Rapid City Counselors
HOLISTIC APPROACH to MENTAL HEALTH

Rapid City Counseling Inc.
909 St. Joseph St., Ste 201
Rapid City SD 57701-5037
605-299-9100

0. 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):

Other, please describe::

Current Symptoms (circle all that apply & note factors that aggravate or relieve symptoms):

Other::

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

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1. CLIENT INITIAL REGISTRATION

DATE:

CLIENT'S LAST NAME:

CLIENT'S FIRST NAME:

CLIENT DATE OF BIRTH:

CLIENT'S PREFERRED NAME:

ADDRESS:

CITY:

STATE:

ZIP:

PHONE NUMBER:

RIGHT TO REFUSE SERVICES

Rapid City Counseling Inc. (d.b.a. Rapid City Counselors) may terminate services for the following reasons. 1. If there is a lack of compliance with company policies (such as attendance, prompt payment of services rendered.) 2. If our Provider believes that you are not benefiting from treatment. 3. If the services requested are an inappropriate fit for servicing Providers. 4. If client conduct is inappropriate

FINANCIALLY RESPONSIBLE PERSON

Relationship to Client:

PRIMARY INSURANCE

Choose One:

Carrier or Designate If Self Pay:

Primary Medical Insurance Policy Holder's First & Last Name. -(Self-Pay: Enter your name):

EMAIL ADDRESS:

SOCIAL SECURITY # (IF MINOR-PARENT/GUARDIAN SSN):

GENDER:

PRIMARY CARE PHYSICIAN:

MENTAL HEALTH CARE

MAIN CONCERN:

Are you a returning client?:

If yes, when and with which Provider?:

Please list past counseling/ treatment/evaluation (provider, approximate dates, and primary concerns treated):

REFERRED BY:

Primary Medical Insurance Policy Holder's Date of Birth (DOB). - (Self-Pay enter client's DOB):

Primary Medical Insurance Policy Holder's Relationship to Client:

Primary Medical Insurance Policy Holder's Phone # - (Self-Pay Enter Client's Phone Number):

Primary Medical Insurance Policy # - TRICARE (ENTER Service Member's DBN/SSN) - (Self Pay enter 000000)):

PRIMARY Medical Insurance Group #:

PRIMARY Policy Holder's Residential Address (Street, City, State, Zip) - -(Self-Pay or Same as Client) type "same":

SECONDARY INSURANCE (IF APPLICABLE)

SECONDARY Medical Insurance Company:

SECONDARY Medical Insurance Policy Holder's Name:

SECONDARY Medical Insurance Policy Holder's DOB:

SECONDARY Medical Insurance Policy Holder's Relationship to Client:

SECONDARY Medical Insurance Policy Holder's Phone # if Different from Client:

SECONDARY Medical Insurance Policy Holder's Insurance Policy # - (Tricare DBN/SSN):

SECONDARY Medical Insurance Policy Holder's Group #:

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0. SOCIAL MEDIA POLICY

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 my Instagram or Facebook feeds. However, if you use an easily recognizable name on Instagram or Facebook and I happen to notice that you've followed me on those platforms, 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, 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 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

NAME::

DATE:

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0. 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 by calling (605)299-9100. You may also send a written complaint to the Secretary of the US Department of Health and Human Services. Rapid City Counselors office personnel can provide you with the appropriate address upon request.

☐ I acknowledge that I have read the Notice of Privacy

NAME: I acknowledge that I have read the Notice of Privacy:

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0. 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:

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2. FINANCIAL POLICY & INFORMED CONSENT

Client Full Name:

This agreement defines financial obligations from Rapid City Counseling Inc. (DBA: Rapid City Counselors), hereafter abbreviated as RCC to our clients. We strive to provide each client with excellence in service while minimizing administrative costs.

Insurance & Financial Policy

At Rapid City Counseling Inc., we strive to make the billing process as transparent as possible. If you have a health insurance policy, it may provide coverage for mental health treatment; however, you—not your insurance company—are ultimately responsible for the full payment of our fees. We strongly encourage you to confirm your mental health benefits directly with your insurance provider before beginning treatment.

As a courtesy, Rapid City Counseling Inc. checks your insurance benefits prior to starting services. Please note, however, that the information provided by your insurance company may be inaccurate or subject to change at any time. We are unable to negotiate or advocate for benefits directly with your insurance company. If your insurance fails to cover our services, you remain responsible for the full amount of each session. Any unpaid balances not resolved within 60 days of your last service may be charged to the credit card we have on file.

Insurance companies may also require our clinicians to assign you a mental health diagnosis and, in some cases, to provide additional clinical information such as treatment plans, summaries, or copies of your entire record. This information may be stored by the insurance company in its databases and used at its discretion.

Payment Responsibility: Clients (or their responsible party) are responsible for all co-payments, co-insurance, and deductibles at the time of service.

Adjustments & Assignments: The total amount due may be adjusted based on final payment received from your insurance company. Insurance benefits are assigned to the provider as credit toward outstanding balances.

Non-Covered or Medically Unnecessary Claims: Our practice is not liable for claims deemed medically unnecessary by your insurance company. Clients are financially responsible for any charges not covered. If insurance does not pay directly to our office, the client is responsible for paying the total amount for services rendered.

Payment Agreement: By receiving services, you acknowledge the obligation to pay the assessed charges in full at the time of service unless alternative arrangements have been authorized.

Out-of-Network Coverage: If we are not in-network with your insurance company, a superbill may be provided for you to submit to your insurance company for possible reimbursement.

Insurance Coverage Inquiries: All questions about your insurance coverage should be directed to your insurance provider using the contact information on the back of your insurance card.

