Rapid City Counseling Inc.
528 Kansas City St.,
Suite 5
Rapid City SD 57701-2766
605-299-9100

Rapid City Counseling Inc.
Adolescent Intake Questionnaire

Client Contact Information
(portion completed by caregiver/parent)

Adolescent's Name: _____

Adolescent's Preferred Name: _____

Gender:_____

Date of Birth: _____

Academic Grade: _____

Adolescent's Race/Ethnicity: _____

What concerns do you have for your adolescent's counseling?: _____

Has your adolescent ever had a psychological evaluation?: _____

If yes, what were the results? (Please provide a copy of the results if you have them.): _____

Describe any family concerns or information in relation to your family that you would like to share and that may assist us in meeting your adolescent's needs: _____

Parent/Legal Guardian Information

Primary Caregiver's Name: _____

Primary Caregiver's Phone Number: _____

Primary Caregiver's Email Address: _____

Primary Caregiver's Street Address: _____

Primary Caregiver's City, State, Zip: _____

Secondary Caregiver's Name (if applicable): _____

Secondary Caregiver's Phone Number (if applicable): _____

Secondary Caregiver's Email Address (if applicable): _____

Secondary Caregiver's Street Address (if applicable): _____

Secondary Caregiver's City, State, Zip (if applicable): _____

Please list ALL other people living in the home: _____

Parent's Relationship Status: _____

If separated or divorced, adolescent's age at the time of separation: _____

Legal Custody with: _____

Physical Custody with: _____

Where is the adolescent's primary residence?: _____

Is there a parenting plan in place? (If yes, a copy MUST be provided to Rapid City Counseling and sent via email to info@rapidcitycounselors.com: _____

Medical History

Adolescent's Primary Physician: _____

Physician's Phone Number: _____

Allergies: _____

Current Medications: _____

Previous Medications: _____

Previous Medical Conditions_____

Prolonged illnessnes: _____

If yes, medications taken? Side effects of medications or illness?: _____

Previous surgeries: _____

Exercise Frequency: _____

Exercise Type: _____

Areas of life functioning

Nutritional Habits: _____

Sleep Habits: _____

Electronic Usage & Limitations: _____

Your Expectations & Consequences for Adolescent: _____

Academic Concerns: _____

To your knowledge, is your adolescent sexually active?: _____

Has your adolescent had any legal issues? If so, explain them: _____

Substances

To your knowledge, has your adolescent experimented with alcohol or drugs?: _____

If so, has this been problematic in their life?: _____

Does your adolescent use tobacco products or vape? If so, how often?: _____

Does your adolescent drink caffeinated beverages?: _____

If yes, how much do you anticipate they drink per day?: _____

Primary Concern (Section filled out by adolescent)

What are you major concerns?: _____

Do you want to incorporate any chosen faith into your counseling?: _____

Have you had any mental health treatment in the past?: _____

Previous diagnosis/mental health treatment: _____

If yes, previous therapist seen for complaint: _____

Describe treatment: What helped relieve symptoms in prior treatment?: _____

Are you currently experiencing any mental health problems? (check all that apply):
☐ Depression
☐ Anxiety
☐ Panic Attacks
☐ Anorexia/Bulimia/Binge Eating/Emotional Eating
☐ ADHD
☐ Autism Spectrum
☐ OCD/OCPD
☐ PTST/Trauma
☐ Bipolar (Manic/Depressive Disorder)
☐ Schizophrenia
☐ Personality Disorder
☐ Substance Abuse/Alcohol Abuse
☐ Suicidal/Self Harm Behaviors
☐ Relationship Difficulties
☐ Problems Coping with Stress
☐ Phobias
☐ Other, please describe: _____

Current Symptoms (check all that apply & note factors that aggravate or relieve symptoms):
☐ Appetite Issues
☐ Avoidance
☐ Excessive Energy
☐ Fatigue
☐ Fidgety, Restlessness
☐ Frequently Tearful/Crying spells
☐ Guilt
☐ Hallucinations
☐ Impulsivity
☐ Irritability
☐ Libido Changes
☐ Loss of Interest
☐ Racing Thoughts
☐ Risky Activity
☐ Ruminating Dark Thoughts
☐ Sleep Changes
☐ Sad Most days
☐ Other: _____

Please share any other concerns that you may have about your adolescent's mental well-being and behaviors:

Client Registration Form

DATE _____
Returning client? *(Circle One)* *Yes / No*
If yes, what was your last name when previously seen? _____

CLIENT'S LEGAL NAME: _____
Maiden Name: _____
GOES By:_____ *First Middle Last*

CLIENT GENDER: _____ **AGE:** _____ **BIRTHDATE**: _____-_____-_____

CLIENT MARITAL STATUS: *(circle one)* N/A-
Child Single Married Divorced Separated Widowed Long-Term Partner
SPOUSE'S NAME: _____
BIRTHDATE: _____

ADDRESS:_____
Number & Street APT. # City State ZIP
PHONE: Cell (____) _____ Work (____) _____
EMAIL_____ **SSN:** _____
DRIVER'S LICENSE STATE & NUMBER: _____
REMINDER CALLS: Please provide the best number to receive reminder calls _____
Others who may be contacted for scheduling:
Name _____Relationship_____
Phone # _____

