FOR OFFICE USE ONLY DATE:_____

CID_____ NEW REOPEN UPDATE THERAPIST:_____

PHONE:_____(HOME)_____(CELL)_____(WORK)

NAME:_____
LAST FIRST MIDDLE MAIDEN

ADDRESS:_____
STREET/ROUTE APT./P.O. BOX CITY STATE ZIP CODE

COUNTY:_____ DATE OF BIRTH:_____ SEX: _____

PRIMARY RACE _____ SECONDARY RACE _____ VETERAN: _____ YES _____ NO

ENGLISH PROFICIENCY _____ MOTHER'S FIRST NAME: _____RELIGION:_____

MARITAL STATUS: NEVER MARRIED____ MARRIED____ SEPARATED____ DIVORCED____ WIDOWED____

REFERRAL SOURCE:_____ LEGAL GUARDIAN'S NAME: _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL:_____

ADDRESS:_____

FAMILY MEMBERS PRESENTLY LIVING IN YOUR HOUSEHOLD:

NAME	DATE OF BIRTH	AGE	RELATIONSHIP	EMPLOYER

** IF HOMELESS, CHOOSE ONE OF THE FOLLOWING: _____ CONTINUALLY HOMELESS FOR A YEAR OR MORE
_____ 4 OR MORE EPISODES OF HOMELESSNESS IN THE LAST 3 YEARS ____ HOMELESS BUT 1 OR 2 NOT APPLICABLE

EDUCATION (LAST YEAR COMPLETED)_____ SPOUSE'S EDUCATION_____

YOUR OCCUPATION:_____ EMPLOYER:_____

SPOUSE'S OCCUPATION:_____ EMPLOYER:_____

ARE YOU EMPLOYED NOW? YES_____ NO_____ FULL-TIME_____ PART-TIME_____

DURATION OF EMPLOYMENT_____ TOTAL JOINT YEARLY INCOME _____

SOURCE OF INCOME _____

SOCIAL SECURITY #:_____ MEDICARE #: _____

MEDICAID #:_____ INSURANCE COMPANY NAME:_____

POLICY NUMBER:_____ GROUP NUMBER:_____

PHYSICIAN:_____ DATE OF LAST PHYSICAL:_____

ARE YOU CURRENTLY PREGNANT? ___ YES ___ NO PREVIOUS PSYCHIATRIC HOSPITALIZATION: _____ YES _____ NO

WHERE: _____ ADMISSION DATE:_____ DISCHARGE DATE:_____

PREVIOUS COUNSELING: ___ YES ___ NO WHERE:_____ DATES:_____

CURRENT MEDICATIONS:_____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?_____

OFFICE USE ONLY

Private Pay	County	Medicare	FeeMod/	CID_____	APPLE_____
Insurance	City	TXIX	Means	EAP	MAC_____

DAKOTA COUNSELING INSTITUTE

CLIENT INSURANCE INFORMATION

Medicare Number:_____

Medicaid Number:_____

Health Insurance Company Name: _____

Insurance Company address: _____

_____

_____

Policy Number:_____ Group Number:_____

Insured's Name (Policyholder):_____

Insured's Date of Birth:_____

Insured's Address: _____

_____

I authorize my health care provider to release information requested on my insurance form. I authorize payment of any benefits directly to Dakota Counseling Institute. I understand that I am fully responsible for any charges that are not covered by my insurance policy. This authorization will remain in effect until revoked by me in writing.

Patient / Parent / Guardian Signature:_____

DAKOTA COUNSELING INSTITUTE

FINANCIAL AGREEMENT

The typical fees for service are as follows:

Outpatient Intake Therapy	$220.00
Outpatient Therapy	$172.00
Psychiatric Evaluation	$285.00
Medication Management	$156.00

These rates are subject to adjustment due to the variance in the length of sessions and/or June 1st of each year due to contractual inflation.

