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

(Please Print)

Date ___________________

Child's Information ____

First *MI* *Last*

Primary Residence_____________________________________ City____________________ State______ Zip_________

Soc Sec # _______-_____-______ Birth Date ___________________ Age__________ Gender: M _____ F_____

Grade in School ________________ School of Attendance ____

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

Primary Custodial Parent: Mother _____ Father _____ Joint _____

Most recent legal paperwork (court order) is required before meeting with child.

Biological Mother's Information

Responsible for the Account: _____ Yes _____ No

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 (only if we can contact you by e-mail): ____

Workplace ____ Work Phone _______________________________

Stepfather's Information (if an insurance provider)

Name ____

Address____ City _____________________ State______ Zip_________

Soc Sec # _______-_____-______ Birth Date _________________

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

Biological Father's Information
Responsible for the Account: _____ Yes _____ No

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 (only if we can contact you by e-mail): ____

Workplace ____ Work Phone _____________________________

Stepmother's Information (if an insurance provider)

Name ____

Address____ City ___________________ State______ Zip_________

Soc Sec # _______-_____-______ Birth Date ________________

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

Referral Information

How did you hear of our services? *(Please check appropriate box)*

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

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

Medical Information

Family Physician Name ____

Clinic Address ____

Phone _________________________________ Most Recent Exam ____________________________________

Medical Problems ____

____

____

Please explain why you feel you need therapy ____

____

____

Previous psychological or psychiatric treatment ____

____

____

____

Please list present medications ____

____

____

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: MOTHER

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

All sessions are billed under the minor child's or children's name. Parents are responsible for costs per court agreements.

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 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.

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.

Mother's Signature: ____ **Date:** ____________________

(Parent, or Guardian Signature)

Print Name: ____

THERAPY AGREEMENT: FATHER

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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.

Father's Signature: ____ **Date:** ___________________

(Parent, or Guardian Signature)

Print Name: ____

SFPS FINANCIAL AGREEMENT

STANDARD FEES:
Our standard fees are $248 for the initial session and $155 per standard 45 minute session after the initial session. 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 will be billed at **$61.80 per hour ($1.03 per minute**). NON-TESTIMONIAL COURT APPEARANCE, as well as any COURT PREPARATION and COURT DOCUMENT REVIEW will be billed at **$200 per hour**. PROFESSIONAL WITNESS TESTIMONY for court hearings, depositions or trials will be 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 CORRESPONDENCE, COURT PREPARATION, COURT HEARINGS, DEPOSITIONS & TRIAL FEES, 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.

SIOUX FALLS PSYCHOLOGICAL 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 even 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

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

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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

THERAPY AND ASSESSMENT CLINIC | CHILD & ADOLESCENT THERAPY CLINIC | COMMUNITY COUNSELING CLINIC

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

Consent to Release/Obtain Information - Family Reunification Therapy

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

Social Security Number: _______-_____-___________ Birth Date: ________________________________

and, myself, as a biological parent of the minor client, ____
(Parent Name)

Social Security Number: _______-_____-___________ Birth Date: ________________________________

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**
- **BIOLOGICAL FAMILY MEMBERS AND STEP-PARENTS,**
- **THERAPISTS OF RECORD,**
- **SCHOOL ADMINISTRATION and STAFF,**
- **MEDICAL DOCTORS,**
- **ALL OTHER PROFESSIONALS COLLATORALLY RELATED TO THIS MATTER**

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

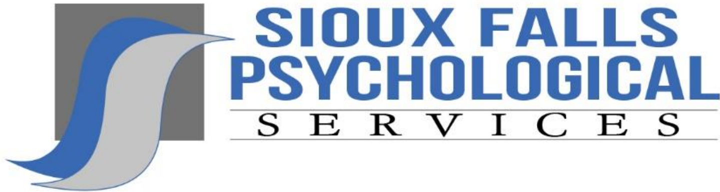
- I understand that I am authorizing **GRETCHEN L. HARTMANN** & SFPS and those identified below to initiate contact with and/or release and exchange information**. *I agree NOT to release my child's progress notes to parents or attorney's of record*.** The information I authorize a person or entity to 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 anytime. 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 **ONE YEAR FROM THE DATE OF SIGNATURE, OR VERBAL REVOCATION**

Client/Guardian Name (please print): ____

Relationship to Client: ____

Client/Guardian Signature: ______________________________________ Date: ____________



2017 Family Reunification Policies

Dear Parent/Guardian(s),

Family Reunification Therapy is family therapy that aims to help families in high conflict address relevant issues, find strategies to work together and break down animosities between parents and children that lead to alienating and estranging behaviors.

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 prior to meeting with children. Upon meeting with all relevant members of the 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 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 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 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 the minor child's insurance as therapy is aimed at improving family dynamics for the best interests of the minor child.

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

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