SIOUX FALLS PSYCHOLOGICAL SERVICES | STRONGHOLD COUNSELING SERVICES, INC. | river COUNSELING SERVICES

Community Counseling Clinic
Registration Information
(Please Print)

Date _____

Client _____
First *MI* *Last*

Address _____ City _____ State _____ Zip _____

Soc Sec # _____-_____-_____ Birth Date _____ Age_____

Gender: M ☐ F ☐ Other _____

Adults:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer :_____ Phone: _____

Occupation:_____

Spouse _____ Birth Date _____ Soc Sec # _____-____-_____

Spouse's Employer _____ Business Phone _____

Minors:

Parent or Legal Guardian of the Child

Financially Responsible for the Account: YES or NO

Name _____

Relationship to the Child _____

Address_____ City _____ State_____ Zip_____

Soc Sec # _____-_____-_____ Birth Date _____

Employer :_____ Phone: _____

Occupation:_____

Home Phone: _____ OK to leave messages? _____

Cell Phone: _____ OK to leave messages? _____

E-mail Address (required): _____

We use a HIPAA-Compliant email program that assures any email we send you is encrypted and fully protects your confidentiality

Permission for us to email you Protected Health Information? YES ☐ or NO ☐

In Case of Emergency, contact (required) _____

Relationship to Client: _____

Emergency Contact Phone Number: _____

How did you hear of our services?

Physician/MD: _____ Paster/Church: _____

Therapist: _____ Other Agency: _____

☐ Internet Search ☐ Another Client ☐ Family Member ☐ Friend ☐ Radio Ad ☐ Attorney

☐ Insurance Company ☐ Help Line ☐ Avera Behavioral Health ☐ Employer or EAP ☐ The Local Best

Other: _____

Medical Information

Family Physician Name _____

Clinic Address _____

Phone _____ Most Recent Exam _____

Medical Problems _____

_____

Please explain why you feel you need therapy _____

_____

_____

Previous psychological or psychiatric treatment _____

_____

_____

Please list all current medications _____

_____

_____

Community Counseling Clinic

Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures and Requiring Authorization

I may use or disclose PHI (your identifying information) for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have reasonable cause to suspect that a child under the age of eighteen has been abused or neglected, I am required by law to report that information to the state's attorney, the Department of Social Services, or law enforcement personnel.

Health Oversight: If the South Dakota Board of Examiners of Psychologists or other oversight committee is conducting an investigation, then I am required to disclose your mental health records upon receipt of a subpoena from the Board.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I may not release information without your written authorization or court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance, if this is the case.

Serious Threat to Health or Safety: When I judge that a disclosure of confidential information is necessary to protect against a clear and substantial risk of imminent harm being inflicted by you on yourself or another person, I may disclose such information to those persons who would address such a problem (for example, the police or the potential victim.)

Worker's Compensation: If you file a workers' compensation claim, I am required by law to provide your mental health information relevant to that particular injury, upon demand, to you, your employer, the insurer and the Department of Labor.

HIPAA Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting our office. SFPS may at times communicate with you via HIPAA-compliant secure encrypted email. Medical records, by release, may be transmitted using this same secure platform.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices.

Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may want to contact Douglas Anderson, PsyD, at (605)-334-2696. If you believe that your privacy rights have been violated and wish to file a complaint with the office, you may send your written complaint to Douglas Anderson, PsyD, 2109 S. Norton Avenue, Sioux Falls, SD 57105. You may also send a written complaint to the Secretary of the U.S Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPPAA Notice Form.

_____ _____

Client Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail as well as post it in the office.

COMMUNITY COUNSELING CLINIC
THERAPY AGREEMENT

CONFIDENTIALITY AGREEMENT:
The therapy relationship is a professional and confidential relationship. What is revealed in this setting is confidential and is protected by professional and ethical standards. All material is confidential and cannot be released without your written consent. The laws of the state of South Dakota make certain exceptions to this confidentiality privilege. If there is reasonable suspicion that you may harm yourself or others, then your therapist is required by law to inform others in order to protect them or yourself. If there is reasonable suspicion of child abuse, or neglect or abuse of a vulnerable adult or elderly adult, a verbal report will be made to the Department of Social Services.