Any insurance coverage or changes in coverage should be reported to the front desk. Pre-authorization of services is the responsibility of the insured. Dakota Counseling Institute is unable to guarantee payment by the insurance company due to the individuality of each plan. Some reasons for denial may be pre-existing condition, non-covered diagnosis, or no mental health benefits. The agency will assist with the filing of insurance, but all charges are the responsibility of the client from the date the service is rendered. As a reminder, your insurance contract is between you, your employer when applicable, and the insurance company.

Dakota Counseling Institute will work with patients on their outstanding balances as long as the payments are reasonable and regular. We accept cash, checks, Visa and MasterCard. Returned checks are subject to an additional collection fee. Balances older than 30 days are subject to interest charges of 1.5% per month.

I have read and understand the above information.

_____ _____

Signature of Client/Parent/Guardian Date

_____ _____

Witness Date

Dakota Counseling Institute, Inc.
About Our Notice of Privacy Practices

In compliance with the law, we are committed to protecting your personal health information.

The attached Notice of Privacy Practices state:

- Our obligation under law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this Notice and to obtain your written acknowledgment that you have received a copy of this Notice.

Patient Acknowledgment of Receipt

I, _____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices at Dakota Counseling Institute.

_____

Client Date

_____

Parent/Guardian Date

Documentation of Good Faith

___ Attempted to distribute the Notice of Privacy Practices to the client/parent/legal guardian, but they declined to acknowledge receipt.
___ The Notice of Privacy Practices was mailed to the client/parent/legal guardian.
___ Other _____

_____

Staff Member Date

DAKOTA COUNSELING INSTITUTE
TREATMENT CONTRACT

The following is a contract between Dakota Counseling Institute professional staff and you, the consumer, to provide treatment to you. By signing this contract, both parties acknowledge that they have read, understand and agree with the terms set forth in this document.

Informed Consent: By signing this contract, you give consent to receive treatment by DC Institute professional staff. You have a right to be informed of your diagnosis. You have the right to receive information about the nature, purpose, and risks of any tests, treatment, or procedures suggested to you. You are encouraged to ask the clinician working with you any questions you may have regarding your treatment and its potential outcome. If your treatment involves individual, group, couple, or family therapy sessions, you must understand that the issues, which brought you to seek therapy, may become worse before they get better. For example, you may feel more anxious or depressed in the beginning phases of treatment. In rare cases, you may experience loss of contact with reality, or you may experience strong suicidal intent, both of which could necessitate a period of hospitalization in a psychiatric facility. During the course of therapy, interpersonal relationships may change. If you have experienced significant trauma at some time in the past, you may experience flashbacks or a reliving of past experiences and feelings associated with these.

Confidentiality: Confidentiality means that the information you share with DC Institute and its employees will not be released to other individuals or outside agencies, with the following exceptions:

1. If you sign a release specifying to whom the information is released, what information you want released, and for what time period the release of information is valid.

2. Some insurance companies and EAP's request information about your treatment. When you sign on with an insurance company and/or EAP, you sign a waiver or a release of authorization for such information. Therefore, we will release the requested information to your insurance company and/or EAP unless you inform us in writing that you do not want us to do this. Once we receive your request in writing, all information gathered about you after the request is received will not be released to your insurance company and/or EAP. However, if you make such a request, you become solely responsible for the cost of your treatment.

3. Upon a proper court order, your records and/or the testimony of your primary mental health professional may be released.

4. All mental health professionals are mandated reporters. This means that the clinician working with you has to report child abuse or abuse of other dependent persons. **This process will follow all guidelines set forth by State Law.**

5. If your primary mental health professional judges you to be a danger to yourself or others and you refuse voluntary hospitalization, necessary information will be released to outside agencies to insure your and others' safety and to insure continuity of treatment. **This process will follow all guidelines set forth by State Law.**

6. Your financial obligation, name and address may be referred to outside collection agencies, including small claims court, if your account is delinquent.