REFERRED BY: _____
PRIMARY PHYSICIAN: _____
PLEASE LIST PAST THERAPY/TREATMENT/EVALUATION: *(Provider Name, approximate dates)*
_____

CLIENT EMPLOYER: _____**OCCUPATION:** _____

EMERGENCY CONTACT PERSON: _____
CONTACT PHONE: _____

ADDITIONAL INFORMATION - *WHEN CLIENT IS A MINOR*
(Only provide Information not provided above)
NAME OF MOTHER: _____
DOB: _____
STEP-FATHER: *(if any)* _____
ADDRESS:_____ **PHONE:** _____
EMPLOYER NAME: _____ **WORK PHONE:** _____
OCCUPATION: _____
EMPLOYER ADDRESS:_____

NAME OF FATHER: _____
DOB: _____
STEP-MOTHER: *(if any)*_____
ADDRESS: _____ **PHONE**: _____
EMPLOYER: _____ **WORK PHONE:** _____
OCCUPATION: _____
EMPLOYER ADDRESS: _____

LEGAL GUARDIAN(S): (If other than parents)_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT:_____

CHILD'S SCHOOL: _____ **GRADE:** _____
SCHOOL CONTACT PERSON: _____ **TITLE:** _____

OTHER PEOPLE LIVING IN HOME:

NAME	AGE	RELATIONSHIP	NAME	AGE	RELATIONSHIP
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

PLEASE FILL IN COMPLETELY

Primary Insurance
Carrier:_____
Policyholder: _____
Policyholder's DOB: _____ Relationship: _____
Policy #: _____
Group#: _____
Policyholder's SSN#: _____

Secondary Insurance
Carrier:_____
Policyholder: _____
Policyholder's DOB: _____ Relationship: _____
Policy #: _____
Group#: _____
Policyholder's SSN#: _____

Billing Information: If our biller should need to contact you for any reason, please provide a number where you can be reached at and who we can speak to.

Name: _____ **Phone Number:** _____

Client Registration Information

****

Additional Informed Consent

If you have any questions about these additional informed consent policies, please ask before signing below. Your signature indicates that you have read these policies and that you seek and agree to enter into mental health services under those conditions. You understand that no promises have been made to you as to the results of any treatment or procedure provided by this provider. Further, it indicates your understanding that Rapid City Counseling Inc., d.b.a. Stacy L. Keyser may terminate services if there is a lack of compliance with these policies or if she believes that you are not benefiting from treatment. PAYMENT DUE AT TIME OF SERVICE: Payment for your portion of charges is due at the time of service, unless other arrangements have been made with Stacy L. Keyser. Appointments must be cancelled at least 24 hours in advance. You may be billed for missed or late-cancelled appointments.
PLEASE SIGN HERE TO ACKNOWLEDGE YOU'VE BEEN MADE AWARE OF THIS POLICY CONSENT FOR EVALUATION AND TREATMENT:

_____

Consent is given for evaluation and treatment by Stacy L. Keyser. It is agreed that either the Stacy L. Keyser or I may discontinue evaluation, consultation and/or treatment at any time and that the client is free to accept or reject the services offered or provided. ASSIGNMENT OF INSURANCE BENEFITS / PAYMENT AGREEMENT: Rapid City Counseling Inc., d.b.a. Stacy L. Keyser will file all insurance claims unless otherwise directed. In the event that a client or responsible party is entitled to insurance benefits of any type arising from any policy which insures the client or other liable person, those benefits are hereby assigned to the provider for credit toward bills. The client and/or responsible party shall be financially responsible for any charges not paid by insurance. If payment is not made directly to the provider, payment in full is due from the client or responsible party. The undersigned agrees to pay the provider the assessed charges, in full, at the time of service unless other arrangements have been authorized. Rapid City Counseling Inc., d.b.a. Stacy L. Keyser reserves the right to charge 1.5% monthly interest and/or late fees on statements for accounts 60 days past due and not paid in a timely manner. If your account reaches 90 days past due without a payment of no less than 25% of the client obligation, or efforts are not made to set up a payment plan, Stacy L. Keyser reserves the right to pursue collections on your account. Please note there will be a $50 fee on all NSF checks. NOTE TO SEPARATED / DIVORCED PARENTS: Rapid City Counseling Inc., d.b.a. Stacy L. Keyser will not bill the other parent unless that parent makes arrangements with us. It is your responsibility to seek any reimbursement from that parent. If your child is a client, you are requested to inform the other parent that your child is receiving services at Rapid City Counseling Inc., d.b.a. Stacy L. Keyser . MISSED APPOINTMENTS AND LATE CANCELLATIONS: Your insurance cannot be billed for missed or late-cancelled appointments and you are fully responsible for the payment of the missed or late-cancelled appointment. The charge for a missed or late-cancelled appointment is 75% of the scheduled service.
RELEASE OF INFORMATION FOR MEDICAL INSURANCE COVERAGE TO INSURANCE, MANAGED CARE OR EAP COMPANY: In order to process and determine benefits payable, I hereby authorize my provider to release any necessary part of the client's record, as specified by the Notice of Privacy Practices, to any insurance carrier or entitlement program, which may be obligated to pay all or part of treatment charges. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall remain in effect and valid until this office receives a written revocation signed by the client or other authorized person. I certify that the information I have furnished is true and correct. Rapid City Counseling Inc., d.b.a. Stacy L. Keyser bills through a variety of companies. Check with provider for specific contact numbers. Personal checks, that identify you, will be presented for deposit at your provider’s financial institution. ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION OR CREDIT CARD / DEBIT CARD AUTHORIZATION: As a convenience to clients, an EFT or Credit Card/Debit Card option is available for payment of services rendered by Rapid City Counseling Inc., d.b.a. Stacy L. Keyser. Please request an EFT/Credit Card/Debit Card Authorization Form to authorize a payment on your account. MISSED APPOINTMENTS: If you consecutively miss TWO appointments without acknowledgement and calling to reschedule your missed appointment, Stacy L. Keyser may choose to discontinue services with you. CONSENT FOR THE USE OF EMAIL AND TEXTS: Rapid City Counseling Inc., d.b.a. Stacy L. Keyser cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Rapid City Counseling Inc., d.b.a. Stacy L. Keyser is not liable for improper disclosure of confidential information that is not caused by intentional misconduct.
By signing below the client and/or responsible party is acknowledging and consenting to receive non-encrypted email and text message communication.
Notice of Privacy Practices: I acknowledge that I have received the Notice of Privacy Practices from Rapid City Counseling Inc., d.b.a. Stacy L Keyser:

