

FOR OFFICE USE ONLY

CID: _____

NEW

REOPEN

UPDATE

DATE: _____

THERAPIST: _____

NAME: _____

LAST

FIRST

MIDDLE

MAIDEN

PHONE: _____

HOME

CELL

WORK

ADDRESS: _____

STREET

APT/ P.O. BOX

ADDRESS: _____

CITY

STATE

ZIP CODE

COUNTY

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ SEX _____

ENGLISH PROFICIENCY: _____ PRIMARY RACE: _____ SECONDARY RACE: _____ RELIGION: _____

MOTHERS FIRST NAME: _____ LEGAL GUARDIAN'S NAME: _____

MARITAL STATUS: NEVER MARRIED ___ MARRIED ___ SEPERATED ___ DIVORCED ___ WIDOWED ___ VETAN: YES / NO

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

BILLING 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 PAST 3 YEARS _____ HOMELESS BUT 1 OR 2 ARE NOT APPLICABLE

EDUCATION (LAST YEAR COMPLETED) _____ SPOUSE'S EDUCATION: _____ SPOUSE'S OCCUPATION _____

YOUR OCCUPATION: _____ EMPLOYER: _____ DURATION OF EMPLOYMENT: _____

EMAIL ADDRESS _____

By selecting this box, you are consenting to receiving your statement and invoices electronically instead of in paper form. Please be sure to have email address and cell phone number on this form. Thank you.

TOTAL JOINT INCOME: _____ SOURCE OF INCOME: _____ EMPLOYED: FULL-TIME _____ PART-TIME _____

REFERRAL SOURCE: _____ PRIMARY PHYSICIAN/CLINIC: _____

INSURANCE/COVERAGE: _____ POLICY NUMBER: _____

PREVIOUS COUNSELING YES / NO WHERE? _____ ADMIN/DISCHARGE DATES _____

PREVIOUS PSYCHIATRIC HOSPITALIZATION? YES / NO WHERE? _____ ADMIN/DISCHARGE DATES _____

CURRENT MEDICATIONS: _____

WHOM MAY WE CONTACT IN CASE OF EMEGENCY _____

NAME

CONTACT NUMBER

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: _____

Updated 2017

Financial Agreement

The typical fees for service are as follows:

Outpatient Intake	\$236.20
Outpatient Therapy	\$107.30-\$208.80
Psychiatric Evaluation	\$265.90 - \$346.60
Medication Management	\$142.90-283.80

These rates are subject to adjustment due to the variance in the length of sessions, intensity of service provided, and/or June 1 of each year due to contractual inflation. The typical therapeutic hour and follow-up appointments are 55 minutes. The typical psychiatric evaluation is 45-90 minutes with follow-up appointments 15-30 minutes.

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. Denials may be due to non-covered diagnosis or other non-covered events. 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 clients 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 ½% per month.

I have read and understand the above information.

Signature of Client/Parent/Guardian

Date

Witness

Date

Updated July 2024

FINANCIAL ELIGIBILITY (Calendar Year 2026)

Instructions

Please read and complete all questions on this form. This information will be used to determine your eligibility for services funded by the Division of Behavioral Health.

Behavioral Health Provider Use Only

☐ **Eligible** – Annual Review Date: _____

☐ **Ineligible**

BH Provider: _____

CID #: _____

Signature: _____

Personal Information *(Please Print)*

Client Name: _____
(First)
(MI)
(Last)

Parent/Guardian or Representative (if applicable): _____

☐ Yes ☐ No I (SED or SUD client) have applied for and been denied Medicaid and CHIP-NM.

☐ Yes ☐ No I (SMI client) have applied for and been denied SSI.

Description of Household

Total Number of Persons Living in Household (dependent on household income): _____

Financial Information

Annual Gross Income: All sources of earned and unearned income for the household members included above. Do not include any income earned from a child under the age of 18 or any dependent attending school.

1) Earned Income (*i.e. wages*) \$ _____

2) Unearned Income (*i.e. child support, TANF, SSDI*) \$ _____

Minus Annual Deductions/Expenses:

3) \$ _____ Earned Income Deduction (*Deduct 20% of Earned Income. Do not deduct 20% from unearned income.*)

4) \$ _____ Childcare Expenses (*up to \$6,000/year*)

5) \$ _____ Child Support Payments

6) \$ _____ Annual out of pocket prescription medication costs and lab work.

7) \$ _____ Annual health insurance premiums.

8) \$ _____ Assistive devices purchased within the last 12 months.

