?			
Problems w/ SA: Hangovers: OD's: Binges: Blackouts: Relationship: Medical: Legal: School: Employment::			
Gambling or other addictions?			

If you are in Recovery, what is your plan?

Socio-economic history

Deborah L Smith, Ed.M./LMHC ~ Adult Biopsychosocial Assessment Date/Time _____

Who primarily raised you most of your life? Were your parents married? Divorced/Separated? Any step-parents?

What number child are you? _____ child of _____ children born to mom and dad. How many brothers and sisters do you have?

Full Brothers: _____ age/dob_____ Half-brothers: _____ age/dob_____ Stepbrothers: _____ age/dob_____

Full Sisters: _____ age/dob_____ Half-sisters: _____ age/dob_____ Stepsisters: _____ age/dob_____

What was it like growing up in your family? Needs met? Did you go without? Were you worried about stuff as a kid?

Any history of abuse or any trauma as a child?

Physical/Sexual Abuse_____

Other _____

Did you witness any abuse_____

Exposed to trauma _____

Any domestic violence issues or substance abuse issues with parents/step-parents? How has that affected you?

Current Living Situation

Are you married, living with someone, single, separated, divorced, widowed _____ For how long_____

How many times have you been married (or serious long-term relationships)? _____

#1_____

#2_____

#3_____

Describe relationship with spouse / partner. Does he/she think there's any serious problems in the relationship?

_____

_____

Are/were there any domestic violence issues or any substance abuse issues with spouse/partner?

_____

_____

Do you have any children/step-children? Ages_____

Any CPS involvement with your kids?_____

Describe your relationship with your children or step-children?_____

Who lives in household now? Any changes expected? (*Birth of a baby, separation/divorce, family members moving in/out*)

Are you dealing with any grief issues? _____

Legal history *(Arrests, incarcerations)*

Education / Profession / Training

Employment

Spiritual/Religious:

Are you active in religious activities? _____Any specific denomination? _____

Describe your spirituality: _____

Do you believe your spirituality can help you with your problem?_____

Financial Problems that are affecting your life or relationships?

Deborah Smith, MEd, LMHC

CLIENT INFORMATION

Last name:	First Name	MI
Home Phone:	Work Phone:	Cell Phone:
Address:		Birth date: Age:
City:	State:	Gender: ☐ Male ☐ Female
Zip:		
Employer:		Soc. Sec. #
Address:		Prior services received at CNSC by you or family member?
City:	State:	☐ Yes ☐ No
Zip:	E-mail Address:	

PERSON COMPLETING FORM (if other than client)

Last name:		Home phone:
First name	M.I.	Work phone:

INSURANCE COMPANY INFORMATION

PLEASE READ CAREFULLY, AS THIS IS A LEGALLY BINDING FINANCIAL AGREEMENT. See our Financial Policy for further information. We will bill your primary insurance if an insurance card is provided as a courtesy to you. Services denied due to missing or incorrect information are client's responsibility. Please verify any pre-authorization requirements and policy limitations for mental health services. Claims over 90 days will be applied to the client's balance. We must have all of this information to bill. If information is not provided, services will become the responsibility of the client.

We do not bill secondary insurance.

Primary Insurance:			ID No.
Address:			Group/Plan No.
City:	State	Zip:	Phone No.
Subscriber information is required for billing purposes			
Subscriber Name:			Relationship:
Address:			Birth date: Age:
City:	State	Zip:	Gender: ☐ Male ☐ Female
Employer:			Soc. Sec. #

GENERAL INFORMATION

Marital status: ☐ Single ☐ Married ☐ Other

Name of spouse/ partner:

Employment Status:
- ☐ Employed
- ☐ FT/PT student
- ☐ Unemployed

Education:

Highest grade completed _____

Diploma/Degree _____

FAMILY INFORMATION

Others who are living in your home:

Name	*Date of Birth*	*Relationship*

Religious preference: Church:

Are you seeking counseling with a spiritual/religious orientation? ☐ Yes ☐ No

If yes, please describe:

Do you or any others who are in counseling with you require special accommodations? ☐ Yes ☐ No

If yes, what type?

Have you (the client) had prior counseling: ☐ Yes ☐ No If yes please list below

Therapist: Date:
Problem:

Therapist: Date:
Problem:

Therapist: Date:
Problem:

Have you (the client) ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, please describe:

Date: Location:

Date: Location:

Date: Location

Source of referral:

Emergency Contact Name: _____

Relationship: _____ **Phone:** _____

Address: _____

Deborah L. Smith Counseling
Office/Financial Policies

Disclosure Statement:

This disclosure constitutes an agreement between the individual receiving services, their guarantor and Deborah L. Smith.

In this agreement the words "You," "Your," and "Yours" mean the Patient/Debtor. The word "Account" means the account that has been established in your name to which charges are made and payments are credited. The words "We," "Us," and "Our" refers to the clinician you see at this location.