_____

Signature of Adult Client or Responsible Party **DATE**

Rapid City Counseling Inc.

CHILDHOOD AND FAMILY HISTORY - Part 1: Demographics and Family CHILD / HOUSEHOLD INFORMATION

Child's Name: _____ Date of Birth: _____

Gender: _____ Grade: _____

What concerns do you have for your child for which you are seeking assistance?: _____

_____

Mother's Name: _____ Mother's Home/Cell Phone:_____

Mother's Email Address:_____

Mother's Street Address: _____

Mother's City, State, Zip: _____

Father's Name:_____ Father's Home/Cell Phone: _____

Father's Email Address:_____

Is Father's Address Different from Mother's?: _____

Father's Street Address: _____

Father's City, State, Zip: _____

Parents' Status: _____

If separated or divorced, child's age at time of separation: _____

Joint Custody?: _____

Legal Custody with: _____

Physical Custody with: _____

Is there a Parenting Plan in place? (If yes, a copy MUST be provided to Therapist): _____

Please list ALL other people living in the home:

Name,	Age,	Relationship to Child
Name,	Age,	Relationship to Child
Name,	Age,	Relationship to Child
Name,	Age,	Relationship to Child
Name,	Age,	Relationship to Child
Name,	Age,	Relationship to Child

FAMILY HISTORY / HEALTH
Please check all that apply

1. Alcohol / drug difficulties
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If "Others" is checked, please specify: _____

2. Nervousness
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

3. Seizures or epilepsy
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

4. Tourette's syndrome
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

5. Migraine headaches
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

6. Depression
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

7. Anxiety or nervousness
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

8. Emotional disturbance
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

9. Behavior disorder
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

10. Mood disorder
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

11. Reading problems
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

12. Math problems
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

13. Learning disability
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

14. Speech difficulties
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

15. Hyperactive
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

16. Attention difficulties
☐ Child's father
☐ Child's mother
☐ Child's brother(s)
☐ Child's sister(s)
☐ Others
If " Others" is checked, please specify: _____

Are there any other family concerns or information in relation to your family that you would like to share and that may assist us in meeting your child's needs?: _____
_____

CHILDHOOD AND FAMILY
HISTORY - Part 2: Child's
Medical History
MEDICAL HISTORY AND CHILD'S BACKGROUND

List any problems during pregnancy. (Health, Illness, Injuries, Medications): _____
_____

Was pregnancy full-term?: _____ If no, how many weeks?:_____

Birthweight (pounds, ounces): _____

Apgar Score: _____

Check any that apply to delivery:

C-Section
Forceps?
Breech Presentation?
Newborn / Infant Difficulties (Check all that apply)
Born with umbilical cord around neck
Had trouble breathing
Turned blue (cyanosis)
Needed oxygen
Turned yellow (jaundice)
Born with a heart defect
Born with other defects
Injured during birth
Was in the hospital more than 7 days

Any other problems with labor or delivery?: _____

DEVELOPMENTAL MILESTONES

Please list the ages at which your child first:

Sat unaided: _____

Crawled: _____

Walked independently: _____

Spoke single words (other than mama and dada): _____

Talked using 2-3 words: _____

Was toilet trained (daytime): _____

Was toilet trained (at night): _____

Please list any difficulties or delays that occurred in your child's infant years:_____
_____

