Journey Counseling Services, LLC
6209 S Pinnacle Pl, Suite 102
Sioux Falls, SD 57108
Phone: 605-988-8131
www.journeycounselingservices.com

New Client Information

All information received here, and in the initial intake session is considered confidential regardless of subsequent contract for therapy services. If you have questions or concerns, please speak to your therapist prior to filling this out.

Please clearly print the following requested information.

Therapist You Are Seeing: _____ Today's Date: _____

Client: _____
{Last} {First} {Middle Initial}

Birth Date (DOB): _____ Gender: ☐ Male ☐ Female

Social Security Number: _____-____-_____ (required by some insurance plans)

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Information

Home Phone: (_____) _____-_____ Leave Message? ☐ Yes ☐ No

Work Phone: (_____) _____-_____ Leave Message? ☐ Yes ☐ No

Cell Phone: (_____) _____-_____ Leave Message? ☐ Yes ☐ No

Email: _____

Which of the above do you prefer to be contacted at first? _____

Would you like to receive text message reminders 1 day before your appointments? ☐ Yes ☐ No

Would you like access to the Client Portal to schedule your sessions online? ☐ Yes ☐ No
(Requires a valid email address. You will be sent a link by email to setup your log-in information so you can schedule appointments and message me confidentially online if you desire.)

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: (_____) _____-_____

Personal Information

Employed? ☐ Yes ☐ No

Employer: _____

Occupation: _____

Student? ☐ Yes ☐ No School: _____

Education Level Completed: ☐ GED ☐ High School ☐ College ☐ Graduate School

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Significant Other

Spouse/Partner Name: _____ DOB: _____

Spouse/Partner Employer: _____

Children? ☐ Yes ☐ No If yes, ages: _____

Journey Counseling Services, LLC
6209 S Pinnacle Pl, Suite 102
Sioux Falls, SD 57108
Phone: 605-988-8131
www.journeycounselingservices.com

Therapy Information

Please explain why you feel a need for therapy _____

_____

Areas of Concern: (Mark all that apply.)

☐ Depression
☐ Anxiety
☐ Anger
☐ Grief
☐ Life Change
☐ Substance / Alcohol Use
☐ Spiritual Concerns
☐ Relationship / Marriage
☐ Children
☐ Academic Concerns
☐ Job Concerns
☐ Sexual / Gender Concerns
☐ Abuse / Trauma History
☐ Other:

Please explain what you hope to gain from therapy _____

_____

Previous Psychological Treatment? ☐ Yes ☐ No If Yes, please explain: _____

_____

Medical Information

Primary Care Physician: _____

Clinic Name/Address: _____

Most Recent Medical Exam: _____ History of Serious Illness? ☐ Yes ☐ No

If Yes, Explain: _____

_____

Family History of Serious Illness? ☐ Yes ☐ No If Yes, Explain: _____

_____

Please list all current medications you are on:

Medication	Reason Taking	Dose (mg)	Frequency

Referred By

	Physician	
	Agency	
	Pastor / Church	
	Family	
	Friend	
	Former Client	
	Internet Search	
	Advertisement	
	Other (Please Specify)	

Journey Counseling Services, LLC
6209 S Pinnacle Pl, Suite 102
Sioux Falls, SD 57108
Phone: 605-988-8131
www.journeycounselingservices.com

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 report will be made to Child Protective Services.

Payments

We are committed to providing you with the best possible care. Co-pays/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.

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. We reserve the right to charge $30 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 another support service (such as 339-HELP, a 24-hour help line).

Phone Calls

There is no charge for brief calls. However, calls requiring more than ten minutes of time may be charged according to the closest quarter rate at the discretion of your therapist.

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 1, 2015.

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.

Client: _____ _____
(Signature) *(Date)*

Other: _____ _____
(Printed Name) *(Relationship)*

_____ _____
(Signature) *(Date)*

Journey Counseling Services, LLC
6209 S Pinnacle Pl, Suite 102
Sioux Falls, SD 57108
Phone: 605-988-8131
www.journeycounselingservices.com

Informed Consent: Therapist Supervision

Education & Training

All of the therapists at Journey Counseling Services, LLC have completed the required education (at least a Master's Degree) and training to become a licensed professional in the State of South Dakota. They are well educated and expected to maintain a high level of competency and ongoing learning as part of their employment with the group. Part of their training process has included a significant amount of direct client contact and practice as a psychotherapist. Each provider has areas of specialized focus where they have extra interest and training to be able to provide assistance with specific issues. If your therapist does not have the expertise needed to help with your situation they may consult with another provider in our office or your therapist may work with you to find someone who is a better fit for your needs.

Supervision & Consultation

All providers at Journey Counseling Services, LLC utilize ongoing supervision/consultation for continued growth and development. This ensures quality of care for our clients and is part of best practice in the profession. Confidentiality is always maintained during supervision or consultation. If you have any questions about this process please ask your therapist.

Supervision Toward Licensure

As part of obtaining a license to practice counseling in the State of South Dakota all pre-licensed providers are required to file a plan of supervision with an approved supervisor and work under the guidance of that supervisor until the hours required for licensure are completed. At Journey Counseling Services, LLC all providers who are not licensed are under the supervision of Michael E. Wheaton, MA, LMFT. He is an approved supervisor in the State of South Dakota.