THERAPISTS AND CO-THERAPISTS, RECORDING, LIVE SUPERVISON, AND SCOPE OF PRACTICE:

- Your therapist will be completing a M.A. in either Counseling or Marriage and Family Therapy at Kairos University. Therapists in the Marriage and Family Therapy Clinic are supervised by faculty supervisors in the Kairos counseling and marriage and family therapy programs.
- Your assigned therapist will handle your therapy until the end of their graduate program. Upon graduation, you will be introduced and transferred to a new lead therapist.
- "*Co-therapists*" are other student therapists who will join session to experience other student therapy. Co-therapists may vary from session to session. Co-therapists are silent observers who do not take progress notes.
- All sessions will be video recorded or observed by a live student group for both your benefit and your therapist's learning. The confidentiality of these recordings and live observation will be maintained by the therapist. Your therapist may choose portions of the recording to be viewed by their supervisor.
- "*Live Supervision*" is a session that takes place with you and your therapist and is observed behind a one-way window; you cannot see or hear observers, but are welcome to meet the student group either before or after your session.

The Scope of Practice for therapists in the Community Counseling Clinic does not include disability or custody determinations.

PAYMENT OF FEES:
Fee payment is expected at the time of the session. A sliding fee scale is used based on need and the ability to pay. You and your therapist will need to agree upon a suitable fee. The fee agreed upon with _____ as my therapist is $_____ for a 45-50 minute session.

EMERGENCIES:
If you are in need of emergency psychological help at a time when your therapist is not available, it is your responsibility to call 911 or some other emergency service (such as 339-HELP, a 24-hour help line). If you are in crisis and want to talk with your therapist, the therapist, if available, will talk with you, or will return your call as soon as possible.

SERVICE ANIMALS:
As a privately owned businesses that serves the public, we do not allow animals in the office, with the exception of service animals. Under the Americans with Disabilities Act, a service animal is defined as a dog that has been individually trained to do work or perform tasks for an individual with a disability.

_____ _____
Client Signature **Date**

_____ _____
Parent/Guardian Signature **Date**
If the client is below age 18, a parent or guardian must also sign consent.

Print name of Client: _____

FEE SCALE

1. How many family members are living in your home or supported by your income? _____

2. Do you have insurance that will cover your therapy services? Yes☐ No☐

3. If you answered "yes" to question 2, please indicate your insurance company and policy number.

Insurance Company _____	Phone Number _____
ID Number _____	Group Number _____
Policy Holder_____	Policy Holder DOB _____
Client's Relationship to Policy Holder _____	

4. If you answered "no" to question 2 or cannot afford to use your insurance, please indicate the income level that best applies to your gross yearly family income. Please note: you may be asked to bring a copy of last year's tax return to your next session.

Income	Fee Per Session
$50,000-Above	$25.00
$50,000-$40,000	$20.00
$40,000-$30,000	$15.00
$30,000-$20,000	$10.00
$20,000-Below	$5.00

Your personal investment in your therapy is very important. If you should be experiencing hardship, please talk with your therapist to reach an acceptable fee. Fee payment is expected at the time of your session.

My/our signatures(s) below indicate that I/we understand this fee agreement and intend to abide by it.

Signature _____ Date _____

Signature _____ Date _____

Telemental Health Informed Consent

I understand and agree to receive telemental health services from my therapist. This means that my therapist and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document and the Sioux Falls Psychological Services/Stronghold Counseling Services Therapy Agreement form.

I understand the potential risks of telemental health, which may include the following: 1) the video connection may not work, or it may stop working during a session; 2) the video or audio transmission may not be clear; and 3) I may be asked to go to my therapist's office in person if it is determined that telemental health is not an appropriate method of treatment for me.

I recognize the benefits of telemental health, which may include the following: 1) reduced cost and time commitment for treatment due to the elimination of travel; 2) ability to receive services near my home or from my home; and 3) access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via videoconferencing. I understand that my therapist uses HIPAA-compliant technology to transmit and receive video and audio and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws. I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality. Furthermore, I understand that recording my sessions is prohibited.

I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this or make a referral if travel to the therapist's office is not feasible for me. I understand that closer providers may not be available depending on my location.

I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

My signature indicates that I agree to participate in telemental health under the conditions described in this document. I have been given a copy of this document.

Signature(s): _____
(Client, Parent, or Guardian Signature)

Date: _____

Print Name: _____