CHILD'S HEALTH CONDITIONS

Please indicate all ages condition existed

1. Ear Infections
- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16+ years

2. Meningitis
- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16+ years

3. Seizures or epilepsy
- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16+ years

4. High fevers (over 103 For 39 C.)
- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16+ years

5. Head Injury
- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16+ years

6. Trouble with Ears or Hearing
- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16+ years

7. Trouble with Eyes or Vision
- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16+ years

8. Surgery
- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16+ years

9. Hospitalizations
- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16+ years

10. Heart problems
- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16+ years

11. Lead Poisoning
☐ Never
☐ 0-1 year
☐ 2-5 years
☐ 6-10 years
☐ 11-15 years
☐ 16+ years

12. Allergies to Food
Never
0-1 year
2-5 years
6-10 years
11-15 years
16+ years

13. Allergies to Environment
☐ Never
☐ 0-1 year
☐ 2-5 years
☐ 6-10 years
☐ 11-15 years
☐ 16+ years

14. Anemia
☐ Never
☐ 0-1 year
☐ 2-5 years
☐ 6-10 years
☐ 11-15 years
☐ 16+ years

15. Poisoning or Overdose
☐ Never
☐ 0-1 year
☐ 2-5 years
☐ 6-10 years
☐ 11-15 years
☐ 16+ years

16. Diabetes (check age at onset)
☐ Never
☐ 0-1 year
☐ 2-5 years
☐ 6-10 years
☐ 11-15 years
☐ 16+ years

17. Asthma (check age at onset)
☐ Never
☐ 0-1 year
☐ 2-5 years
☐ 6-10 years
☐ 11-15 years
☐ 16+ years

18. Pneumonia
☐ Never
☐ 0-1 year
☐ 2-5 years
☐ 6-10 years
☐ 11-15 years
☐ 16+ years

Child's Physician: _____

Child's Physician: _____

Physician's Phone Number: _____

Is your child currently taking any medications?: _____

Child's current medication(s) and reason(s): _____
_____

Please list any IMPORTANT medical information, injuries and reasons for hospitalizations or surgeries.: _____
Please share if your child has had any prolonged illnesses. If they had to take medication over a long period of time, what was the medication and were there any side effects?: _____
_____

Has your child ever had a neurological exam?: _____

Neurologist's Name:_____ Date of Exam: _____

Reason for Exam: _____

Has your child had a psychological evaluation?: _____

If yes, what were the results? (Please provide therapist a copy of results if you have them.):
_____

Has your child ever had psychological counseling or therapy?: _____

If yes, counselor's name: _____

If yes, reason for counseling: _____

Allergies to medicines?: _____

If yes, please list medication and describe reaction.: _____

Allergies to foods?: _____

If yes, please list food(s) and describe reaction.: _____

Please list any other concerns about your child's health.: _____

COORDINATION

Please rate your child's abilities in the following areas:

1. Walking
☐ Good
☐ Average
☐ Poor

2. Running
☐ Good
☐ Average
☐ Poor

3. Balancing
☐ Good
☐ Average
☐ Poor

4. Throwing
☐ Good
☐ Average
☐ Poor

5. Catching
☐ Good
☐ Average
☐ Poor

6. Shoelace Tying
☐ Good
☐ Average
☐ Poor

7. Buttoning
☐ Good
☐ Average
☐ Poor

CHILDHOOD AND FAMILY
HISTORY - Part 3: Child's
Functional History

FUNCTIONAL CONDITIONS

Please check all that apply to show when a condition started or existed.

Sleeping problems

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

2. Crying often and easily

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

3. Clingy

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

4. Possessive with parents

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

5. Head banging

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

6. Thumb sucking

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

7. Nail biting

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

8. Rocks back and forth

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

9. Has tics / twitches

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

10. Accident prone

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

11. Temper tantrums

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

12. Over-activity (seems to always be moving)

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

13. Irritability

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

14. Self-destructive behavior

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

15. Extreme reactions to noise or sudden movement

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

16. Tactile sensitivity (bothered by tags or other materials)

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

17. Tendency to make odd sounds, grunts or snorts

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

18. Tendency to twitch or jerk arms or head

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

19. Trouble getting along with peers

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

20. Trouble listening to authority and following rules

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

21. Seems to "zone out"

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

22. Low self-image or -esteem (negative self-talk)

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

23. Eating difficulties

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

24. Eats odd things (non-nutritive)

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

25. Wetting or soiling problems

- ☐ Never
- ☐ 0-1 year
- ☐ 2-5 years
- ☐ 6-10 years
- ☐ 11-16 years
- ☐ Current

CHILDHOOD AND FAMILY HISTORY - Part 4: Child's Behavioral History

TEMPERAMENT

Please indicate whether your child exhibits any of the following behaviors:

- ☐ Is easily overstimulated in play:
- ☐ Seems overly energetic in play:
- ☐ Has a short attention span:
- ☐ Seems impulsive:
- ☐ Lacks self-control:
- ☐ Overreacts to problems:
- ☐ Seems unhappy most of the time:
- ☐ Withholds affection:
- ☐ Uncomfortable meeting new people:
- ☐ Hides feelings:
- ☐ Has trouble with changes:
- ☐ Cannot calm down:
- ☐ Requires lots of attention:
- ☐ Has fears:

What does your child do when he/she is stressed, angry or frustrated?: How does your child express his/her sadness?:

