Michael D. Smith, Psy.D, P.C. Licensed Psychologist

Licensed Psychologist A Professional Company 1314 Main Street, Suite 203 Louisville, Colorado 80027 (303) 424-8250

Client's Application for Service Client Information: (Child's Information if client)

Client N	lame:					
	First	Middle	Last			
	ss:					
Home Phone Number:			Work #:			
Client	Date of Birth:	Birth: Client Social Security #:				
Name o	of Insured or EAP Me	mber:				
Insured	or EAP Member ID:	<u> </u>	Insured Date of Birth:			
Occupation:						
Insured	Social Security #: _					
Name o	of Insurance Compan	v or FAP Emple	oyer:			
			:			
Addres	s to send insurance	claims:				
C	onsent for Treatmen	t and Statement	t of Financial Responsib	ility		
 I voluntarily consent to participate in mental health treatment through Mich PsyD, P.C. 			alth treatment through Michael	D. Smith,		
	•		Initials			
• 1	understand that I am respond	onsible for payment	at the time services are render	ed.		
			Initials			
а		ve such notice, I ur	e event that I need to cancel anderstand that I am responsit			
۲	aymont or the coccion (4	, 100).	Initials			
			in the event of a claims denial. nentation to assist in settling my			
			Initials			
а		l hourly rate (\$150 a	nird-party consultations includin an hour) or prorated accordingly			
			Initials			

•	I understand that a delinquent account (over 30-days past due) will be charted interest of 1.5 percent (18 percent annual rate) thereafter until paid.		
		Initials	
•	I understand that fees charged by Dr. Michael D. Smitome, or to the person(s) for whom I assume financia fees considered as "usual and customary or contracte services provided. I, however, agree to pay fees in further what I am reimbursed from my insurance company.	Il responsibility, may exceed the ed rate" due to the specialized	
		Initials	
Signa	ture:(Adolescent 15 to 17 must sign with parent cosign)	Date:	
Signa	ture:	Date:	