Client Information & Confidentiality Preferences

(Please Print Clearly)

Name(s): ____

Today's Date: ____________________ Date of Birth: ____________________

Address to which Dr. Smith may send correspondence:

Address: ____

City: ____________________ State: __________ Zip: __________

Telephone number(s) at which Dr. Smith may reach you:

Main: ____________________

Is it OK to call you at this number? ___ Yes ___ No

Is it OK to leave messages at this number? ___ Yes ___ No

Other, if applicable: ____________________

Is it OK to call you at this number? ___ Yes ___ No

Is it OK to leave messages at this number? ___ Yes ___ No

Email address at which Dr. Smith may correspond with you: ____________________

Emergency contact: ____

Phone: ____________________ Relationship to client: ____________________

How did you hear about Dr. Smith? ____________________

Please continue to the symptom checklist on the reverse...

Symptom Checklist

Name: ______________________________ What brings you to Dr. Smith's office? ________________

____

Individual Symptoms

___ Anger	___ Impulses to harm self	___ Seizures
___ Anxiety	___ Impulses to harm others	___ Shortness of breath
___ Career difficulties	___ Disorientation	___ Sleep difficulties
___ Compulsive thoughts	___ Visual hallucinations	___ Thoughts of suicide
___ Compulsive behaviors	___ Auditory hallucinations	___ Suspiciousness of others
___ Confusion	___ Irritability	___ Difficulty thinking
___ Depression/sadness	___ Lack of energy	___ Weight loss
___ Difficulty concentrating	___ Loss of interest	___ Weight gain
___ Excessive alcohol use	___ Loneliness	___ Nausea/vomiting
___ Excessive drug use	___ Memory problems	Other symptoms:
___ Headaches	___ Panic	_______________________
___ Hopelessness	___ Self-critical thoughts	_______________________

Relationship Difficulties

___ Tension	___ Communication problems	___ Infidelity
___ Arguments	___ Alcohol/Drugs	Other problems:
___ Emotional distance	___ Stress from health problems	_______________________
___ Sexual difficulties	___ Stress from money problems	_______________________

Difficulties With Family and/or Children

___ Tension with children	___ Alcohol / drugs	Other problems:
___ Angry interchanges	___ Financial problems	_______________________
___ Behavioral problems	___ Disorientation	_______________________

Medical Status

Please describe any medical difficulties you are experiencing: ______________________

____

Have you sought treatment for the above medical difficulties? ______________________

Please list any medication you are taking related to your physical health:

____

Please list any medication you are taking related to your mental health (antidepressants, etc):

____

Mandatory Disclosure Statement

License: Shawn T. Smith, Psy.D. is a licensed psychologist in the State of Colorado (license number PSY-3162). Dr. Smith received his Doctorate in Clinical Psychology from the University of Denver in 2006.

Patient Rights: The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Section of the Division of Registrations. The Board of Psychologist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. You may seek a second opinion from another therapist or terminate therapy at any time. Dr. Smith may also terminate therapy at any time. Psychotherapy is not an exact science, and outcomes cannot be guaranteed. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board the Board of Psychologist Examiners. Regarding record keeping, Dr. Smith will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later.

Limits to Confidentiality: Information that you provide in therapy is legally confidential in most circumstances. However, there are exceptions to the general rule of legal confidentiality, as listed in the Colorado Statutes (C.R.S. 12-43-218). These include, but are not limited to: lawsuits against the therapist; complaints, disciplinary proceedings, and reviews of professional conduct; reporting child abuse and neglect; and duty to warn where the patient has communicated to the mental health provider a threat of imminent physical violence against a specific person or persons, including those identifiable by their association with a specific location or entity. When there is a duty to warn, the mental health provider shall make reasonable and timely efforts to notify the person or persons, or the person or persons responsible for the specific location or entity that is specifically threatened. Information may also be disclosed in the event of collection proceedings. Other exceptions to confidentiality include, but are not limited to, insurance reimbursement, communication with third-party payers, and court-mandated treatment. Good clinical practice sometimes requires consultation with other professionals. During such consultation, Dr. Smith will protect your identity. Dr. Smith's Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information (HIPAA statement) will be provided upon request or can be downloaded from *http://www.docsmith.co/files/smith-hipaa-notice.pdf*.

Electronic communication: Email messages, Internet-based teleconferencing, telephone conversations, voicemail, and other forms of electronic communication cannot be guaranteed to be secure or confidential. If you choose to communicate with Dr. Smith using electronic means, Dr. Smith assumes no responsibility for third parties who violate the Electronic Communications Privacy Act.

Emergencies: Dr. Smith does not remain on call outside regular business hours and may be unavailable during regular business hours. In the event of a mental health emergency, please call 911 or proceed to the nearest emergency department, then leave a voicemail message for Dr. Smith at **(303) 818-5162**.

Fee: Fee for service is **$150 per 60 minutes**. Between-session consultations, report-writing, and other services may be prorated based on this fee. Cancellations with less than 24 hours notice, and missed appointments, may be charged at the full fee. Payment is requested at time of service, and collections proceedings may be initiated for accounts that are delinquent for more than 45 days.

I have read this information, and I understand my rights as a client.

______________________________ ______________________________

Signature of Patient(s)

______________________________ ______________________________

Printed Name(s)

______________________________ ______________________________

Shawn T. Smith, Psy.D. Date