(*describe*) _____

Annual Net Income:

9) \$ _____ (*deduct lines 3 through 8 from line 1 and 2*)

Household Size	Annual Income
1	\$29,526
2	\$40,034
3	\$50,542
4	\$61,050
5	\$71,558
6	\$82,066
7	\$92,574
8	\$103,082
9	\$113,590
10	\$124,098

I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report changes in circumstance which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services. I understand that if I am determined eligible and my situation should change before my annual review date, it is my responsibility to notify the Behavioral Health Provider so that eligibility can be reevaluated. Eligibility could be affected by increases in income, changes in the number of persons in the household, and/or any other significant change in financial circumstance.

Signature (Client or Parent/Guardian) _____

Date _____

Dakota Counseling Institute

Summary of Client Records Release Policy

At Dakota Counseling Institute (DCI), your privacy and confidentiality are very important to us. We follow state and federal laws, including HIPAA, when sharing your records with others.

When Can Records Be Shared?

We will only share your information if:

- You give us written permission using a signed release form,
- The law requires it (for example, a court order),
- It's needed for billing or benefits and allowed by law, or
- It's needed to help coordinate your care with another provider (called continuity of care).

What You Can Request

You have the right to see or get a copy of your records. Just let us know in writing, and we'll respond within 30 days. We recommend reviewing your records with your therapist or another member of our professional staff first. In some cases, we may charge a small fee to cover printing or mailing.

What We Usually Share

With your permission, we may share things like:

- Assessments and diagnoses
- Dates and types of services
- Medications we prescribed
- Summaries of your treatment progress

We do not usually share detailed therapy progress notes unless:

- You ask for them yourself,
- An insurance company needs them to review benefits,
- You have filed for a benefit (e.g., disability, vocational rehabilitation, etc.) and detailed notes are requested to make a determination, or
- A court legally orders us to share them.

Who Might Ask for Records?

We may get requests from:

- You or your legal guardian
- Your lawyer
- Insurance companies or Medicaid
- Social Security or disability agencies
- Other healthcare providers or schools
- The Division of Behavioral Health (for things like overall numbers or demographics, but nothing that will personally identify you)

We'll only share information with those you've given us written permission to share with — unless the law says otherwise.

Have Questions?

If you have questions about your records or want to request a copy, talk to your therapist or call our office.

Updated: 06/19/2025

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____, authorize DAKOTA COUNSELING INSTITUTE
(DAKOTA COUNSELING INSTITUTE 910 W. HAVENS MITCHELL SD 57301 (605) 996-9686 FAX: (605) 231-5897)

☐ Release information to: _____

☐ Obtain information from: _____

Reason for Disclosure:

- | | |
|---|--|
| ☐ Treatment planning/ coordinating/ continued care | ☐ Billing or claims |
| ☐ Evaluation/ assessment | ☐ Legal Purposes |
| ☐ Personal Use/ Self Request | ☐ School |
| ☐ Insurance | ☐ Other: _____ |
| ☐ Disability Determination | |

This information is regarding _____
(clients name)

_____-_____-_____
(Social Security Number)

Date of Birth

The following information is being released/ requested (BE SPECIFIC "ENTIRE FILE" WILL **NOT** BE HONORED)

- | | |
|---|---|
| ☐ Psychiatric & Psychological Evaluations | ☐ Mental Health progress notes |
| ☐ Medication management notes | ☐ Educational records/ testing |
| ☐ Mental Health History/ Intake Assessment | ☐ Medical Records/ Lab Reports |
| ☐ Substance Abuse evaluation(s) | ☐ Discharge Summary/ Transfer |
| ☐ Treatment plans/ Therapy Summary/Diagnosis | |
| ☐ Other: _____ | |

Right To Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I **must do so in writing**. I also understand that I have the right to refuse to sign this authorization and am not required to sign this form to receive treatment or be eligible for services. I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the relevant Health Insurance Portability and Accountability Act privacy rules. I Understand that any revocation does not cover materials released prior to receipt of the written revocation by Dakota Counseling Institute. I understand that my records may be faxed to the requesting recipient.

Effective time period: this authorization unless revoked earlier, this authorization will be in effect for one year from the date signed. Expiration date: Month: _____ Day: _____ Year: _____

WITNESS

DATE

CLIENT

PARENT/ GAURDIAN

DATE

(NOTE: A COPY SHALL BE AS VALID AS THE ORIGINAL DOCUMENT)

**Informed Consent Form for Child/Adolescent Therapy
Separated/Divorced Parents
Dakota Counseling Institute**

As a mental health center, our responsibility and goal is the well-being of our identified clients. In the case of a child as the primary client, it is essential that parents and/or legal guardians are in agreement regarding the decision to treat, the treatment goals, appointment times and the need to maintain client confidentiality. As a result, it is the policy of Dakota Counseling Institute that all minors presented for treatment have the following authorization and consent on file:

- Both legal parents/guardians agree to the treatment and providing of mental health services for their child and will indicate their consent below. If there is a custody agreement in place, documentation of this agreement will need to be provided to the agency prior to the beginning of services. In the event that there is no documentation, both parents need to sign for authorization and consent.
- In the event that the parent presenting the child for treatment has no access to the other parent due to the following reasons (death, incarceration, missing, has left and made no contact, etc.) and therefore will acknowledge that they are the sole primary caretaker of the child for mental health treatment and will bear all responsibility for such consent.

