# Tina Smelser, MFT #41235

# 4614 California Street San Francisco, CA 94118 415-255-4257

### **Personal Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: home ( ) \_\_\_\_\_ work ( ) \_\_\_cell ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_ zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information**

Single \_\_\_ Married \_\_\_\_ Partnership \_\_\_\_ Divorced \_\_\_\_ Other \_\_\_\_\_\_\_

Do you have children? Yes \_\_\_\_ No \_\_\_\_ Ages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **Employment / Insurance**

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of work you do \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **Medical Information**

Are you currently under a physician’s care? No \_\_\_ Yes \_\_\_Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently using medication? Yes \_\_\_ No \_\_\_ Please list medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a counselor in the past? Yes \_\_\_\_ No \_\_\_\_

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to Tina Smelser? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **Emergency Contact**

Emergency contact person’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact’s phone: home ( ) \_\_\_work ( )\_\_\_\_\_\_\_\_\_\_\_\_cell ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***for office use only:***

[Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First session date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

##### **Please turn the page, read and sign ===>**

#### INFORMATION FOR NEW CLIENTS

**Confidentiality**: what you talk about in therapy is confidential and protected by law. Your therapist respects your right to privacy; it is important to have a safe environment to work in. But there are three times when the law would require us to disclose confidential information without your written permission:

* If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services and/or Adult Protective Services immediately. I am also obliged under the law to report to the appropriate authorities any instance where you disclose that you have accessed, streamed, or downloaded material where a child is engaged in an obscene sexual act.
* If there is a reasonable suspicion that you present a danger of harming someone else
* If it appears likely that you will harm yourself.

**Cancellations**: since your appointment time is reserved specifically for you, and canceling or rescheduling means that the time is not available for anyone else, therefore, we require a minimum of ***24 hours’ notice*** or you will be charged for the missed session. You would be responsible for the full amount usually billed to insurance.

**Payment: *All checks should be made payable to* “Tina Smelser”**

* Payment of the fee is expected at the time of service unless you make special arrangements with your therapist. Sessions are normally once a week and 50 minutes long.
* If you plan to use your health insurance to help pay for counseling, it is your responsibility to discuss the details with your therapist and provide any necessary forms and information.
* There is a $25 service fee for any checks returned by the bank.

**Please read and initial the following statements:**

\_\_\_\_\_ For insurance billing, I authorize the release of any medical or other information necessary to process this claim.

\_\_\_\_\_ I authorize payment to Tina Smelser of medical benefits for mental health services provided by Tina Smelser

\_\_\_\_\_ I agree to the fee of $ \_\_\_\_\_\_ per session.

\_\_\_\_\_ I have read the information on this page and agree to the stated conditions.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## (TS 12/15)

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4614 California Street, San Francisco, CA 94118

**INSURANCE INFORMATION**

If you plan to use your insurance for payment of therapy, please complete the following and discuss payment with your therapist on the first visit.

* I am using Insurance for therapy.

Name of Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I am NOT using Insurance. *Please check one of the following three options:*
	+ I do not have insurance coverage.
	+ I have insurance coverage and chose not to use it. I have discussed this with my therapist, and understand that in doing so, I am waiving any right to reimbursement.
	+ I have insurance coverage, and discussed this with my therapist, and understand that the services provided by CCI therapist are not covered by my insurance plan and I am obligated to pay the non-insurance rate for services.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(12/2015)