Mark L. Smith, MA, LPC, LCSW
PROFESSIONAL SERVICES, LLC
14825 E 42nd St. S, Suite 208
Independence, MO 64055
Phone 816-353-5363
Fax 816-295-6100
www.independencecounselor.com

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