7. Contact with your HMO for coordination of care.

8. If you are under the age of 18, or have a legal guardian, your parents/legal guardians have the right to obtain information about your treatment, and the right to sign releases of information to other agencies about your treatment on your behalf.

9. If services are funded, wholly or in part, through State Contract or Medicaid monies, the State of South Dakota, Division of Mental Health, will receive certain demographic information about you and may, periodically, review records to assure our compliance with contract requirements. At no time will we release your name or your address. If you have further questions about this, please ask staff.

If you receive services from more than one professional staff member of Dakota counseling Institute, members of your treatment team will likely exchange information in order to coordinate services and provide you with the best treatment available.

Grievance Procedure: Dakota Counseling Institute is committed to providing high quality mental health services through its various programs. Our goal is to provide the most effective services possible, and we want you to be satisfied with the services you receive. As is the case with any service provider, however, occasionally there will be times when a person receiving services is dissatisfied with the services provided by the agency. If you believe that you have a legitimate complaint regarding services provided to you, please try to discuss the situation or the nature of your dissatisfaction with the staff member providing services to you. Most problems are likely to be resolved at this level.

If the problem is not resolved by talking directly to the staff person providing services to you, you may submit a written explanation of your complaint to the Clinical Director of Dakota Counseling Institute. The Clinical Director will respond to your complaint verbally and in writing within 15 days of receiving it. If the problem is not resolved at this level, you may forward your complaint in writing to the Executive Director of Dakota Counseling Institute. The Executive Director will respond to your complaint verbally and in writing within 15 days of receiving it.

If you and the Executive Director do not resolve the problem to your satisfaction, you may contact the Division of Mental Health at the following address and phone number:

Division of Mental Health
Hillsview Properties Plaza, East Hwy 34
c/o 500 East Capitol
Pierre, SD 57501-5070

Phone: 1-800-265-9684
Fax: (605) 773-7076

I have read this treatment contract and agree with the terms set forth in this document.

_____ _____
Client Date

_____ _____
Parent/Guardian Date

_____ _____
Witness/Therapist Date

Parental Consent: I, _____ parent/legal

guardian of _____, hereby consent to have this child treated by

Dakota Counseling Institute professional staff.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness/Therapist Date

(Please initial)

_____ I have been provided with a copy of the Consumer's Rights.

[Revised 7/05]

DAKOTA COUNSELING INSTITUTE
NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Dakota Counseling Institute, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding your Health Record/Information

Each time you visit Dakota Counseling Institute, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serve as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Dakota Counseling Institute, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your heath information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164,522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Dakota Counseling Institute is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notices,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. You may request a copy of the current notice from any of our locations.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, contact the practice's Privacy Officer, Michelle Carpenter, Executive Director, at 605-996-9686 or at m.carpenter@dakotacounseling.net

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
US Dept of Health and Human Services
200 Independence Ave SW
Room 509F, HHH Building
Washington, DC 20201

DAKOTA COUNSELING INSTITUTE
CONSUMER RIGHTS

As a consumer of Dakota Mental Health Center, your rights include, but are not limited to the following:

- The right to confidentiality and privacy of all medical records and information given in treatment.
- The right to be treated with respect and dignity.
- The right to receive treatment that is sensitive to you as an individual in a non-discriminatory manner.
- The right to actively participate in your treatment plans as well as any modification of that plan to insure your understanding and agreement with this plan.
- The right to know the reasons why a particular treatment is considered appropriate.
- The right to refuse any proposed treatment or medication unless in an emergency.
- The right to receive an explanation of diagnosis and prescribed medications and any side effects.
- The right to be fully informed of the fees for therapy.
- The right to locate alternative sources of assistance.
- The right to be informed of the volunteer or student status of a therapist.
- The right to review your case records unless conditions arise as specified by South Dakota Codified Law.
- The right to assert grievances if your rights are violated.
- The right to have access to advocacy services at any time.