BEHAVIORAL SYMPTOMS - ATTENTION / INATTENTION

Please check all that currently apply:

- ☐ Fails to give close attention to details, makes careless mistakes:
- ☐ Has difficulty maintaining attention in tasks or play activities:
- ☐ Does not seem to listen when spoken to directly:
- ☐ Does not follow through on instructions and fails to finish work:
- ☐ Has difficulty organizing tasks and activities:
- ☐ Avoids or reluctantly engages in tasks requiring sustained mental effort:
- ☐ Often loses things necessary for tasks or activities:
- ☐ Is distracted by things around him/her:
- ☐ Is forgetful in daily activities:
- ☐ Difficulty maintaining alertness, listening to requests, executing decisions:

☐ Fidgets with hands or feet or squirms in seat, difficulty being still:
☐ Leaves seat in classroom or other situations in which remaining seated is expected:
☐ Runs about or climbs excessively in situations when it is inappropriate:
☐ Has difficulty playing or engaging in activities quietly:
☐ Is "on the go" or often acts as if "driven by a motor":
☐ Talks excessively:
☐ Blurts out answers before questions have been completed:
☐ Has difficulty awaiting turn:
☐ Interrupts or intrudes on others (butts into conversations, etc.):
☐ Depressed mood or irritable mood most of the day:
☐ Depressed mood or irritable mood most of the day:
☐ Persistent fear of social or performance situations:
☐ Decrease in pleasure in activities (things are less fun):
☐ Excessive fear of specific objects or situations:
☐ Decrease or increase in appetite:
☐ Excessive or persistent worry about a parent or caregiver:
☐ Difficulty sleeping or seems to sleep a lot:
☐ Reluctance or refusal to go to school:
☐ Fatigue or loss of energy (tires easily or seems tired often):
☐ Excessive need for reassurance:
☐ Feelings of worthlessness, down on himself/herself:
☐ Concerns about their competence or ability:
☐ Loss of ability to concentrate:
☐ Inability to relax:
☐ Reluctance to be alone, wants parent or caregiver around:
☐ Complains of aches and pains:
☐ Feels hopeless, may wish he/she was dead:
☐ Unusual fears or aversions:

HOME BEHAVIOR

What types of discipline to you use with your child?: _____

_____

What form of discipline do you find to be most effective?: _____

What are your child's main hobbies and interests?: _____

What are your child's main hobbies and interests?: _____

What does your child enjoy doing the most?: _____

What do you see as your child's strengths, abilities, talents?: _____

_____

Rapid City Counselors
Stacy Keyser, MS, LPC-MH
528 Kansas City St., Suite 5;
Rapid City, SD 57701
www.rapidcitycounselors.com
Phone: 605-299-9100
Fax: 605-250-5159

Client Email / Text Message Informed Consent

Email and text messages can be a convenient, preferred and requested form of communication between clients/responsible parties and providers. However, such communications create risks to your confidentiality. We want you to be aware of the risks and make an informed decision regarding these forms of communication.

Risk of Using Email and Text Communication

The transmission of client information by email and/or texting has several risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

➢Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

➢Emails and text senders can easily misaddress an email or text and send the information to an undesired recipient.

➢Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.

➢Employers and online services have a right to inspect emails sent through their company systems.

➢Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.

➢Emails and texts can be used as evidence in court.

➢Emails and texts should be assumed to be unencrypted and, therefore, it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the Use of Email and Text Communication

Rapid City Counselors cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Rapid City Counselors is not liable for improper disclosure of confidential information that is not caused by intentional misconduct. Client/responsible party must acknowledge and consent to the following conditions:

➢Email and texting are not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.

➢Email and texts should be concise. The client/responsible party should call and/or schedule an appointment to discuss complex and/or sensitive situations.

➢Emails may be printed and filed into the client's medical record. Texts may be printed and filed as well.

➢Provider will not forward client's/responsible party's identifiable emails and/or texts without the client's/responsible party's written consent, except as authorized by law

➢Clients/responsible parties should not use email or texts for communication of sensitive personal information.

➢Provider is not liable for breaches of confidentiality caused by the client/responsible party or any third party.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication using email and/or texts between Rapid City Counselors and me, and consent to the conditions as outlined, as well as any other instructions that may be imposed to communicate with me by email or text.

PLEASE FILL OUT COMPLETELY

Client Name: _____

Email Address: _____

Mobile Number 1: _____ Mobile Number 2: _____

Client/responsible party is responsible for updating the information on this form if it changes.

_____I do **NOT** consent to the use of email or text message communications.

_____ _____

Signature Client/Responsible Party Date

_____

Printed Name Client/Responsible Party

A photocopy or fax of this authorization shall have the same force and effect as the original.

