Dakota Hope Counseling, LLC

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DakotaHopeCounseling.com | MichellePliska@DakotaHopeCounseling.com

ADULT THERAPY INTAKE FORM

If you have any questions or need assistance in completing these questions, please do not hesitate to ask for help. Please provide a copy of your insurance card (front and back) ahead of your first session. I look forward to serving you!

Client Name: _____

Street Address:_____ City:_____ State:___ Zip:_____

Date of Birth:_____ Age:_____ Gender:_____

Your Primary Phone:_____(Home, Work, Cell)

Your Secondary Phone:_____ (Home, Work, Cell)

Your Primary Email:_____

Is it ok to leave voice mails?_____ Is it ok to text you?_____Is it ok to email you?_____

Your Workplace:_____ Your Work Phone:_____

Who is the primary person responsible for payment of this account:_____(Self) _____(Other)
If other please fill out below.

Name of person responsible for account:_____

Their Address:_____City:_____State:___ Zip:_____

Their Phone:_____ Their Email:_____

Their Employer:_____ Their Occupation:_____

Their Date of Birth:_____

Do you consent to release/discuss account information to/with them? Yes or No

What is this person's relationship to the client?_____

EMERGENCY CONTACT

In case of an Emergency, please contact:_____

Emergency Contact Phone:_____

Emergency Contact's Relationship to the Client:_____

SPOUSE OR SIGNIFICANT PARTNER INFORMATION

Name:_____

Street Address:_____City:_____State:___Zip:_____

Date of Birth:_____ Age:_____ Gender:_____

Phone:_____ Email:_____

Do you given consent and permission to contact via phone or email? Yes or No

Is it ok to leave a voicemail? Yes or No Is it ok to text? Yes or No

Relationship status: Married Significant Partnership Separated Divorced

FOR FAMILY THERAPY

Additional Participant Information (any other family members or individuals of significant relationship who will be attending therapy)

Name:_____ Relationship:_____

Gender:_____ Age:_____

Name:_____ Relationship:_____

Gender:_____ Age:_____

Name:_____ Relationship:_____

Gender:_____ Age:_____

Name:_____ Relationship:_____

Gender:_____ Age:_____

HOW DID YOU FIND THIS PRACTICE:

☐ Word of Mouth ☐ I'm a former client ☐ Order of Psychologist ☐ Psychology Today

☐ Doctor's Recommendation ☐ Google, using these words:_____

☐ Other:_____ _____

THE REASONS FOR YOUR VISIT:

_____

_____

_____

How intense is your emotional distress?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please describe:_____

_____

Overall, how much do the problems affect your ability to perform in school or work, get along with others and perform daily tasks?

(Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)

Please describe:_____

_____

When did these problems start? What was going on in your life at that time?

_____

_____

_____

PSYCHIATRIC AND MEDICAL HISTORY

Please list any ***psychiatric or "mental"*** health problems you have been diagnosed with:

_____

_____

Please list any ***medical or "physical"*** health problems that you have been diagnosed with:

_____

_____

_____

Please list any medications you currently take and what they are for:

_____

_____

_____

Name of Primary Care Provider:_____ Phone:_____

When was your last check up?_____

Results of your last check up?_____

_____

Would you like me to collaborate with your PCP? Yes or No

Name of your psychiatrist:_____ Phone:_____

When was your last psychiatric visit?_____

What were the results of the last psychiatric visit?_____

Would you like me to collaborate with your psychiatrist/medication provider? Yes or No

MENTAL HEALTH TREATMENT HISTORY

Has you ever been hospitalized for psychological or psychiatric reasons? Yes or No

If yes, please describe when, where, and for which reasons.

_____

_____

Please tell mw about any other mental health professionals you have consulted with in the past (approximate dates, type of professional seen, reason for consultation, nature of treatment, outcome of treatment, etc).

_____

_____

_____

Would you like me to collaborate with any of your previous mental health professionals? Yes or No

CURRENT HABITS

Please describe your current habits in each of the following areas:

Smoking:_____

Drinking: _____

Drug Use:_____

TV/Internet/Video Game Use:_____

Caffeine Intake:_____

Exercise:_____

Eating: _____

Sleeping: _____

Fun & Relaxation:_____

Chores & Responsibilities:_____

RELATIONSHIPS

Please describe your relationships with each of the following people, if applicable:

Biological Mother:_____

Biological Father:_____

Step Parents:_____

Legal Guardians:_____

Siblings:_____

Extended Family:_____

Friends:_____

Colleagues or classmates:_____

Others that you'd like to note:_____

STRESSFUL LIFE EVENTS

Please describe any significant or stressful life events that you have been experiencing:

	No	Yes	If yes, please describe.
A recent move or change in work?			
Trauma?			
Work difficulties?			
Weight control issues?			
Sexual identity concerns?			
Self injury?			
Death or illness of a loved one or pet?			
Family conflict? Or Separation or Divorce			
Chronic pain or illness?			