To maximize beneficial consumer outcome, consumers should be aware of their responsibilities. The consumer is responsible for:

- Following recommended and agreed upon treatment plan
- Financial obligations of mental health services
- Punctuality of appointments and notification to center if unable to attend a session
- Consideration of the rights of the staff and other consumers
- Being respectful of the property of others
- Maintaining cleanliness and order
- Providing accurate medical and personal information

MICHELLE L. CARPENTER
Executive Director

ROSWITHA KONZ, M.A.
Clinical Director

JANAE OETKEN, CCDCIII
Clinical Supervisor

DCI
DAKOTA COUNSELING INSTITUTE

March 4, 2013

In our continuous effort to improve the process of requesting refills for previously prescribed medications, we have updated our policy. **All refill requests need to be made Monday thru Thursday. Refill requests are still to be called into your pharmacy, without exception**. Your pharmacist in turn will take care of receiving authorization for renewal of the medication from us.

As stated in previous communication, we recommend that you plan your refill needs carefully. You will need to plan at least 24 hours for your refill request to be processed, or the following Monday if your request was received on a Thursday. Please keep in mind that any prescriptions for controlled substances will not be renewed until 2-3 days before your refill is due.

Sincerely,

Roswitha Konz, M.A.
Clinical Director

DAKOTA COUNSELING INSTITUTE

PARENTAL INFORMATION SHEET

CHILD:_____ TODAY'S DATE:_____

CHILD LIVES WITH: _____
(NAME)

_____
(STREET ADDRESS)

_____
(CITY/STATE/ZIP)

_____
(TELEPHONE)

_____
(RELATIONSHIP TO CHILD)

BIOLOGICAL FATHER: _____
(NAME)

_____
(STREET ADDRESS)

_____
(CITY/STATE/ZIP)

_____
(TELEPHONE)

BIOLOGICAL MOTHER: _____
(NAME)

_____
(STREET ADDRESS)

_____
(CITY/STATE/ZIP)

_____
(TELEPHONE)

PARENTS ARE:
(Please check one) [ ] married and living together [ ] married and separated

[ ] legally divorced [ ] not married and living together

[ ] not married and living separately

If divorced or living separately, please check one:

[ ] both parents have legal custody

[ ] mother's parental rights have been terminated

[ ] father's parental rights have been terminated

DAKOTA COUNSELING INSTITUTE

910 West Havens
Mitchell SD 57301

Phone: 605-996-9686
Fax: 605-996-1624

Patient Name: _____ Age/DOB: _____ Date: _____

Address: _____

Current Grade/School: _____ On IEP?: _____

Full name and relationship of person filling out form: _____

Height_____ Weight_____ TPR-BP_____

List Parents, brothers and sisters as well as others living in the home (Specify whether full, half, step or foster):

First Name Last Name	Sex	Age	Occupation or School Grade	Address (if different from above)	Relationship to child
Father:					☐Biological ☐Step ☐Foster
Mother:					☐Biological ☐Step ☐Foster
					☐Full ☐Half ☐Not ☐Step ☐Foster Related
					☐Full ☐Half ☐Not ☐Step ☐Foster Related
					☐Full ☐Half ☐Not ☐Step ☐Foster Related
					☐Full ☐Half ☐Not ☐Step ☐Foster Related
					☐Full ☐Half ☐Not ☐Step ☐Foster Related

Is Child Adopted? ☐Yes ☐No Child's age at Adoption: _____

Name and address of child's doctor: _____

Reason for Referral: _____

Who referred you to this facility? _____

What behaviors are your child exhibiting that is of concern to you? _____

_____

Have others expressed concern about your child (i.e. friends, school, police)? ☐ No ☐ Yes Describe: _____

_____

_____

_____

Medical History (dates/type)
Current Medications and why prescribed:

_____

_____

_____

Allergies

_____

Physical Health

Disabilities/Limitations: _____

Hospitalizations: _____

Surgeries: _____

Mental Health

Counseling: _____

Psychotherapy: _____

Hospitalizations: _____

Problems (past/present)