Revised: 11-21-2019 DW

Rapid City Counselors
Stacy Keyser, MS, LPC-MH
528 Kansas City St., Suite 5;
Rapid City, SD 57701

Social Media Policy

This document outlines my office policy related to the use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Fanning

I keep a Facebook page for my professional practice to allow people to share my blog posts and practice updates with other Facebook users. All the information shared on this page is available on my website. You are welcome to view my Facebook page and read or share articles posted there, but I do not accepts clients as Fans of this page. I believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and I believe it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list. In addition, the American Counseling Association's Ethics Code prohibits my soliciting testimonials from clients. I believe that the term "Fan" _comes too close to an implied request for a public endorsement of my practice. Note that you should be able to subscribe to the page via RSS without becoming a Fan and without creating a visible, public link to my page. You are more than welcome to do this.

Following

I publish a blog on my website, and I post psychology news on LinkedIn, Instagram, and Facebook. I have no expectation that you as a client will want to follow my blog or those social media feeds. However, if you use an easily recognizable name on one of those social media platforms and I happen to notice that you've followed me, we may briefly discuss it and its potential impact on our working relationship. My primary concern is your privacy. If you share this concern there are more private ways to follow me, such as using and RSS feed, which would eliminate your having a public link to my content. You are welcome to use your own discretion in choosing whether to follow me. Note that I will not follow you back. I follow other health professionals on Instagram. I do not follow current or former clients on blogs or other social media platforms. My reasoning is that I believe casual viewing of clients' _online content outside of the therapy hour can create confusion regarding whether it's being done as a part of your

treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Interacting

Please do not use SMS (mobile phone text messaging) or any messaging service through any social media platform, such as Facebook or LinkedIn, to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall posts, @replies, hashtags, or other means of engaging with me in public online if we have an established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility of these exchanges becoming a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone.

Use of Search Engines

It is NOT a regular part of my practice to search for clients using Google, Facebook, or any other search engine. An extremely rare exception may be during times of crisis. If I have reason to suspect that you are in danger and you have not been in touch with me via our usual means (appointments, phone, or email) there might be an instance in which using a search engine to find you, find someone close to you, or to check on your recent status updates, becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Google Reader

I do not follow current or former clients on Google Reader, and I do not use Google Reader to share articles. If there are things you want to share with me that you feel are relevant to your treatment whether they are news items or things you have created, I encourage you to bring these items of interest into our sessions.

Business Review Sites

You may find my counseling practice on sites such as ProCounselor, Psychology Today, LinkedIn, HealthGrades, Google, or other platforms that list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating or endorsement from you as my client. The American Counseling Association Ethics Code states that it is unethical for counselors to solicit testimonials. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality of you. You should also be aware that if you are using these sites to communicate with me indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or social networks for your own privacy and protection. If you feel I have done something harmful or unethical and you do not

feel comfortable discussing it with me, you can always contact the American Counseling Association, which oversees licensing, and they will review the services I have provided. The ACA can be reached at: American Counseling Association; 6101 Stevenson Ave., Suite 600; Alexandria, VA 22304; or 800-347-6647.

Location-Based Services

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in" _from my office or if you have a passive LBS app enabled on your phone.

Email

I prefer using the only the Client Portal to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet Service Providers (ISP). While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the System Administrator(s) of the ISP. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Conclusion

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about this policy or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

I acknowledge that I have read the Social Media Policy of Rapid City Counselors.

_____ _____

Signature of Client (or Guardian, if Client is a minor) *Date*

Rapid City Counselors
528 Kansas City St., Suite 05,
Rapid City, SD 57701
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NOTICE OF PRIVACY PRACTICE

Rapid City Counseling, Inc

NOTICE OF PRIVACY PRACTICES
This notice describes how psychological information about you may be used and disclosed and how you can get access to this information.

Please review this carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY
Effective Date, Restrictions, and Changes to Privacy Policy

We are required by applicable federal and state law to maintain the privacy of your psychological information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your psychological information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect July 15, 2019 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all psychological information we created or reviewed before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice available to our clients at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses & Disclosures of Psychological Information for Treatment, Payment, and Health Care Operations

Our office may use or disclose your protected health information (PHI) for treatment, payment and health care operation purposes. To help clarify these terms, here are some definitions:

• PHI refers to information in your health/medical record that could identify you. This does not include psychotherapy notes.
• Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when your provider consults with another health care provider, such as your family physician or another psychologist or counselor.

• Payment is when we obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
• Health care operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
• Use applies only to activities with our office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
• Disclosure applies to activities outside our office, such as releasing, transferring or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

Our office may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above 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 form from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes that are made about your conversation during a private, group, joint or family counseling session with your therapist. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that 1) we have relied on that authorization, or 2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

Our office may use or disclose PHI without your consent or authorization in the following circumstances:
• Child Abuse: If our office has reasonable cause to suspect that a child under the age of eighteen has been abused or neglected, we are 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 is conducting an investigation, then we are required to disclose your mental health records upon receipt of a subpoena from the Board.
• 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 a 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 we judge that a disclosure of confidential information is necessary to protect against a clear or substantial risk of imminent harm being inflicted by you on yourself or another person, our office may disclose such information to those persons who would address such a problem (for example, the police or the potential victim).
• Workers Compensation: If you file a workers compensation claim, our office is 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. Patient's Rights and Psychologist's Duties Patient Rights:

