



New Client Information – Premarital/Marriage Enrichment

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. Today's Date: _____

Contact & Personal Information

| | Partner 1 (will be primary contact) | Partner 2 |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| Last Name | | |
| First Name | | |
| Date of Birth | | |
| Phone | | |
| Leave Message? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Email | | |
| Address | | |
| City | | |
| State/Zip | | |
| Education | <input type="checkbox"/> GED <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Graduate School | <input type="checkbox"/> GED <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Graduate School |
| Children | | |
| Employed | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ |

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.)

Who Were You Referred By

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



THE 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, check (returned-check fee will be \$20), 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 or work 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 the suicide support line at **800-273-8255** which is available 24/7 to provide **free and confidential** help.

No Weapons

For the safety of our staff and the people we serve, weapons of any kind are not permitted in our facility.

Phone Calls

There is no charge for routine brief calls. However, calls requiring more than ten minutes of time may be charged at \$5 per 5 minute increment with a minimum charge of \$10.

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 June 07, 2021.

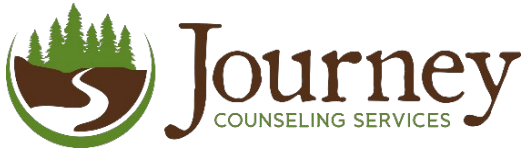
If you have questions about this agreement, please do not hesitate to ask. We are here to help.

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
2525 W Main St, Ste 214
Rapid City, SD 57702-2439
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, Michael Wheaton, at (605) 988-8122. 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 June 07, 2021.

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.



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, check (returned-check fee will be \$20), 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 or work 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 the suicide support line at **800-273-8255** which is available 24/7 to provide **free and confidential** help.

No Weapons

For the safety of our staff and the people we serve, weapons of any kind are not permitted in our facility.

Phone Calls

There is no charge for routine brief calls. However, calls requiring more than ten minutes of time may be charged at \$5 per 5 minute increment with a minimum charge of \$10.

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 June 07, 2021.

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

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)

Other: _____
(Printed Name) (Relationship)

(Signature) (Date)