Has your Child Had:

Head injuries? ❑ No ❑ Yes Describe: _____

Seizures? ❑ No ❑ Yes Describe: _____

Abnormal motor movements or twitches? ❑ No ❑ Yes Describe: _____

Has your child had difficulties in:

Eating? ❑ No ❑ Yes Describe: _____

Sleeping? ❑ No ❑ Yes Describe: _____

Speaking? ❑ No ❑ Yes Describe: _____

Menstruating? ❑ No ❑ Yes Describe: _____

How long have these problems existed? _____

Has your child received treatment previously? ❑ No ❑ Yes
Where?

_____

_____

Legal: _____

_____

Does anyone in your family have a history or problems with:

❑ No ❑ Yes Drug Abuse: _____

❑ No ❑ Yes Alcohol Problems: _____

❑ No ❑ Yes Eating Disorder: _____

❑ No ❑ Yes Depression: _____

❑ No ❑ Yes Gambling: _____

❑ No ❑ Yes Nicotine: _____

❑ No ❑ Yes Caffeine: _____

❑ No ❑ Yes Hospitalized for psychiatric/substance abuse reasons: _____

❑ No ❑ Yes Threatened or attempted suicide: _____

_____

Please explain and give names of any medications they are receiving: _____

_____

_____

Has anyone in your family had thyroid problems? ❑ No ❑ Yes

Relationship to patient: _____

Important recent events in your life: _____

Goals from Treatment/Medication Management: _____

_____

Is there any other information you can think of that might pertain to your child's problems or might help us in understanding him/her better?

_____

_____

_____

_____

_____

_____

_____

_____

SCREENING TOOL
CHECK IF YES TO ANY OF THE FOLLOWING CURRENT PROBLEMS

_____Problem paying attention
_____Unable to work quietly at home
_____Unable to work quietly at school
_____Difficulty concentrating,
_____Difficulty finishing tasks
_____Requires lots of supervision
_____Often disobeys parent or teacher
_____Often fidgets/always on the go
_____Difficulty getting along with other children
_____Impulsive - acts without thinking
_____Gets into fights
_____Lies frequently
_____Runs away
_____Truant from school
_____Takes things that don't belong to him/her
_____Plays with matches/sets fires
_____Cruelty to animals
_____Cruelty to others
_____Fails to take responsibility for own behavior
_____Often loses temper
_____Often argues with adults/authority figures
_____Often does not follow rules
_____Rebellious
_____Swears/uses obscene language
_____Often blames others for his/her mistakes
_____Loss of interest in activities
_____Decreased energy
_____Significant weight loss/gain
_____Cannot be cheered up
_____Sleeping too little/too much
_____Down on self/worthless/guilty
_____Unable to have fun
_____Withdrawal from parents
_____Withdrawal from friends
_____Change from school performance

_____Sensitive to rejection
_____Complains a lot about stomach aches/headaches
_____Wishes he/she was not there.
_____"I wish I was dead." "You'd be better off without me, if I was gone."
_____Any self destructive acts such as cutting, scratching, or picking
_____Overdose
_____Physically aggressive
_____Verbally aggressive and threatening
_____Destructive to property or objects
_____Fearful of school
_____Fearful of the dark
_____Fearful of strangers
_____Fearful of animals
_____Fearful of public speaking
_____Fearful of leaving home
_____Other fears_____
_____Generally worried
_____Worry about something happening to him/her
_____Afraid of being apart from you
_____Extremely shy
_____Worry about things before they happen
_____Perfectionist
_____Re-occurring thoughts, acts, or images
_____Doing the same thing over and over again
_____Hoarding
_____Checking over and over
_____Frequently washes hands
_____Excessive fear of germs
_____Alcohol or drug abuse
_____Any known or suspected physical or sexual abuse
_____Any sexual play or acting out - touching of self or others
_____Nightmares
_____Hearing voices (auditory hallucinations)
_____Seeing object/persons others do not see (visual hallucinations)