Smithson Counseling

CLIENT INFORMATION

First Appt. Date: _____
Name:_____ Gender: _____
DOB: _____ Age: _____ E-Mail: _____
OK to E-Mail? oYES oNO
Preferred Phone: _____
Alternate Phone: _____
OK to Leave Messages? oYES oNO
Mailing Address: _____
Preferred Way to Contact: _____
Client SS#_____

Occupation:_____
Education: (highest level attained)_____
Are you satisfied with your work/education? oYES oNO
Comments: _____

(circle all that apply:)
SPOUSE/PARTNER/PARENT/ EMERGENCY CONTACT:_____
Gender: _____ DOB: _____ Age: _____ Phone: _____
(Wk) _____ E-Mail: _____
Home: _____ (Wk) _____
E-Mail: _____ OK to Leave Messages? oYES oNO
OK to E-Mail? oYES oNO
Occupation:_____
Education: (highest level attained_____

Significant health problems:
_____
_____
_____

Significant Family: Including yourself, list the significant members of your family, from oldest to youngest. (Use the back if necessary). Name Relationship Age Where this person lives (i.e. with me, elsewhere--list where) State of the relationship (i.e. good, neutral, conflicted, etc.)_____
_____
_____
_____
_____

What are you hoping to achieve through therapy?

_____
_____
_____
_____

Do you have any concerns you would like me to know about?

_____
_____
_____

Previous Treatment (Use back page if necessary) YES NO InPt/OutPt
When?_____
HELPFUL?
_____

Counseling YES SOME NO PSR
Drug/Alcohol:_____
Psychiatric Services/ Medications:
_____
_____ _____

Hospitalization:_____
Self Help:_____
Have you or are you currently thinking of harming yourself? oNO oYES
Comment: _____
Have you or are you currently thinking of ending your life? oNO oYES
Comment: _____
Has anyone in your immediate family attempted or thought of attempting suicide? oNO oYES
Comment:
_____

How did you find me?
_____

Health History Primary Physician:
_____
Phone: _____

Primary Psychiatrist: _____
Phone: _____

Significant health
problems:_____
_____

Current Medications/Supplements (use back of page if necessary) Name of Medication Dosage Frequency Purpose Prescribing Physician Concerns/Questions

Past Medical Conditions (use back page if necessary) What When Treatment/Outcome

Andy Smithson, LCSW

Phone: (208) 312-3648, www.smithsoncounseling.com, andsmithson@truparenting.net

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE

(Unless other specific arrangements have been made with Andy Smithson, LCSW directly)

Sessions are $100 per 55 minutes or appropriate copay with insurance billing. You may pay with card, cash or checks. Payment is required upon close of each counseling/coaching session. Sessions not canceled 24 hours in advance will be charged the full session fee and will be required to be paid before the following therapy session. $25 will be charged for all returned checks and declined credit/debit cards. Any payment information is securely stored in your file and may be updated upon request. I agree, by my signature on this form, to pay $100/55 min. for all scheduled appointments. I authorize Andy Smithson, LCSW to charge me for sessions attended as well as those scheduled but not canceled 24 hours in advance, across multiple dates of service. I certify that my signature below authorizes each individual charge for all dates of service. I agree that this financial agreement will continue for as long as services are provided or until I inform Andy Smithson, LCSW in person or by certified mail that I wish to end it. I agree to pay for all services rendered prior to the date/time I end the relationship. I agree that I am responsible for payment, although other persons may make payments on my (or client's) account. I agree to pay $25 for returned checks or declined credit/debit cards and understand that unpaid balances may be sent to collection.

I, _____, request that Andy Smithson, LCSW, provide services to
Person Responsible for Payment oMyself oAnd/or to _____,
who is my: _____
SS # of person responsible for payment: _____
Phone Number: _____

Signature of Person Responsible for Payment Date :

_____