SIOUX FALLS PSYCHOLOGICAL SERVICES

CHILD & ADOLESCENT THERAPY CLINIC

2109 S. NORTON AVENUE
SIOUX FALLS, SD 57105
P: 605.334.2696 F: 605.339.9944
offermehope.com

Registration Information: CO-PARENTING FAMILY THERAPY

(Please Print) Date ___________________

Co-Parent Client Information: Mother _____ Father _____

Name ____

Address____ City _____________________ State______ Zip_________

Soc. Sec # _______-_____-______ Birth Date ______/_______/_________

Primary Phone: ___________________________ (Home, Work, Cell), OK to leave messages? _____ Yes _____ No

Secondary Phone: _________________________ (Home, Work, Cell), OK to leave messages? _____ Yes _____ No

E-mail Address: ____
(*primary method of communication with therapist*)

Workplace ____ Work Phone _____________________________

Children's Information (Please list Biological/Legal Children of Co-Parents involved):

1. Name: ____
First *MI* *Last*

Birth Date ____/_____/_______ Age__________ Gender: M _____ F_____ O_____ Grade in School ____________

2. Name: ____
First *MI* *Last*

Birth Date ____/_____/_______ Age__________ Gender: M _____ F_____ O_____ Grade in School ____________

3. Name: ____
First *MI* *Last*

Birth Date ____/_____/_______ Age__________ Gender: M _____ F_____ O_____ Grade in School ____________

4. Name: ____
First *MI* *Last*

Birth Date ____/_____/_______ Age__________ Gender: M _____ F_____ O_____ Grade in School ____________

5. Name: ____
First *MI* *Last*

Birth Date ____/_____/_______ Age__________ Gender: M _____ F_____ O_____ Grade in School ____________

Step-Parent's Information (if applicable)**:** Step-Mother _____ Step-Father _____

Name ____

Address____ City ____________________ State______ Zip_________

Soc Sec # _______-_____-______ Birth Date ________________

Primary Phone: _________________________ (Home, Work, Cell) OK to leave messages? _____ Yes _____ No

Other Family Members Significant to Minor Child(ren)'s Care (Step or Half Siblings, Grandparents, Partners, etc.)

Name ____ Relationship: ____________________________

Name ____ Relationship: ____________________________

Name ____ Relationship: ____________________________

Name ____ Relationship: ____________________________

Name ____ Relationship: ____________________________

Name ____ Relationship: ____________________________

Current Legal or Operational Parenting Plan for Co-Parents Legal/Biological Child(ren):

Parents: Married _____ Divorced _____ Separated _____ Deceased: Mother_____ Father _____

Physical Custody & Care: Mother _____ Father _____ Joint (Shared Parenting Plan) _____

Schedule for Parenting Time Plan (Please briefly explain how your child(ren's) parenting time is managed; days, weekends, set, rotating, based on a parent's work schedule?): ____

____

____

____

Is this a Court Ordered or Stipulated Agreement for Family Reunification Therapy? ☐ No ☐ Yes—if yes, continue section:

Attorneys of Record _______________________________________, ____

Judge: _____________________ County: __________________________ ☐ Order or Stipulated Agreement Provided

Next Hearing Date if scheduled _______/________/______________

If not referred by Court or legal counsel, how did you hear of our services? *(Please check appropriate box)*

_____ Physician/MD
_____ Pastor/Church
_____ Other Therapist
_____ Insurance Company/EAP
_____ Help Line
_____ Former Client
_____ Friend
_____ Family
_____ Internet, Radio, TV
_____ Other Agency
_____ Other *(Please specify)*

Name of person who referred you? *(Optional)* ____

Medical Health Information:

Family Physician Name ____

Clinic Address ____

Phone _________________________________ Most Recent Exam _____________________________________

Medical Concerns ____

____

____

Other Mental Health Physician or Therapist (Individual Therapy or Psychiatrist):

Name ____

Clinic Address ____

Phone ________________________ Has Provided Care since: ____________

Current Care Plan (Briefly describe reason for MH care and if attending weekly, bi-weekly, etc.): ____________________

____

____

Please explain why you believe you need co-parenting family therapy:

____

____

____

Please list current all medications (prescribed and over the counter):

____

____

____

____

Per the SD Visitation Guidelines, primary custodial parents have a duty to provide access to records and information pertaining to a minor child, including, but not limited to, medical, dental, orthodontia and similar health care, and school records must be made equally available to both parents. Counseling, psychiatric, psychotherapy, and other records subject to confidentiality or privilege must only be released in accordance with state and federal law; but, if available to one parent, must be available to both. Parents must make reasonable efforts to ensure that the name and address of the other parent is listed on all such records (UJS 302 (1.2)).