LATE FEES, INTEREST RATES, COLLECTIONS, AND INSUFFICIENT FUNDS POLICY

Late Fee and Interest: All invoices that remain 60 days past due will be subject to a $25.00 late fee and a 15% annual interest rate on the outstanding balance.

Subsequent Late Fees: If payment is not made within the following month, an additional $10.00 late fee will be applied to the overdue account per month.

Delinquency and Collection Process: If no efforts are made to settle the account after 90 days, the account will be considered delinquent, and the collection process will commence.

Statement Issuance: The client will receive a statement for all invoices the month following services, detailing the outstanding balance and the due amount.

Non-Sufficient Funds (NSF) Fees: A $45.00 fee will be charged for all returned checks due to NSF, and a $25.00 fee will be charged for all debit/credit cards due to NSF.

Legal Disclaimer: This agreement is legally binding between Rapid City Counseling Inc. (d.b.a. Rapid City Counselors) and the Client or Responsible Party. By signing below, the undersigned acknowledges understanding and accepting the terms outlined herein. Failure to comply with the terms of this agreement may result in legal action to recover any outstanding balances, including reasonable attorney's fees and court costs.

SEPARATED / DIVORCED PARENTS: Rapid City Counseling Inc. (d.b.a. Rapid City Counselors), hereafter referred to as RCC, will not bill the co-parent. It is your responsibility to seek any reimbursement from that co-parent. If your child is a client, you must inform the other co-parent that your child receives services at Rapid City Counseling.

DEBIT / CREDIT CARD AUTHORIZATION & RECURRING CHARGES AGREEMENT

This section outlines the terms and conditions governing the use of credit card information and recurring charges between Rapid City Counseling Inc. (d.b.a. Rapid City Counselors) and the undersigned individual, from now on referred to as "the Client."

Credit Card on File:
The Client must have a credit card on file to facilitate the prompt payment of self-pay amounts, copayments, coinsurance, services not covered by insurance, or applicable deductible amounts on the day of service.

Recurring Charges:
By signing below, the Client authorizes regularly scheduled charges to their credit card or bank account for the purposes above. The following conditions apply:

1. Receipt and Statement:
Upon request, RCC will provide a receipt for each payment, and the charge will be reflected on the Client's credit card or bank statement.

2. Notification:
The Client acknowledges and agrees that no prior notification will be provided unless there are changes in the date or amount of the recurring charges. In such circumstances, the client will receive notice via email, EHR text message via our secure SMS system, or telephone call/voicemail.

3. Credit Card Authorization Verification:
Credit Card Authorization forms must be verified every six months. The Client understands that signing a second document may require continued authorization.

Legal Disclaimer:
This agreement is a legally binding contract between the Provider and the Client. By signing below, the undersigned acknowledges understanding and accepting the terms outlined herein. Failure to comply with the terms of this agreement may result in the discontinuation of services or legal action to recover any outstanding balances, including reasonable attorney's fees and court costs.

SELF-PAY

For ALL self-pay services, payment in full is required at the time of service.

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 per fifteen-minute increment. These charges are billed to the credit card, and an invoice will be emailed. These services CANNOT be billed to insurance

APPOINTMENT POLICY

You must notify our office 24 hours before rescheduling or canceling appointments. This notice allows us to accommodate other clients. We provide two courtesy late cancellations, and upon the third late cancellation, RCC charges your card on file a $85.00 fee. This fee will immediately be charged to your card on file. If you consecutively miss two appointments without acknowledgment and call to reschedule, RCC will discontinue services. If you do not communicate that you are not coming to an appointment, it is considered a "no-show," your card on file will immediately be charged an $85 fee. Keeping all scheduled appointments is your responsibility

Printed First & Last Name of Responsible Party:

Relationship to the Client:

Signature of Responsible Party:

Date:

Rapid City Counselors
HOLISTIC APPROACH to MENTAL HEALTH

Rapid City Counseling Inc.
909 St. Joseph St., Ste 201
Rapid City SD 57701-5037
605-299-9100

3. PAYMENT INFORMATION

ACCOUNT HOLDER INFORMATION

Financially Responsible Person: First & Last Name:

Relationship to the Client:

Client's First & Last:

Client's DOB:

DEBIT / CREDIT CARD INFORMATION

Cardholder's Name:

Card Number:

Expiration Date:

CVV (3 DIGIT CODE):

Billing Zip Code:

FINANCIAL STATEMENT & AGREEMENT

RCC requires all clients to have a debit or credit card on file to collect co-payments, co-insurance, deductibles, self-pay, late cancellation, and no-show fees

I agree to notify RCC if my debit/credit card expires, changes, or is lost or stolen so another form of payment can be added. A non-sufficient funds (NSF) fee of $25 will be charged if my card on file has insufficient funds to cover the amount due on my account

Financially Responsible Person's Signature:

Date of Signature::

AUTHORIZATION FOR CHARGES & COLLECTIONS STATEMENT

By signing this form, you permit RCC to charge your
card on file for the amount accrued via co-payment, coinsurance, deductible, self-pay, past balance due, or
other related fees for mental health services rendered.
You agree that no prior notification will be provided
when fees are collected. Additionally, because we are
not a financial institution, any accrued, outstanding
balance in the past 120 days, regardless of insurance
status or RCC not receiving your payments, your account will be processed to our third-party collections
contractor:

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5. Statement of Counseling Children and Adolescents

As a Mental Health Provider treating your child or adolescent, my goal is to create a safe emotional space for your child to explore 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 what they 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 informed about 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 the child's needs.

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

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 to your lawyer or allow your lawyer to subpoena me to court.

● 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 abide by them while your child is in treatment with me.

Name:

Date: