M. Smith Counseling Services, LLC
800 Columbiana Dr. Suite 120 Irmo SC 29063
Phone: (803)931-3331 Fax: (803)931-3536

New Client Intake Form

Demographic Information

Client Name: _____ _____ _____
First MI Last

Date of Birth: ____/_____/_____ Social Security Number: _____-_____-_____

Gender: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): (H) _____ (M) _____

Email Address: _____

Referring Physician Name (Optional): _____

Referring Physician Phone Number: _____

Insurance Information

Primary Insurance Company: _____
Subscriber ID # (including letters): _____
Group Number: _____
Insurance Policyholder Full Name: _____
Insurance Policyholder Date of Birth: _____
Insurance Policyholder Address: _____
Insurance Policyholder Relationship: _____
Insurance Policyholder Social Security Number: _____
Insurance Policyholder Gender: _____

Secondary Insurance Company: _____
Subscriber ID # (including letters): _____
Group Number: _____
Insurance Policyholder Full Name: _____
Insurance Policyholder Date of Birth: _____
Insurance Policyholder Address: _____
Insurance Policyholder Relationship: _____
Insurance Policyholder Social Security Number: _____
Insurance Policyholder Gender: _____

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Billing Authorization

I authorize the release of any medical and insurance information necessary to process insurance claims.

Client/Representative Signature: _____ Date: _____

Relationship to Client: _____

Client Full Name: _____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician, if a referral is required by my insurance plan. I understand that if I do not obtain or have a referral on file, I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Client/Representative Signature: _____

Responsible Party/Payer: _____

Relationship to Client: _____ Date: _____

Client Full Name: _____

Credit Card On File

This section to be completed only if you wish to have a credit card on file for billing purposes.

Credit Card Full Name: _____

Credit Card Number: _____

Expiration Date: _____/_____ Security Code (3 Digits for Visa, 4 Digits for AMEX): _____

Billing Zip Code: _____ E-mail address (billing receipts): _____

** Note: All signatures are required.*

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Preferred Method of Contact

I _____, give consent for M. Smith Counseling Services, LLC to contact me through the following methods to confirm, cancel, or schedule appointments, discuss referral information, and/or discuss general information related to my or my child's treatment.

Primary Phone: _____ Text Reminders: _____

E-mail reminders: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship to Client: _____

_____ _____
Client/Authorized Representative Signature Today's Date

_____ _____
Printed Name Relationship to Client

** Note: All signatures are required.*

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Authorization to Exchange Information

I, _____ (hereinafter "Client") hereby authorize ***M. Smith Counseling Services, LLC*** ("Provider") to disclose/exchange mental health treatment information and records obtained during my psychotherapy treatment, including, but not limited to therapist's diagnosis of me, to the following individuals/entities:

Name	Relationship to Client	Address	Phone:	Fax:

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

The specific uses and limitations of the types of health information to be released are as follows:
(Check all that apply)
☐ Treatment Coordination ☐ Treatment Planning ☐ Other: _____

Such disclosures shall be limited to the following specific types of information:
☐ Psychological diagnosis ☐ Dates of Treatment ☐ Treatment Summary
☐ Initial Treatment Plan ☐ Full Treatment Record ☐ Other: _____

Provider shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable South Carolina law may protect such information.

_____ _____
Client/Authorized Representative Signature Today's Date

_____ _____
Printed Name Relationship to Client

Signature to Revoke consent: _____ Date: _____

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Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by initialing at the end of this page.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1) If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2) If a client threatens grave bodily harm or death to another person.
3) If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years or an elderly person.
4) If a court of law issues a legitimate subpoena for information stated on the subpoena.
5) If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Client/Representative Initials_____

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PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS: Please remember to confirm, cancel, or reschedule your appointment at least 24 hours in advance. Confirmations and cancellations may be completed via our automated text reminder service, cancellations may also be completed by calling or emailing the office. You will be responsible for a $25.00 fee for failure to show for an appointment or if cancellation notice is less than 24 hours. This is necessary because a time commitment is made to you and your appointment slot is held exclusively for you. If you fail to show for or late cancel (with less than 24 hours notice) 4 appointments in a 6-month timespan, you will no longer be considered an active client, and your remaining appointments will be cancelled. If this occurs, you must contact the office to schedule any future appointments.

The standard meeting time for a counseling session is 55 minutes. Requests to change the session length must be discussed with the therapist in advance. If you are late for a session, you may lose some of that session time.

A $15.00 service fee will be charged for checks returned for any reason.

TELEPHONE ACCESSIBILITY AND ELECTRONIC COMMUNICATION: If you need to contact me between sessions, please leave a message on my voice mail or with front desk staff. I am often not immediately available; however, I will attempt to return your call within 24 hours. If a true emergency situation arises, please call 911 or any local emergency room.

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

MINORS: Parents and guardians may be legally entitled to information about a minor client. I will discuss with you what information is necessary for parents to receive and which issues are more appropriately kept confidential.

TERMINATION OF THE COUNSELING RELATIONSHIP: Ending relationships can be difficult. Therefore, it is important to have a termination process to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the counseling is not being effectively used. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified professionals. You may also choose someone on your own or from another referral source.

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS CONTAINED IN THIS DOCUMENT.

_____ _____

Client/Authorized Representative Signature Today's Date

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PRACTICE POLICIES

Client Copy

This is a duplicate of the previous page. Please retain for your records

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your mental health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private. • Give you this notice of my legal duties and privacy practices with respect to health information. • Follow the terms of the notice that is currently in effect. • I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about you or your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but

only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in defending myself in legal proceedings instituted by you. c. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. d. Required by law and the use or disclosure is limited to the requirements of such law. e. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. f. Required by a coroner who is performing duties authorized by law. g. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a Professional Counselor, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a Professional Counselor, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

8. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

9. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to you. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last three years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will notify you of the reason in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE:

This notice went into effect on October 23, 2017 and was updated October, 29 2024

M. Smith Counseling Services, LLC
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Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

BY SIGNING BELOW I AM ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS CONTAINED IN THIS DOCUMENT.

_____ _____

Client/Authorized Representative Signature Today's Date

_____ _____

Printed Name Relationship to Client