river COUNSELING SERVICES
An Entity of Sioux Falls Psychological Services

610 E. 7TH STREET
PLATTE, SD 57105
P: 605.334.2696 F: 605.339.9944
rivercounselingservices.org

REGISTRATION INFORMATION

(Please Print)

Date _____

Client _____
First *MI* *Last*

Address _____ **City** _____ **State** ____ **Zip** _____

Soc Sec # _____-_____-_____ **Birth Date** _____ **Gender:** _____

Marital Status: ____Single ____Married ____Separated ____Divorced ____Widowed ____Other

Employer _____ **Occupation** _____

Home Phone: _____ **OK to leave messages?** _____
Work Phone: _____ **OK to leave messages?** _____
Cell Phone: _____ **OK to leave messages?** _____
If it's ok to contact you by e-mail, include your address here: _____

Spouse _____ Birth Date _____ Soc Sec # _____-____-_____

Spouse's Employer _____ Business Phone _____

In Case of Emergency, contact _____ **Relationship** _____

Emergency Contact Phone _____

Person Responsible for the Account _____
Address _____ **Phone** _____
Employer _____ **Occupation** _____
Birth Date _____ **Relationship to Client** _____

How did you hear of our services? _____
_____

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

Family Physician _____ **Address** _____

Phone _____ **Most Recent Exam** _____

Medical Problems _____

_____

_____

Please explain why you feel you need therapy _____

_____

_____

Previous Psychological/Psychiatric Treatment _____

_____

_____

_____

Please list present medications _____

_____

_____

_____

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, or neglect or abuse of a vulnerable adult or elderly adult, a verbal report will be made to the Department of Social Services.

Payments

We are committed to providing you with the best possible care. Co-pay's/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.

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.

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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 businesses 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. SFPS may at times communicate with you via HIPAA-compliant secure encrypted email. Medical records, by release, may be transmitted using this same secure platform.

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.

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)

Print Name: _____

SFPS FINANCIAL AGREEMENT

STANDARD FEES:
Our standard fees are $248 for the initial session, $155 per standard 45 minute session and $200 per sessions 60 minutes and longer after the initial session. These rates may be adjusted through contract with some insurance providers or other third party contract.

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.

_____ _____

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.

River Counseling Services Client,

Your therapist is well-educated and able to help you deal with a variety of personal and relational problems and concerns. Your therapist may have one of the following licenses (Licensed Psychologist, Licensed Marriage & Family Therapist, Licensed Professional Counselor or Licensed Clinical Social Worker), or they may be in the process of acquiring licensure in their particular area of training and expertise. Feel free to ask them about their education and training. You may wish to know something about their areas of expertise. Our therapists practice within the scope of their training and expertise. If at any time your therapist believes you need a different type of therapy they will talk with you about that and either seek appropriate supervision or refer you to someone who is more able to meet your needs.

At times insurance companies require licensed therapists to be under the supervision of a licensed psychologist. That means your therapist may discuss your case with me from time to time. Confidentiality is maintained in supervision. If you have questions or concerns about your therapy you are welcome to contact me.

Douglas L. Anderson, Psy.D.
Clinical Supervisor, SFPS
Licensed Psychologist, SD #353
Licensed Marriage & Family Therapist #1141

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(Client, Parent or Guardian signature)

Client Copy