• Right to Request Restrictions – you have the right to request restrictions on certain uses and disclosures of protected health information about you. However, our office is not required to agree to a restriction you request.
• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – you have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing someone in our office. Upon your request we will send your bills to another address.)
• Right to Amend – you have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
• Right to an Accounting – you generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
• Right to a Paper Copy – you have the right to obtain a paper copy of the notice from our office upon request, even if you have agreed to receive the notice electronically. Psychologists Duties:
• We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
• We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
• If we revise our policies and procedures, we will give you a copy of the updated policies and procedures upon your next visit to our office.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or if you are concerned that our office has violated your privacy rights, or you disagree with a decision our office has made about access to your records or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact Rapid City Counseling, Inc. by calling (605)299-9100. You may also send a written complaint to the Secretary of the US Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

By signing below, I acknowledge that I have read and accept the Notice of Privacy:

NAME: _____

Rapid City Counseling Inc.
528 Kansas City St., Suite 5
Rapid City SD 57701-2766
605-299-9100

GENERAL INFORMED CONSENT

General Information
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process
You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality
The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:
1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney. Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name. If we see each other accidentally outside of the therapy office, I will not acknowledge

you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Telehealth Services

"Telehealth" is a mode of delivering healthcare services that utilize information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health care providers. Source: SD HB 1183 (2017).

Sometimes convenience, distance, or other circumstances make "in-person" treatment challenging or may even prohibit a treatment from occurring. Thus, after an initial clinical intake and establishment of a therapeutic relationship has occurred, treatment delivery occurring via interactive video conferencing (i.e., virtual "face-to-face" sessions) and/or telephone sessions may occur in lieu of, or in addition to, "in-person" therapy sessions when it is determined clinically appropriate and feasible by Rapid City Counseling, Inc. (hereinafter "Provider"). These sessions will be conducted with the use of real-time interactive audio and visual technology to allow for the provision of mental health services to a remote in-state location.

The video conferencing system utilizes https://rapidcitycounseling.theranest.com/ for telehealth services with Provider meets HIPAA regulations for privacy protection and a Business Associate Agreement (BAA) has been established between Provider and the system, however, privacy cannot be guaranteed. All existing confidentiality protections under federal and South Dakota state law apply to information disclosed during telehealth sessions and reasonable and appropriate efforts will be made to eliminate any confidentiality risks associated with telehealth sessions.

Risks to video conferenced therapy sessions include (but are not limited to): session disconnections due to technology issues, delays due to connection or other technology issues, discomfort with virtual face-to-face versus in-person treatment sessions, difficulties interpreting nonverbal communications or behaviors due to decreased visual availability or clarity, breach of information beyond Provider's control, limited access to immediate resources should instance of risk of self-harm or harm to others are present. Additionally, dependent on your insurance provider, a lack of reimbursement for telehealth sessions may occur.

The provider will weigh the advantages against potential risks prior to proceeding with telehealth sessions and will make you aware of specifics about how risks apply to your treatment before using the technology. All other office privacy practices and policies provided to you apply to telehealth sessions just as they would in-person sessions.

There are, by law, exceptions to confidentiality which apply whether treatment is being provided in-person or via video conferencing and include mandatory reporting of any child, elder, and/or dependent adult abuse as well as any instance in which Provider suspects a person to be of risk of harm to themselves or someone else. Additionally, dissemination of information from Providers to other entities may occur if written consent has been provided. Certain legal situations may also lend themselves to exceptions to confidentiality. While psychotherapy of various kinds has been found to be effective in treating a wide range of mental health disorders, as well as personal and relational issues, there is no guarantee that all

treatment will be effective. Thus, while benefits may be seen from therapy provided via video conferencing, results cannot be guaranteed or assured.

By signing this document, you are declaring your agreement with the following statement: I have read and understood the information provided above. I understand I have the right to discuss any of this information with Provider and to ask any questions I may have. I understand I may choose to revoke this consent via written request and/or inform Provider of my desire to discontinue treatment at any time.

_____

Patient (if 18 or older):

_____

Legal Guardian, if signing for patient/student/person:

_____

Relationship to patient/student/person:

_____

Date:

Rapid City Counseling Inc.
528 Kansas City St., Suite 5
Rapid City SD 57701-2766
605-299-9100 7.

COVID-19 INFORMED CONSENT

Informed Consent During COVID-19

This document contains important information about the COVID-19 public health situation. Please read this carefully and let us know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, it may require us to meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if we believe it is necessary, Rapid City Counseling, Inc. may determine that we need to return to telehealth for everyone's wellbeing.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, we will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone safer from exposure, and sickness. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Select Agree to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free:
- If you have any bacterial or viral symptoms, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, we won't charge you our normal cancellation fee.:
- If a resident of your home tests positive for the infection, or is sick, you will immediately let Rapid City Counseling, Inc. know and we will then [begin] resume treatment via telehealth.:

We may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.
Our Commitment to Minimize Exposure
Rapid City Counseling, Inc. has taken steps to reduce the risk of spreading any infection or virus within the office. Please let us know if you have questions about these efforts.