By executing this agreement, you are agreeing to pay for all services that are received

Monthly Statement:

If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments:

The balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days from the date of statement, unless other arrangements are approved **in writing.** Acceptance of late or partial payments (even if marked "Paid in Full") shall not waive any of our rights to collect the full amount due under this agreement.

We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service. Any co-payments required by an insurance company must be paid by cash/check/credit/debit card **at the time of service. Because this is an insurance requirement, we cannot bill you for co-payments.**

Insurance:

Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You are responsible to pay any portion of the charges not covered by insurance.** If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from your insurance company, and you may be responsible for a higher portion of our fee. If your insurance has a limit to the number of visits you are authorized, you are responsible for tracking the number of visits you have remaining. We do not bill secondary insurance unless the contract between the provider and the insurance company states otherwise.

Past Due Accounts:

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorneys' fees that we incur plus all court costs. In case of suit, you agree the venue shall be in Benton County, Washington. You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce:

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parents' responsibility to collect from the other parent, as a divorce decree is an agreement between those parties and the court, not with the provider.

Personal Injury:

If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-Signature:

If this or another financial policy is signed by another person that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Fees:

We reserve the right to assess a rebilling fee of 1.5% (18% annually) to accounts that are 60 days past due.

There is a fee (currently $25, subject to change without notice) for any checks returned by the bank. If your check is returned to us on more than one occasion, we will require payment in cash for any services rendered.

All evaluation and treatment visits are by appointment only. **Clients who fail to keep a scheduled appointment or cancel with less than 24 hours' notice, will be charged a fee** (currently up to the full amount of the session) regardless of the reason for the no show or late cancellation. If you arrive more than 15 minutes beyond your scheduled time, the clinician will have the option whether or not to see you. If you are not seen, the appointment may be considered a "No Show" and a fee may be charged. If the clinician chooses to see the client, then a full session fee will be charged regardless of the actual time spent in the session. If a No Show or Late Cancellation fee is assessed, this fee must be paid before a new appointment is scheduled. You are responsible for all missed appointment fees. Patients with three missed appointments will be asked to transfer their clinical care provider to another provider.

Basic Clinical Fees:

Initial Therapy Intake (45-60 Min) $175.00

Individual Therapy (30 Min) $65.00 (45 Min) $120.00 (53+ Min) $215.00

Family/Marital/Couple Therapy (60 Min) $130.00

No Show/Late Cancellation (less than 24hrs) $50.00

Special Service Fees:

Health & Behavioral Intervention Therapy will be billed in 15 minute increments at $50.00/15 Min.

Telephone calls (5-10 Min) $15.00 (11-20 Min) $25.00 (21-30 Min) $35.00

Letters and Report Preparations $120.00

I authorize my insurance benefits to be paid directly to the treating physician/therapist named on the heading of this form. I understand that I am financially responsible for all non-covered services. I also authorize the release of any medical information necessary to process claims.

I have read the Office Policies and Financial Agreement and have been offered a copy of this agreement. I understand that by signing this document I am in total agreement to all of the conditions and terms herein, and the agreement will be in full force and effect. I also understand that failure on my part to read the document does not constitute a release from any obligations set forth in this agreement. Refusal to sign agreement will result in denial of services.

Client's Signature: _____ Date: _____

Person Financially Obligated: _____ Date: _____

Provider Signature: _____ Date: _____

Deborah L. Smith Counseling
6816 W. Rio Grande Ave Ste-D
Kennewick, WA 99336
Ph: 509-222-3948 Fx: 509-737-9010

Notice of Privacy Practices Regarding Protected Health Care Information

I am required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

D.L. Smith Counseling respects your privacy and we understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so as described below. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to obtain your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:
- Information obtained by all staff members will be recorded in your medical record and used to help decide what care may be right for you.
- I may also provide information to others providing you care. This will help them stay informed about your care.

For payment:
- I request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:
- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
    1. Medical quality review by your health plan;
    2. Accounting, legal, risk management, and insurance services;
    3. Audit functions, including fraud and abuse detection and compliance programs.

Other Disclosures and Uses of Protected Health Information
We may use and disclose your protected health information without your authorization as follows:

- **To Comply with Workers' Compensation Laws**—if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law which may include:**
    1. To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
    2. To public health or legal authorities
    3. To protect public health and safety
    4. To prevent or control disease, injury, or disability
    5. To report vital statistics such as births or deaths

The law may require us to provide information necessary to a military mission.

- During Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Your Health Information Rights

The health and billing records that are created, and store are the property of the practice D. L. Smith counseling. The protected health information in it, however, generally belongs to you.

You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Our Responsibilities:

We are required to:

1. Keep your protected health information private
2. Give you this Notice
3. Follow the terms of this Notice

Please Note:

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

For help with these rights during normal business hours, please contact our practice manager as directed below.