	No	Yes	If yes, please describe.
Other?			

OTHER IMPORTANT INFORMATION

What are your positive qualities and skills? What do you like about yourself?

What are some goals for your therapy? What would you like to achieve by attending therapy?

What concerns do you have about attending therapy or working on these problems?

Is there anything else that you would like to mention?

Thank you for sharing this information!

THERAPY AGREEMENT: DAKOTA HOPE COUNSELING COPY

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 to protect them or yourself. If there is reasonable suspicion of child, elder or vulnerable adult abuse, a verbal report will be made to Child Protective Services or law enforcement.

Social Media & Confidentiality: I do not accept requests to join, "follow" or interact with current or former clients on personal or group social media platforms. I do not use search engines or seek clients out via digital and social media platforms. I communicate via email or office phone for scheduling and administrative needs. While email platforms have reasonable security protection, I cannot ensure HIPAA-compliant safety; use at your own discretion.

Billing: All individuals, couples, and family therapy sessions are billed to insurance under the primary, presenting client's name. Services required of your therapist outside of the therapy session are not covered by insurance and may incur additional costs. Please see the current Dakota Hope Counseling Fee Schedule included in this packet.

Payments: I am 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. I 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, I 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 counselor know of your intent to cancel your appointment. A text message is preferred.
605-223-5155

Emergencies: If you need emergency psychological help at a time I am not available, it is your responsibility to contact emergency services (Avera 24/7 Hotline 605-322-4065; 988 Suicide and Crisis Hotline; or The Link Community Triage Center 605-275-1000). If you leave a message with Dakota Hope Counseling, I may not be available to return the call in the timeframe you need. Please utilize the crisis services provided herein. True emergencies also warrant a call to 911.

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 Dakota Hope changes our notice, you may obtain a revised copy.

By signing this for,m you acknowledge that you have received a copy of Dakota Hope Counseling's Notice of privacy Practices. If you have questions about this agreement, please do not hesitate to ask. I am 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. Please request additional copies for all participants of couples or family therapy.***

Client/Parent/Guardian Signature:_____Date:_____

Print Name: _____

DAKOTA HOPE COUNSELING: SERVICE FEES & INSURANCE INFORMATION

Mental Health Services		Fee
Intake Session, 90791	Psychiatric Diagnostic Evaluation 60+ minutes	$225.00
Therapy Session, 90837	Psychotherapy Session, 60 minutes	$200.00
Therapy Session, 90834	Psychotherapy Session, 45 minutes	$185.00
Therapy Session, 90832	Psychotherapy Session, 30 minutes	$115.00
Consultation		$100.00
Cancellation Fee	Session cancellation of less that 24 hours notice	$50.00

Insurance Information: Please fill out and provide a copy of insurance card (front and back), and required information.

Primary Insurance Company:_____ Phone:_____

Member ID _____ Group Number:_____

Policy Holder_____ Policy Holder DOB:_____

Client Relationship to Policy Holder_____

Secondary Insurance Company:_____ Phone:_____

Member ID _____ Group Number:_____

Policy Holder_____ Policy Holder DOB:_____

Client Relationship to Policy Holder_____

Initial: _____ I understand that I am responsible for all charges regardless of insurance coverage.

Assignment of Insurance Benefits: The undersigned hereby authorize 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 found 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.**

_____ _____

Authorized Signature of Subscriber Date

Print Name_____

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Dakota Hope Counseling: Uncovered Fees

Additional services requested of your therapist outside of the therapy session that do not have a medical billing code are not covered by health insurance. Services such as a request for a legal appearance for a professional witness testimony, preparation of professional witness appearance, travel time and mileage for court appearance, and/or a professional mental health report to another professional or provider are billed at carrying rates; please refer to the professional service fees charted attached whithin this packet. A retainer for the full cost of the hourly rate for a professional services fee are due ahead of completed work or appearance. Unused fees will be fully refunded.

		Fee
Court Testimony	Professional Witness Testimony for Court	$300/hour unit
Preparation	Preparation for court	$200/hour unit
Court Testimony Analysis	Professional Witness analysis of witness testimony	$200/hour unit
Travel (court)	Travel time for court	$155/hour unit
Non-Testimony	Subpoenaed, non-testimony time	$200/hour unit

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Client Signature:_____ Date:_____

Print Name: _____

DAKOTA HOPE COUNSELING: 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 authorizations before releasing your psychotherapy notes. "Psychotherapy notes" are notes that 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 Nor Authorization: We may use or disclose PHI without your consent or authorization in the following circumstances

- **Child, Elder or Vulnerable Adult Abuse:** If your therapist has reasonable cause to suspect that a child under the age of 18 or a vulnerable adult or adult 65+ years of age 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 for Counselors and Marriage & Family Therapists 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 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 the 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 a potential victim).

- **Worker's Compensation:** If you file for a worker's compensation claim, we are required by law to provide your mental health information relevant to the 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 me with questions. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. 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: Dakota Hope Counseling reserves 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.