

Intake Form

Before your visit, it would be helpful for you to fill out this form.

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Name: _____
Address: _____
City: _____ State: _____
Zip: _____
Employer: _____
Home Phone: Work Phone: _____
Cell Phone: _____
Email: _____

Please CIRCLE preferred means of contact and if ok to leave message: _____

WOULD YOU LIKE A TEXT REMINER OF YOUR APPOINTMENT? ___ YES ___ NO

IS IT OK TO SEND YOU EMAIL MESSAGES? _____ TEXT MESSAGES

IS IT OK TO LEAVE A MESSAGE IN YOUR VOICE MAIL? ___ YES ___ NO

Date of birth: _____

Social Security Number: _____

I authorize Mark Smith, MA, LPC, LCSW, to release/exchange information with my health insurance provider for billing purposes.(For a full disclosure of my policies and your privacy rights please visit my Web

Site, www.independencecounselor.com)

Insurance Provider: _____

Address: _____

City: State: Zip: _____

Phone: _____

Member number: _____

Group Name or number: _____

I here by voluntarily consent to mental health services which may include assessment and referral recommendations deemed necessary and advisable. I agree to provide at least 24 hours notification if I must cancel any appointments and failure to do so may result in my being charged for the session. I understand I am responsible to pay any fees not covered by my insurance provider for counseling services rendered by Mark L. Smith, MA, LPC, LCSW.

Signature Date: _____

[Intake Info and release.doc](#) [Counseling Contract](#)