SIOUX FALLS PSYCHOLOGICAL SERVICES

STRONGHOLD COUNSELING SERVICES, INC.

Registration Information – Augustana Student

(Please Print)

Date _____

Client _____
First *MI* *Last*

Birth Date _____ Age_____ Year in College: _____ GPA:_____

Gender: M ☐ F ☐ Other _____

Major:_____ I am currently taking _____ credits per semester

Employed? ☐ Yes ☐ No If yes, how many hours/week? _____ Employer _____

Relationship Status:
☐ Never Married ☐ Cohabitating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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:_____

Please place an "X" by ALL items which are concerns or difficulties at this time.

☐ Academic Concerns
☐ Alcohol/Drug Use
☐ Anger
☐ Anxiety
☐ Choosing a Career/Major
☐ Dating Violence
☐ Death/Grief/Loss
☐ Depression
☐ Discrimination
☐ Eating Problems
☐ Family Relationships
☐ Other
☐ Financial Concerns
☐ Childhood Sexual Assault
☐ Loneliness/Homesickness
☐ Peer Relationships
☐ Physical Abuse
☐ Pregnancy
☐ Problems Concentrating
☐ Sleep Problems
☐ Rape/Sexual Assault
☐ Romantic Relationships
☐ Self-Worth/Confidence
☐ Sexual Identity
☐ Sexuality
☐ Spirituality/Religion
☐ Suicidal Thoughts
☐ Stress
☐ Test Anxiety
☐ Time Management
☐ Unwanted Habits
☐ Crisis Situation
☐ Fearing Failure
☐ Sexual Harassment

**By providing a telephone number and submitting this form you consent to be contacted by SMS text message. Message and data rates may apply. You can STOP messaging by sending STOP and get more help by sending HELP. Your phone number will not be used for marketing purposes. Our privacy policy can be found at kairos.edu/privacy.*

Family:

Father - Age: _____ Occupation: _____ If deceased, year of death: _____

Mother - Age: _____ Occupation: _____ If deceased, year of death: _____

Number of Brothers: _____ Ages: _____ Number of Sisters: _____ Ages: _____

Do you have children? _____ If so, what are their ages? _____

Health:

List health problems _____

_____

List all current medications _____

_____

List previous psychological treatment _____

Have you ever contemplated suicide? If yes, when? _____

How would you rate your alcohol usage? _____

How do you generally deal with stressful situations? _____

_____

Briefly state the main concerns you would like to discuss with your counselor _____

_____

_____

_____

_____

_____

To what extent do you feel you can make some changes in your life? _____

_____

_____

Student Counseling Services

This sheet will be held confidentially and is only utilized to track use of Sioux Falls Psychological Services by Augustana students, so that we can best serve your needs. If you have any questions, please ask your counselor.

Class _____ Gender _____

Age_____ Been to Counseling Before? ☐ Yes ☐ No

Student Status: ☐ Full Time ☐ Part Time Housing Status: ☐ On Campus ☐ Off Campus

Reason(s) for requesting to counseling (Check all that apply)

- ☐ Depression
- ☐ Anxiety
- ☐ Grief
- ☐ Eating Disorders
- ☐ Family Issues
- ☐ Adjusting to Life Transitions
- ☐ Academic Concerns
- ☐ Substance Abuse
- ☐ Relationship Difficulties
- ☐ Religious Concerns
- ☐ Trauma
- ☐ Developing Career/Future Goals
- ☐ Sexual Assault

Other _____

How Did You Hear About Augie Counseling at Sioux Falls Psychological Services?

☐	Friend		Office of the Dean of Students
☐	Residence Life		Health and Counseling Services
☐	Faculty		Website
☐	Other		

AUDIT Questionnaire: Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 Times Per Month	2-3 Times Per Week	4 or more times a Week	
2. How many drinks containing alcohol do you have on a typical day while you are drinking?	0 to 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year.		Yes, during the last year.	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year.		Yes, during the last year.	
					Total	

>8

Scoff Questionnaire: Question	Yes	No
Do you make yourself sick because you feel uncomfortably full?	☐	☐
Do you worry you have lost control over how much you eat?	☐	☐
Have you recently lost more than 15 pounds in a 3 month period?	☐	☐
Do you believe yourself to be fat when others say you are too thin?	☐	☐
Would you say that food dominates your life?	☐	☐

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, a verbal report will be made to Child Protective 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.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices dated April 14, 2003.

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

My signature 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: _____

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: _____

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.

Sexual Assault: Since Augustana legally has to report sexual assaults on campus, if you tell your counselor about a sexual assault they will fill out a form available to Augustana at the end of the year that does not in any way identify individuals involved but does share some details about where things happened in order to encourage a safe campus at Augustana.

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.

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

(Client, Parent, or Guardian Signature)

Print Name: _____