Please initial ________

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.

Billing

Co-Parenting family therapy sessions are billed under presenting parent's name to insurance provider unless otherwise agreed upon in writing. Family Reunification Therapy may require additional services not covered by insurance such as ongoing correspondence between yourself and your co-parent, your therapist, attorneys of record, & other professionals; written professional reports to the Court and/or preparation and appearance to Court as a professional expert witness by your therapist may also be requested or required. Please see the attached SFPS Financial Agreement for costs of services listed above: Parents are *equally* responsible for *ALL* costs not covered by insurance unless SFPS has verification on file of an alternate legal agreement or court order.

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. 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 business 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.

Parent's Signature: ______________________________ **Date:** ____________________

(Parent, or Guardian Signature)

Print Name: ______________________________

SFPS FINANCIAL AGREEMENT

STANDARD FEES:
Our standard fees are available upon request; the initial intake session is billed as a diagnostic evaluation, and subsequent sessions are billed as psychotherapy sessions for 30 minute, 45 minute, or 60 minute increments. These rates may be adjusted through contract with some insurance providers or other third party contract.

CORRESPONDENCE, COURT PREPARATION, COURT HEARINGS, DEPOSITIONS & TRIAL FEES:
Family Reunification Therapy requires ongoing correspondence between your therapist, parents, attorneys, other therapists, doctors and school administration & staff. Correspondence *commenced* by your therapist via email, telephone, or post is billed at **$60.00 per hour ($1.00 per minute).** Travel time (out of SF limits) & Non-testimonial waiting time is billed at **$155.00 per hour**. Court Preparation (file review) and Court Letter of Update/Report is billed at **$200 per hour**. Professional Witness Testimony or Expert Witness Evaluation for court hearings, depositions, or trials is billed at **$300 per hour.**

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

Insurance Company ____ Phone Number _____________________

ID Number ____ Group Number ______________________

Policy Holder____ Policy Holder DOB __________________

Client's Relationship to Policy Holder ____

Secondary

Insurance Company ____ Phone Number _____________________

ID Number ____ Group Number ______________________

Policy Holder____ Policy Holder DOB __________________

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.

I specifically understand that insurance will not cover any of the professional court-related work, and that I am personally responsible for these fees. I understand that I must pay these fees per monthly billing or set up a trust account with SFPS billing office to cover these costs.

____ _________________________

Authorized Signature of Subscriber **Date**

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.

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.

2019 Family Reunification Policies

Dear Parent/Guardian(s),

Family Reunification Therapy is family therapy that aims to help families struggling with high conflict. FRT assists families to develop healthy relational dynamics among parents and children. Your family therapist will work with all relevant family members, both individually and collectively to help your family find strategies to work together, break down animosities among parents and children that lead to alienating and estranging behaviors, and create parameters that meet the needs of your family's optimal functioning health.

The role of this therapist, Gretchen L. Hartmann, LMFT, DMin is solely to work therapeutically with a family. This Therapist will meet with each parent first before deciding if/when to meet with minor children. Upon meeting with all relevant members of your family, this Therapist will determine the direction for therapy. Sessions could focus solely on children, or a child and a parent, or both parents, and/or the entire family.

Parents who share *joint legal custody* must BOTH consent to therapy. This Therapist will collaborate with any and all other professionals collaterally involved in your family's matter. A consent for release of information that covers all potential professionals and relevant family members (step-parents or grandparents) involved in this matter is included. This Therapist may or may not contact you before initiating contact with one of these professionals; all collaboration is confidential. Progress notes requested in your or your child's matter are released ONLY if both parents consent for release of records; however, this Therapist has a professional and ethical duty to determine if release of a parent or child's records are in his or her best interests. This Therapist will move to quash release of records if she determines it could harm you or your child/children.

