SIOUX FALLS PSYCHOLOGICAL SERVICES | STRONGHOLD COUNSELING SERVICES, INC. "A House on the Rock" | river COUNSELING SERVICES

Minor - Registration Information

(Please Print)

Date _____

Child's Information _____
First *MI* *Last*

Primary Residence_____ City_____ State_____ Zip_____

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

Gender: M ☐ F ☐ Other_____

Grade in School _____ School of Attendance _____

Parents: Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Deceased: Mother ☐ Father ☐

Primary Custodial Parent: Mother ☐ Father ☐ Joint ☐

Most recent custody court order is required before meeting with child.

Parent or Legal Guardian of the Child

Financially Responsible for the Account: ☐ Yes ☐ No

Name _____

Relationship to the Child _____

Address _____ City _____ State _____ Zip _____

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

Gender: M ☐ F ☐ Other _____

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

Employer :_____ Phone: _____

Occupation:_____

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

Spouse's Employer _____ Business Phone _____

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

In Case of Emergency, contact (required) _____

Relationship to Client: _____

Emergency Contact Phone Number:_____

Is the child covered under the guardian's health insurance policy? ☐ Yes ☐ No

If "No", please provide the information for the *holder of the insurance policy*:

Name _____

Relationship to the Child _____

Address_____ City _____ State_____ Zip_____

Soc Sec # _____-_____-_____ Birth Date _____

Primary Phone: _____ ☐ Home ☐ Work ☐ Cell

E-mail Address:_____

Referral Information

How did you hear of our services?

Physician/MD:_____ Pastor/Church:_____

Therapist:_____ Other Agency:_____

☐ Internet ☐ Client ☐ Family Member ☐ Friend ☐ Radio ☐ Newspaper ☐ Attorney

☐ Insurance Company ☐ Help Line ☐ Avera Behavioral Health ☐ Employer/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 _____

_____

_____

_____

Per the SD Visitation Guidelines, primary custodial parents have a duty to provide access to records and information pertaining to a minor child, including, but not limited to, medical, dental, orthodontia and similar health care, and school records must be made equally available to both parents. Counseling, psychiatric, psychotherapy, and other records subject to confidentiality or privilege must only be released in accordance with state and federal law; but, if available to one parent, must be available to both. Parents must make reasonable efforts to ensure that the name and address of the other parent is listed on all such records (UJS 302 (1.2)).

Please initial _____

THERAPY AGREEMENT

Confidentiality

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.

Payments

We are committed to providing you with the best possible care. Co-pay's/co-insurance are due at the time of service unless another agreement has been reached between you and your therapist. We accept cash, checks, MasterCard, Visa and Discover. Any amount not paid by a third party is expected to be paid by you within 30 days unless other arrangements have been made. If after 60 days no payment is received, your therapist will review and advise on additional action. Between 90 and 120 days with no payment, your account will risk being sent to collections including any/all demographic information you provide.

Cancellations

If you are unable to attend a scheduled session, it is your responsibility to let this office know of your intent to cancel your appointment. Appointments must be cancelled at least 24 hours prior to the session in order to avoid being charged. You will be charged $50 if you do not cancel and do not attend the session. Exceptions include weather, family emergencies and unexpected illness.

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 a crisis during regular office hours and want to talk to your therapist, the therapist if available will talk with you, or will return your call as soon as possible. There is no charge for brief calls. However, calls requiring more than five minutes of time may be charged according to the closest quarter rate at the discretion of your therapist.

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.

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. We may at times communicate with you via HIPAA-compliant secure encrypted email. Medical records, by release, may be transmitted using this same secure platform.

I understand that I am prohibited from recording my sessions.

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

If you have questions about this agreement, please do not hesitate to ask us. We are here to help you.

My (our) signature(s) below indicates that I have read the above policies, and that I intend to abide by them. I have been given a copy of these policies.

Signature(s): _____ **Date:** _____

(Client, Parent, or Guardian Signature)

Print Name: _____

FINANCIAL AGREEMENT

A current fee schedule is available upon request. If you are insured your actual financial responsibility will be based on contractual agreements with your insurance company.

