# Dakota Hope Counseling, LLC

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## TEEN 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!

Kindly, complete on behalf of your child.

**Name of person completing this form:**_____

Your relationship to the child:_____ Your Date of Birth_____

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

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

Your home address:_____City_____ State__ Zip_____

Your Workplace:_____ Your Work Phone:_____

**Name of other parent/legal guardian(s):**_____

Their relationship to the child:_____ Their Date of Birth_____

Their Phone:_____ Their Email:_____

Their home address:_____City_____ State__ Zip_____

**Child/Teen's first name:**_____ Last Name:_____

Age:_____ Birth Date:_____(Month day, year)

Ethnicity:_____ Religion:_____ Sex/Gender:_____

Home address:_____

Who does your child live with?_____

**Other family members that are significant to the child's care** (Step parents or partners, siblings, grandparents, aunties, uncles, etc.)

Name:_____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

**Current legal or operational parenting plan if applicable.**

Who has physical or residential custody and care?_____

Who has legal custody?_____

What is the scheduling for parenting time (Please briefly explain how your child(ren's) parenting time is managed; days, weekends, set, rotating, based on parent's work schedule?)

_____

_____

_____

Are there pending visitation or custodial legal court proceedings or legal orders/agreements for child start psychotherapy? Yes or No

If yes, kindly continue:

Attorneys of Record:_____, _____

Judge:_____ County:_____

Next Hearing Date if scheduled:_____

***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 healthcare, and school records which 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 other parent is listed on all records (UJS 302(1.2)). Please initial:_____***

**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:_____ _____

**ACADEMIC INFORMATION**

Name of your child's school:_____ Grade:_____

Program:_____ Typical Grades:_____

**THE REASONS FOR YOUR CHILD'S VISIT:**

_____

_____

_____

**How intense is your child's emotional distress?**

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

Please describe:_____

_____

**Overall, how much do the problems affect your child's ability to perform in school, get along with others and perform daily tasks such as chores?**

(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 child's life at that time?**

_____

_____

_____

**PSYCHIATRIC AND MEDICAL HISTORY**

Please list any ***psychiatric or "mental"*** health problems your child has been diagnosed with:

Please list any ***medical or "physical"*** health problems that your child has been diagnosed with:

Please list any medications your child currently takes and what they are for:

Name of Family Doctor:_____ Phone:_____

When was your child's last check up?_____

Results of your child's last check up?_____

Name of your child's psychiatrist:_____ Phone:_____

When was your child's last psychiatric visit?_____

What were the results of the last psychiatric visit?_____

**MENTAL HEALTH TREATMENT HISTORY**

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

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

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

_____

_____

**CURRENT HABITS**

Please describe your child's 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 child's 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 your child has been experiencing:

| | No | Yes | If yes, please describe. |
|---|---|---|---|
| **A recent move or change in school?** | | | |
| **Abuse or neglect?** | | | |
| **Bullied or ignored by peers?** | | | |
| **Academic difficulties?** | | | |
| **Weight control issues?** | | | |
| **Sexual identity concerns?** | | | |
| **Self injury?** | | | |
| **Death or illness of a loved one or pet?** | | | |
| **Family conflict?** | | | |
| **Separation or divorce?** | | | |
| **Other?** | | | |

**OTHER IMPORTANT INFORMATION**

What are your child's positive qualities and skills? What do you like about your child?

Please tell us about your child's interests (sports, hobbies, talents, etc).

Does your child agree that the problem they are seeking help for is problematic?

What are some goals for your child's therapy? What would you like them to achieve by attending therapy?

What concerns do you have about your child 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'll 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 when 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, 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 to couple or family therapy.***

Parent or 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 authorize 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 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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## (CLIENT COPY)

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## Dakota Hope Counseling: Fees Not Covered By Insurance

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 whiten 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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Parent or Guardian Signature:_____ Date:_____

Printe 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.