Additional Supervision Toward Second License

Some providers may have one license while continuing to pursue an additional license. For example, they may be licensed as a Licensed Professional Counselor (LPC) and still be in supervision as part of their process of pursuing the higher level license of Licensed Professional Counselor – Mental Health (LPC-MH). In these situations, the provider will again have a plan of supervision filed with the State.

Supervision & Insurance Billing

Some insurance companies allow insurance billing for providers working under the direct supervision of a credentialed provider. In these situations, we may be able to bill insurance for you. When this is done the insurance records may show Michael E. Wheaton, MA, LMFT at Journey Counseling Services, LLC as your provider due to his role as supervisor for your therapist. This can sometimes occur for both pre-licensed and licensed providers who are not yet credentialed with a particular insurance company.

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

My signature below indicates that I have read and understand the above and I have been given a copy.

Client: _____ _____
(Signature) *(Date)*

Journey Counseling Services, LLC
6209 S Pinnacle Pl, Suite 102
Sioux Falls, SD 57108
Phone: 605-988-8131
www.journeycounselingservices.com

FINANCIAL AGREEMENT

STANDARD FEES:
The standard fee is $205 for the initial session which includes diagnostic assessment. Following the initial session the standard fee is $130 per 45 minute session. These rates may be adjusted through contract with some insurance providers or other third party contract. See "Fee Schedule" posted in the office or on the website for additional rate information. Fees are subject to change with a 30 day notice.

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. As a service to you, we will check co-pays/co-insurance and deductibles with your insurance company at the time we receive your insurance information. *Remember this information is no guarantee of benefits. You are ultimately responsible for any cost not covered by your insurance plan.*

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

Primary **(Copy of insurance card provided: ☐ Yes ☐ No)**

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

Secondary **(Copy of insurance card provided: ☐ Yes ☐ No , if applicable)**

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

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**

Alternate Agreement (include reason): _____

_____

Journey Counseling Services, LLC
6209 S Pinnacle Pl, Suite 102
Sioux Falls, SD 57108
Phone: 605-988-8131
www.journeycounselingservices.com

This page left intentionally blank.

Journey Counseling Services, LLC
6209 S Pinnacle Pl, Suite 102
Sioux Falls, SD 57108
Phone: 605-988-8131
www.journeycounselingservices.com

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 report will be made to Child Protective Services.

Payments

We are committed to providing you with the best possible care. Co-pays/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.

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. We reserve the right to charge $30 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 another support service (such as 339-HELP, a 24-hour help line).

Phone Calls

There is no charge for brief calls. However, calls requiring more than ten minutes of time may be charged according to the closest quarter rate at the discretion of your therapist.

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 1, 2015.

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.

Client: _____ _____
(Signature) *(Date)*

Other: _____ _____
(Printed Name) *(Relationship)*

_____ _____
(Signature) *(Date)*

Journey Counseling Services, LLC
6209 S Pinnacle Pl, Suite 102
Sioux Falls, SD 57108
Phone: 605-988-8131
www.journeycounselingservices.com

Informed Consent: Therapist Supervision

Education & Training

All of the therapists at Journey Counseling Services, LLC have completed the required education (at least a Master's Degree) and training to become a licensed professional in the State of South Dakota. They are well educated and expected to maintain a high level of competency and ongoing learning as part of their employment with the group. Part of their training process has included a significant amount of direct client contact and practice as a psychotherapist. Each provider has areas of specialized focus where they have extra interest and training to be able to provide assistance with specific issues. If your therapist does not have the expertise needed to help with your situation they may consult with another provider in our office or your therapist may work with you to find someone who is a better fit for your needs.

Supervision & Consultation

All providers at Journey Counseling Services, LLC utilize ongoing supervision/consultation for continued growth and development. This ensures quality of care for our clients and is part of best practice in the profession. Confidentiality is always maintained during supervision or consultation. If you have any questions about this process please ask your therapist.

Supervision Toward Licensure

As part of obtaining a license to practice counseling in the State of South Dakota all pre-licensed providers are required to file a plan of supervision with an approved supervisor and work under the guidance of that supervisor until the hours required for licensure are completed. At Journey Counseling Services, LLC all providers who are not licensed are under the supervision of Michael E. Wheaton, MA, LMFT. He is an approved supervisor in the State of South Dakota.

Additional Supervision Toward Second License

Some providers may have one license while continuing to pursue an additional license. For example, they may be licensed as a Licensed Professional Counselor (LPC) and still be in supervision as part of their process of pursuing the higher level license of Licensed Professional Counselor – Mental Health (LPC-MH). In these situations, the provider will again have a plan of supervision filed with the State.

Supervision & Insurance Billing

Some insurance companies allow insurance billing for providers working under the direct supervision of a credentialed provider. In these situations, we may be able to bill insurance for you. When this is done the insurance records may show Michael E. Wheaton, MA, LMFT at Journey Counseling Services, LLC as your provider due to his role as supervisor for your therapist. This can sometimes occur for both pre-licensed and licensed providers who are not yet credentialed with a particular insurance company.

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

My signature below indicates that I have read and understand the above and I have been given a copy.

Client: _____ _____
(Signature) *(Date)*

Journey Counseling Services, LLC
6209 S Pinnacle Pl, Suite 102
Sioux Falls, SD 57108
Phone: 605-988-8131
www.journeycounselingservices.com

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 our HIPAA Security Officer, Brian Eclov, at (605) 988-8131. If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to the Secretary of the U.S. Department of Health and Human Services. The appropriate address can be provided 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 1, 2015.

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.