INSURANCE REIMBURSEMENT: If you have medical insurance providing coverage for mental health counseling, we can help you receive your maximum allowable benefits. We accept assignment of benefits (direct reimbursement from insurance companies) when authorized by you at the bottom of this form. Processing your insurance claims and tracking reimbursement is a benefit we provide for you. To do so, we need your up-to-date insurance information. To avoid a delay in reimbursement, we ask you to inform us if your insurance plan changes or you are issued a new insurance card. We encourage you to contact your insurance company prior to therapy to verify copay, deductible, or coinsurance information. You are ultimately responsible for any cost not covered by your insurance plan.

INSURANCE INFORMATION:
(Fill out and provide a copy of insurance card(s) and required information.)

Primary

Insurance Company _____ Phone Number _____

ID Number _____ Group Number _____

Policy Holder_____ **Policy Holder DOB** _____

Client's Relationship to Policy Holder _____

Secondary

Insurance Company _____ Phone Number _____

ID Number _____ Group Number _____

Policy Holder_____ Policy Holder DOB _____

Client's Relationship to Policy Holder _____

Initial below

_____ ***I understand that I am responsible for all charges regardless of insurance coverage.***

ASSIGNMENT OF INSURANCE BENEFITS:
The undersigned hereby authorized the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____

Authorized Signature of Subscriber **Date**

Print Name: _____

Notice of Privacy Practices

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 Requiring Authorization

We may use or disclose PHI (Protected Health Information) for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission about and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes your therapist has made about conversations with you during a private, group, joint, or family counseling session, which are 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 or Authorization

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

Child Abuse: If your therapist has reasonable cause to suspect that a child under the age of eighteen has been abused or neglected, your therapist is 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 we are required to disclose your mental health records upon receipt of a subpoena from the Board or committee.

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 we 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 your therapist judges 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, your therapist 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 worker's compensation claim, we are 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.

Questions and Complaints

If you have questions about this notice, disagree with a decision we have made about access to your records, or have other concerns about your privacy rights, you may contact the Clinical Director 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 Sioux Falls Psychological Services, Attention Clinical Director, 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 Clinical Director can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Effective Date, Restrictions and Changes to Privacy Policy

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

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will post the latest revision of this notice in the office and provide a copy if requested.

SIOUX FALLS PSYCHOLOGICAL SERVICES, STRONGHOLD COUNSELING SERVICES, AND RIVER COUNSELING SERVICES CLIENT;

Mental health professionals are able to help you deal with a variety of personal and relationship problems and concerns. In South Dakota several different mental health licenses are issued to practice mental health treatment. Those licenses may reflect different types of training, different areas of focus, and so on. They include:

- Licensed Psychologist
- Licensed Certified Social Worker
- Licensed Certified Social Worker – Private Independent Practice
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor
- Licensed Professional Counselor – Mental Health

Our professional team members are either licensed or in the process of acquiring licensure in their particular areas of training and expertise. Feel free to ask them about their education, training, and areas of expertise. Our therapists practice within the scope of their training and expertise. If at any time your therapist believes you need a different type of therapy they will talk with you about that and either seek appropriate supervision or refer you to someone who is more able to meet your needs. Most importantly, your therapist wants to meet you where you are, build a meaningful relationship with you, and walk with you through the challenges that face your life and your relationships. Your therapist is able to help you walk through grief, improve coping and relationships skills, and discover hope.

As the Director of Counseling Services, I routinely provide supervision and consultation for our team of professionals. Your therapist may discuss your treatment with me from time to time in order to best serve you. If during your course of therapy you have questions or concerns about your therapy, I encourage you to discuss this with your therapist. If you are not satisfied with the outcome of that conversation, I invite you to contact me directly.

Douglas L. Anderson, PsyD
Licensed Psychologist
Licensed Marriage and Family Therapist
Director of Counseling Services

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 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): _____ **Date:** _____

(Client, Parent, or Guardian Signature)

Print Name: _____

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