Smoky Mountain Individual/Family Therapy
Kristin Roberts, LCSW

419 High Street
Sevierville, Tn.
865-774-2444
Fax: 865-774-2444

223 Mineral Street
Newport, TN 37821
423-625-1678
Cell: 608-1548

Treatment Agreement

Hours: Sevierville: Mondays, Wednesdays, and Fridays 9:00 a.m. to 8:00 p.m.
Newport: Tuesdays and Thursdays 9:00 a.m. to 7:00 p.m.

Fees: My fee is $100 per session for individuals, couples, and families. The intake fee is $120. EAP is free. I recommend that you call your insurance company so you will be informed as to your copay, deductible, and any preauthorization requirements. You will receive a monthly statement, and insurance is billed weekly. I am on most managed care panels, but the procedures change frequently. It is best to pay your co pay at the time of your visit. (Billing is provided by my Business Associate, Southern Medical Billing, 423-839-1437. We will discuss any requests from insurance companies.

Sessions: I will likely suggest that we meet for a few times while we assess your needs and goals and decide how to work together. Usually people come weekly at first. Length of treatment varies according to the nature of the problem.t We will decide on mutually defined goals according to what you need. I will be glad to make referrals to a psychiatrist if you need medication, or other referrals to community resources. I will coordinate with your family physician if appropriate. If you cannot keep an appointment, please cancel within 24 hours at least. Due to high demand currently, I am not able to hold appointments unless we have made a plan to do so. Failed appointments or late cancelations are subject to charges unless there is a crisis situation.

Availability: I do not have a secretary, so please use my confidential voice mail, or cell phone: 423-608-1548. I will get back to you as soon as possible. I typically take 5-6 weeks of vacation per year and provide a back-up therapist at these times.

Experience: I received my Masters Degree in Social Work from the University of TN in 1982. I have 35 years of experience in general psychotherapy, and I am licensed in the state of TN. I have my Diplomate of Clinical Social Work, and I am a member of the Academy of Certified Social Workers. See SMIFT.org for more details.

Confidentiality: All of the material you share with me is kept in complete confidence with some specific exceptions which are outlined in detail in my Notice of Privacy Practices posted in the waiting area. I can also make a copy of this available to you.

I have read and understand the process and expectations above. My signature below indicates my full and informed consent to treatment and my intention to be an active participant in my own therapy.

_____ _____
Client Signature **Date**

_____ _____
Witness **Date**

Assignment of Benefits/Release of Information Authorization

I request that Kristin Roberts, LCSW file claims on my behalf with my insurance company for professional services rendered t me or to a member of my family. I authorize Kristin Roberts, LCSW and/or his/her agent to contact my insurance company and/or managed care organization to verify my coverage and to obtain benefit information.

I understand that my insurance company and/or managed care organization my require information about my treatment in order to process the claim, and that this includes diagnosis, background information, progress notes, and/or treatment plans. I further authorize Kristin Roberts, LCSW and/or her agents to release this information to my insurance company and/or managed care organization as needed to process those claims.

I assign payment to Kristin Roberts, LCSW for services provided. This includes all applicable benefits that would otherwise be payable to me. I understand that this amount is not to exceed the regular charge for services.

I understand that I am financially responsible for any charges not covered by my insurance company (including charges for missed appointments and cancellations with less than 24 hours' notice). Costs of collections services will be added to my account.

I may revoke this release at any time in writing. Any release which has been made prior to the receipt of my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my confidentiality. This release is good from the date below until my written revocation.

I have read and understand the above policies. My signature below indicates my full and informed consent to abide by the billing practices described.

_____ _____

Client Signature Date