If your family was court ordered or you agreed as part of a court order to begin family reunification therapy, you must provide this Therapist with a copy of the most current court order and all other court orders that are pertinent to the history of your matter; this also includes home studies or other forensic evaluations. This Therapist does NOT make recommendations for custody, visitation, or other *legal* issues related to your matter, unless expressly ordered by the Court. Court orders for such recommendations will be regarded as the authority for this Therapist to follow in your matter. This Therapist will provide the Court (or Counsel) professional assessment for the Court's (or parties') consideration; upon approval or legal agreement, recommendations will be implemented. This Therapist will follow all currently ordered parameters of your legal matter. This Therapist will assist evaluators and the Court to meet the best interests of your child/children and your family. This Therapist may be required by a court of law to provide testimony regarding this Therapist's professional opinions and recommendations for therapy based on accurate, objective, and independent review of privileged information obtained throughout the therapy process. This Therapist *does not* participate in dual roles of evaluator and therapist.

Due to the additional work required outside of the therapy setting in family reunification therapy, this Therapist charges separate fees for all activity falling outside of the therapy session. All communication responses (email or telephone) to parents, collateral contacts, or court appearance/testimony and court-related work product/preparation will be billed accordingly (see the adjoining financial agreement for a list of these fees). These fees are NOT covered by insurance. Legally responsible parents/guardians are financially responsible for these costs. Sessions are billed under all individually applicable client's (children and/or parents) insurance. Family reunification therapy is aimed at improving family dynamics for the best interests of the minor child/children; however, children are not necessarily present for all sessions.

Upon thorough review and understanding of these policies for Family Reunification Therapy, please sign and date below.

Parent/Guardian Signature: ____ Date:______/______/_______

CONSENT TO RELEASE OR OBTAIN INFORMATION

FOR FAMILY THERAPY REUNIFICATION SERVICES (Case Collaboration)

This is a consent for release of information about: ____
(Client (SELF) Name)

and, CO-PARENT of shared legal child(ren), ____
(Co-Parent Name)

for CO-PARENTING FAMILY THERAPY of Minor Children: ______________________________________

I authorize Sioux Falls Psychological Services (SFPS) and **GRETCHEN L. HARTMANN, LMFT, DMin.**
(Therapist)

to release AND exchange information with ALL of the below-noted individual directly working for the best interests of the above-named minor child

- **ATTORNEYS OF RECORD and in a COURT OF LAW** (if court ordered)
- **BIOLOGICAL FAMILY MEMBERS AND STEP-PARENTS**,
- **THERAPISTS OF RECORD** (if applicable),
- **SCHOOL ADMINISTRATION & STAFF** (if applicable)**,**
- **MEDICAL DOCTORS** (if applicable),
- **ALL OTHER PROFESSIONALS COLLATORALLY RELATED TO THIS MATTER**

THE INFORMATION WILL BE USED/DISCLOSED FOR THE FOLLOWING PURPOSES: All Assessments & Diagnostic information, Legal File Information, Recommendations, & Medical Information.

- I understand that I am authorizing **GRETCHEN L. HARTMANN** & SFPS and those identified below to initiate contact with and/or release and exchange information**.** ***I understand BOTH myself and Co-Parent must agree to release notes if requested***. The information I authorize a person or entity to receive may not be re-disclosed and is no longer protected by federal privacy regulations.
- I understand that all information acquired in the course of family reunification therapy may be compelled for testimony in a court of law, and that my therapist will offer testimony based on accurate, objective, and independent review of this privileged information.
- I understand that unless noted **this release shall be reciprocal**, allowing both SFPS and the source noted below to receive and exchange information.
- I understand that my verbal or written notice to SFPS will revoke this consent at any time. I further understand I may be held liable in a court of law if I choose to override court-ordered services.
- I understand that I may or may not be informed of requests for information depending on the nature of the request and/or standing court order.
- I understand that information regarding my care may be shared internally to assure effective services.
- I understand that unless noticed this release can be transmitted by facsimile or electronically.

This authorization expires **UPON RELEASE OF COURT ORDER, OR VERBAL REVOCATION**

Client Name (please print): _____________________________________, **DOB:** ____/____/__________

Client Signature: ____ Date: __________________

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

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)

Client Copy