Instructions for Assistance or Filing a Complaint:

If you have questions, want more information or want to report a problem about the handling of your protected health information, contact **Deborah L. Smith 6917 W. Grandridge Blvd., Ste D, Kennewick, WA, 99336** or call us at **(509) 222-1348**. If you believe your privacy rights have been violated, you may deliver a written complaint to Deborah L. Smith and you may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint, if you so choose to. If you complain, we will not retaliate against you. We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. Please allow 3 working days for such requests to be completed. You may see your record, or get more information about it, by contacting Deborah L. Smith.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient's Printed Name

Patient's Signature (13 yrs. or older must sign) Date

Printed name if signed on patient's behalf Relationship to patient

Signature of parent/guardian Date

Deborah L. Smith, Ed.M. / LMHC

Consent for Treatment Form

Mental health is dependent upon many variables including an individual's hereditary makeup and environmental experiences. Each client will respond uniquely to treatment. Deborah Smith offers qualified mental health services using widely accepted methods. She makes no claims as to the anticipated results of the treatment and recognize that, in a very few individuals, treatment poses the risk of unanticipated reactions and in some cases symptoms may be alleviated through no treatment at all. Nevertheless, it is our intent to assist each client in defining problems and working towards satisfactory evaluation and/or resolution of those problems as outlined within the scope of the Individual Treatment Plan or the recommendations section of their evaluation report.

Confidentiality: Information about clients is held in strictest confidence. No information will be released without written informed consent from the client, except under specific circumstances required by the law. In the Notice of Privacy Practices you will receive information on confidentiality in more detail. Please read it carefully. In recognition of individual right to privacy when seeking evaluation and treatment, we ask you not to reveal the name or identity of any other client being seen in this office.

Civil Rights: You have the following rights as a consumer of mental health services:

- To be treated with respect and dignity
- To receive help to develop a plan of care and services that meet your unique needs
- To refuse any proposed treatment, consistent with state regulations
- To receive care that does not discriminate against you and is sensitive to your sex, race, national origin, language, age, disability, religion/spirituality, and sexual orientation
- To be free of any sexual exploitation or harassment
- To review your case records (See Notice of Privacy Practices)
- Confidentiality as described in relevant statutes and regulations (See Notice of Privacy Practices)
- To lodge a complaint with the ombudsman person, Regional Support Network (RSN) or provider, if you believe that your rights have been violated. If you lodge a complaint or grievance, you also will be entitled to a fair hearing. You shall be free of any act of retaliation. The Ombudsman's phone number is 1-509-735-8681 or 1-509-257-0660
- To choose a primary care provider pursuant to WAC 275-57-1110(5)

I have read the client's rights and have been offered a copy of this agreement. I have been given an opportunity to ask questions regarding all proposed treatment and I agree to consent to services. I further agree that the outcome of my treatment is largely dependent upon my effort and cooperation. I indemnify and hold harmless the therapist and administration from all claims arising directly or indirectly from the services rendered under this agreement. Such indemnification shall include reasonable attorney fees and costs.

Client Name: _____ Date: _____

Client Signature: _____ Date: _____

Deborah L. Smith, Ed.M. / LMHC

Appointment Reminder Agreement

As noted in the financial policy, a fee is charged for a no show or late cancellations (less than 24 hours of scheduled appointment).

In an effort to help you avoid fees for missed appointments or late cancellations, we offer to call you the business day before your appointment to remind you. These calls are a courtesy and are not in any way a dismissal of payment if you feel the reminder call was not made. These reminder calls are made between 9AM and 5PM. If you give us a telephone number to call to remind you of an appointment, you are giving us permission to make a reminder call to you at the number provided. You also authorize us to identify our office and leave the date and time of your appointment on an answering machine, or with any individual who answers the telephone should you not be available.

The only information that will be given is the name of the staff member making the call, the name of the clinician the appointment is with, the appointment date, the appointment time, and a return phone number if it is requested. No other private health information will be given out.

If you do not wish to receive a reminder phone call for your appointments, you need only inform us that you do not wish to receive a call.

Y ____ I would like to have reminder phone calls (Please circle one)

1st Contact Number _____ Home Work Cell

2nd Contact Number _____ Home Work Cell

N ____ I do not want to have reminder phone calls. Please mark **NO CALL** on my account.

I understand that by marking no I will not receive reminder calls, however, a phone number will remain on my account in case of emergency and/or if the staff needs to change my appointment on behalf of the provider.

Y ____ I would like to receive Email reminders _____

I acknowledge that I have read and understand this appointment reminder call policy

(This form will be retained in your medical record)

Patient Printed Name _____

Printed Name of Guardian or Representative _____

Signature of Patient or Representative _____ Date _____

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D.L. Smith Counseling respects your privacy and we understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so as described below. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to obtain your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

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- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
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- We may use and disclose your information to conduct or arrange for services, including:
    1. Medical quality review by your health plan;
    2. Accounting, legal, risk management, and insurance services;
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- **To Comply with Workers' Compensation Laws**—if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law which may include:**
    1. To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
    2. To public health or legal authorities
    3. To protect public health and safety
    4. To prevent or control disease, injury, or disability
    5. To report vital statistics such as births or deaths

The law may require us to provide information necessary to a military mission.

- During Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Keep for your records!!!!

Revised on 3/3/2020

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- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
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- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

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