Journey Counseling Services, LLC
2525 W Main St, Ste 214
Rapid City, SD 57702-2439
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. Today's Date: _____

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

Preferred Name or Nickname: _____

Birth Date (DOB): _____ Assigned Sex: ☐ Male ☐ Female

Contact Information

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? _____

Is it okay to use your email for:

Appointments: ☐ Yes ☐ No **CC Receipts:** ☐ Yes ☐ No **Statements:** ☐ Yes ☐ No

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

Would you like access to the Jituzu 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 Phone Number: _____

Personal Information

Employed? ☐ Yes ☐ No

Employer: _____

Occupation: _____

Student? ☐ Yes ☐ No School: _____

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

Sexual Orientation: _____ Gender Identity: _____

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

Spouse/Partner Name: _____ DOB: _____

Spouse/Partner Employer: _____

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

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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 / Family
- ☐ 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)	

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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 $40), 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 $40 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 $2.50 per minute with a minimum charge of $25.

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)*

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FINANCIAL AGREEMENT

STANDARD FEES:
The standard fee is $260 for the initial session which includes diagnostic assessment. Following the initial session, the standard fee is $160 per 45 minute session and $220 per 60 minute session. These rates may be adjusted through contract with some insurance providers or other third party contract. See "Fee Schedule" posted on the website for additional rate information or request a copy. 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.

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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(Signature) *(Date)*

Other: _____ _____
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_____ _____
(Signature) *(Date)*

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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.

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)**

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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!

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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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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.