



New Client Information - Minor

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 Age: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

School Currently Attending: _____ Grade: _____

Parent/Guardian Contact Information

Primary Guardian: _____
{Last} {First} {Middle Initial}

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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.)



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.)

- | | |
|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Relationship / Marriage |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Children |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Academic Concerns |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Job Concerns |
| <input type="checkbox"/> Life Change | <input type="checkbox"/> Sexual / Gender Concerns |
| <input type="checkbox"/> Substance / Alcohol Use | <input type="checkbox"/> Abuse / Trauma History |
| <input type="checkbox"/> Spiritual Concerns | <input type="checkbox"/> 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



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THERAPY AGREEMENT

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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.

Financial

The parent who initially sets up counseling for the child is considered the guarantor. This means that this parent is considered financially responsible for covering the cost of services and communicating cost and reimbursement with the other parent. **It is the responsibility of the parents to provide the appropriate payments to the therapist, not the responsibility of the therapist to provide billing according to court ordered co-parenting financial agreements.** It is not feasible to expect the therapist to send separate, divided bills to each parent according to their agreed-upon percentage rates. When requested, the therapist will provide receipt of payment to the parent(s) for their payments. It is the parents' responsibility to work together to share receipts, not the therapist's responsibility to update parents on what the other has and has not paid.

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.

Scheduling

Parents are expected to communicate regarding scheduled appointments. The therapist expects that the parent scheduling session will show respect to the needs of the child to spend time with both parents and will refrain from specifically scheduling appointments as a way to take away time from the other parent.

Cancellations

If your child is unable to attend a scheduled session, it is the responsibility of the parent who scheduled the session to let this office know of the intent to cancel the 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).

Legal Proceedings

In some cases, one or both parents may decide to take legal action regarding custody of the child. Therapy and legal testimony are very different services and the therapist's goal is to create a supportive, safe relationship with the child for the purpose of achieving therapy goals. The therapist cannot and will not provide a recommendation regarding custody of the child when acting as the therapist for the child. The therapist will communicate with legal professionals as required by law, but all professionals and parents should know that the therapist's responsibility is for confidentiality and the protections of the counseling relationship, not to assist one parent in 'winning' their case. The therapist cannot speak to one parent's attorney without the consent of the other parent. In most cases, this is not a productive idea and the therapist recommends that there not be any communication between therapist and attorney(s). when required by law, the therapist will communicate with legal professionals.



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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)



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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.

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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): _____



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The following pages are for the client to keep.



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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 Eclow, 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.