Welcome!

SMITH COUNSELING SERVICES

Child Mental Health Specialist & Licensed Independent Clinical Social Worker

Dana Smith, LICSW, MSW, CMHS, PLLC

REGISTRATION FORM:

Section I: **Client Information**

Client Name: ____
First Middle Last

Address: ____

City: ______________________ State: _________ Zip_______________

Phone (_______) ____________________

Cell Phone (_______) ____________________

Is it alright for me to leave a message with you at the above numbers? ☐ Yes ☐ No

Is it alright for me to send you a reminder text to your cell phone? ☐ Yes ☐ No

If yes, what carrier do you use? ☐ AT&T ☐ Verizon ☐ US Cellular ☐ _______________

Date of Birth: _______________ **Age:** _________ ☐ Male ☐ Female

Social Security Number: ______________________

Check Appropriate Box: ☐ Minor Child ☐ Single ☐ Dating ☐ Married
☐ Widowed ☐ Separated ☐ Divorced ☐ Life Partner

If Student, Name of School_______________________________

City/State_____________________________ ☐ FT ☐ PT

Spouse, Significant other, or Parent's Name:

____

Employer_____________________________ **Work Phone**_______________

How did you hear about my services?

____

Person to contact in case of emergency______________________________

Phone (_______) _______________________ Relationship _______________

Your Email Address (optional) ______________________________________

Section II **Responsible Party**

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other ______________
Name: ____
Address: ____
City: _____________________________________ State: ___________
Zip: ______________ Phone: (____) _______________________
Employer____
Work Phone: (____) _______________ SSN# ____________________________

Section III **Insurance Information (if applicable)**

Note: It is <u>not necessary to fill out</u> Section III, if <u>you provide a copy</u> of your insurance card/s <u>or do not wish for your insurance to be billed</u> for services.

Name of Insured: _______________________________ DOB: _______________
Relationship to Client: ____________________________
SSN#: ___________________________
Name of
Employer: __________________________ Work Phone: (____)
____
Address of Employer: ____
City: ________________________ State: _________ Zip: ____________
Insurance Company____
Grp #________________________ ID#___________________________________

Include any letters and numbers, spaces also (exactly like on the card)

Ins Co Address: ____
City/State/Zip: ____
Ins Co. Phone: ____

-- DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No

IF YES, *COMPLETE THE FOLLOWING*. IF NO*, SKIP TO SECTION IV* --

Name of Insured: ______________________________ DOB: ________________

Relationship to Client: ____________________________________

SSN#: __________________________

Name of Employer: ____

Work Phone: (____) ________________

Address of Employer: _________________________________

City: _______________ State: ________ Zip: ___________

Insurance Company: ____

Grp # ________________________ ID# __________________________________

Ins Co Address: ____

Ins Co. Phone: ____

Section IV:

Release of Benefits

I authorize my insurance benefits to be paid directly to Dana Smith, LICSW, MSW, CMHS, PLLC dba Smith Counseling Services. I understand that I am financially responsible for non-covered services. I also authorize the release of any protected health information necessary for billing and payment processing.

Financial Disclosure

At the intake session, and further appointments, the co-payments and any additional fees not covered by insurance, are due at time of service. Clients will be billed for missed appointments, unless the office is notified 24 business hours ahead of time, or alternative arrangements are mutually agreed upon by both parties.

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Individual/Legally Responsible Person's Signature **Date**