We are committed to keeping our environment safe and healthy. If you show up for an appointment and we believe that you have a fever or other symptoms, we will have to require you to leave immediately. We can follow up with services by telehealth as appropriate. If your clinician tests positive for the coronavirus, we will notify you so that you can take appropriate precautions.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.
Your signature below shows that you agree to these terms and conditions.

Client Signature Patient (if 18 or older): _____

Legal Guardian, if signing for patient/student/person: _____

Relationship to patient/student/person: _____

Date: _____

Rapid City Counseling Inc.
528 Kansas City St., Suite 5
Rapid City SD 57701-2766
605-299-9100 9.

FINANCIAL POLICY EFFECTIVE: 10/11/ 2021

Client First Name: _____

Client Last Name: _____

This agreement is to define financial obligations to our practice by the clients we serve. We strive to provide each client with excellence in service while minimizing administrative costs.

Payment is due at the time of service. As a courtesy, we will file your medical insurance claims. The estimated co-payment for treatment is due at the time treatment is provided. This amount may be adjusted depending on the final payment from insurance. Questions concerning insurance coverage should be directed to your insurance company using the number on the back of your insurance card.

Credit Card on File.
It is mandatory to have a credit card on file so that your copayment, % of services not covered by insurance, or applicable deductible amount can be paid on the day of service. Must be verified every six months and signing a second document is required.

All invoices 60 Days Past Due will be charged a $25.00 late fee and an 18% annual interest rate. If no payments are made by the following month, an additional $10.00 late fee will incur. If no efforts are made to pay on the account at 90 days, the account is considered delinquent and the collection process begins. You will receive a statement for all invoices 90 days and older regardless of pending insurance due upon receipt.

Self-pay:
Payment in full is expected at the time of service for ALL self-pay clients. Please ask for a superbill if the intention is to submit to insurance for reimbursement.

Payment Methods & Insufficient Funds:
Cash, Check, ACH (Bank Transfer), Master Card, Visa, Discover, and AmEx. All returned checks & denied credit card payments are charged a $45.00 fee per occurrence.

Out of Session Services:
Phone calls, Emails, and Texting your provider will incur charges. All emails and texts exceeding 20 words and phone calls exceeding 5 minutes will incur a charge of $35.00. These charges are

billed to the client, the credit card on file will be charged, and invoices will be emailed. These services cannot be billed to insurance.

Appointment Policy

Please notify our office 24 hours in advance for rescheduling or canceling appointments. This notice allows us to accommodate other patients. We provide two courtesy late cancellations or no-shows. Two repeated NSF's or denied credit card payments may be cause for dismissal from our practice. If reschedules or cancellations are within 24 hours, we reserve the right to charge $85.00 directly to the client. Keeping appointments is the client's responsibility.

Our team is committed to providing you excellence in mental health care.

Printed Name: _____

Signature: _____

Date: _____

Relationship to the Client*: _____

(*Client Parent, Grandparent, Legal Guardian, Sibling)

Rapid City Counseling Inc.
528 Kansas City St., Suite 5
Rapid City SD 57701-2766
605-299-9100

Credit / Debit Card Payment Consent (TN)

Client name: (Card holder) _____

Name on card if different than client: _____

Credit card information including bearer's name, card number, expiration date, billing zip code, and CVV is required to be given before the first appointment.

I authorize Rapid City Counselors, Inc. to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that Rapid City Counseling, Inc. will charge my card as a late-cancel or a no-show if I do not show up for the appointment. I will be billed 70% of the full appointment rate.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials: _____

Card holder Initials (If different than client): _____

Date: _____

Signature:_____

Rapid City Counseling Inc.
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Rapid City SD 57701-2766
605-299-9100

Statement of Counseling Children and Adolescents

As a counselor treating your child or adolescent, my goal is to create a safe emotional space for your child toexplore and manage their own feelings. To that end, I want to be clear that as a therapist I see my role as treatment-oriented, not as a party in legal disputes.

I will:

● Keep your child's physical and emotional safety as my top priority at all times.

● Ask you to avoid coaching your child on what to do or say in therapy or ask your child for an accounting on whatthey have said to me about their lives and feelings.

● Communicate regularly with both parents to the extent I am able about their concerns and keep them informedabout the treatment plan for their child.

● Ask for a copy of any pertinent court orders addressing custody access, consent to treat and privacy.

● Follow legal mandates regarding your privacy and the reporting of the risk of harm to children.

● Speak to court-appointed Law Guardians under court order to assist them in describing and representing thechild's needs.

● Require the payment of copays at the time of service and prepare monthly documentation if needed forreimbursement.

I will not:

● Compromise the privacy of any child unless there is a safety concern.

● Speak to lawyers representing either parent in a custody or divorce dispute. Please do not ask me to speak toyour lawyer or allow your lawyer to subpoena me to court.

● Conduct custodial evaluations – as that is outside the scope of my current practice.

● Consent to any recordings of sessions or phone calls without my knowledge.

● Testify in court unless required to do so by a judge. My daily billed rate for appearing in court is a minimum of
$350.00 for two hours plus travel.

● Hold joint sessions with divorced or separated parents with or without their child present.

Please sign to indicate that you have read these disclosures and are willing to abideby them while your child is in treatment with me.

Name: _____

Date: _____