I understand that any Dakota Counseling Institute therapist is not agreeing to be an expert witness or to testify on my behalf or on the behalf of any other individual other than my child at any deposition, court proceeding, or in any other way. Should the therapist be subpoenaed, I understand I am responsible for any costs associated with the subpoena. I understand the clinician may or may not meet with me, my attorney, or any other party or attorney in any custodial or divorce proceeding at his/her sole discretion. Dakota Counseling Institute may also charge for the receipt of any correspondence or acceptance of any telephone calls, other than those directly from the court for the child receiving treatment.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

Minor Child _____ DOB: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Welcome to Dakota Counseling Institute! We are grateful that you have chosen us to support your child on their journey towards emotional well-being and personal growth. We understand that seeking therapy can be a big step for both you and your child. Our goal is to create a safe, nurturing environment where your child can express themselves freely and work through any challenges they may face.

During our sessions, we focus on building trust and rapport, which is essential for effective therapy. We will collaborate with you to understand your child's unique needs and work together to set achievable goals. Your insights and involvement are invaluable to us. We encourage open communication, so please feel free to share any questions or concerns you might have at any time. We are here to support both you and your child throughout this process.

Participating in your child's therapy is crucial because it allows you the opportunity to gain insight into their struggles, provide better support at home, reinforce the therapeutic strategies being taught and contribute to more positive outcomes for your child's mental health.

What to expect when bringing your child/adolescent for therapy:

***Initial assessment:**

The first session involves an intake process where the therapist gathers information about your child's concerns, developmental history, and family dynamics. Parents are present during this session. Following the session, your child will be scheduled for an appointment with a therapist that best fits their personality and needs.

***First Session with Assigned Therapist:**

The first session with the assigned therapist will involve communication with the child and parents about the therapy process, identifying goals for treatment and gathering any additional information that might be helpful in providing the best treatment. You will likely be involved in the therapy process by attending sessions, discussing progress with the therapist, and practicing strategies at home. The frequency of sessions will also be discussed during this time.

***Subsequent Sessions:**

You will likely be involved in the therapy process by attending sessions, discussing progress with the therapist, and practicing strategies at home. Subsequent sessions may or may not involve parent participation during the session. We ask that you remain

in the building if you are not involved in the session. This allows your child to feel safe and secure that you are available if necessary.

It is important to remember that therapy is a process, and progress may not be immediate.

Thank you for entrusting us with your child's care. We look forward to working together to foster growth and resilience!

REGARDING SUBPOENAS AND PROFESSIONAL STAFF TESTIMONY

Occasionally, professional staff members of Dakota Counseling Institute are ordered to provide testimony in court regarding their professional contact (e.g. psychotherapy, medication management, casemanagement, psychological testing, mental health evaluation, emergency assessment) with clients. For any professional staff member to appear in court, he or she must have been served an official subpoena to appear in court on a stated date and time.

When a member of the professional staff is subpoenaed to testify regarding treatment of a current client, the staff member will discuss any possible testimony with the client at their next session. A rough outline of content of the testimony will be discussed with the client and, when possible, with the client's attorney.

Professional staff members giving testimony in court are considered expert witnesses, meaning they will be asked to give opinions and discuss hypothetical questions rather than simply asked to repeat factual data. Clients will need to be aware that their attorneys will be billed for the time professional staff are out of the office and thus unable to see other clients, whether or not they are called to testify in the end. Therefore, if, for example, a professional staff member is ordered to be in court at 9:00 am, does not testify until 11 am and then is on the stand for an hour, the attorney will be billed for three hours. Hours are billed in 30 minute increments at the psychotherapy rate valid at the time of testimony. Insurance companies, medicaid/medicare, and any other third party payors will not be billed for court testimony. You need to be aware of this as in the vast majority of cases attorneys will recover these costs from you, the client. Attorneys will also be billed for the time it takes to travel to and from the office to the court house where testimony is to be given.

By signing below, you indicate that you have read and understand the above information regarding professional staff testimony, and agree to the terms and conditions outlined above.

Client Signature

Date

Witness Signature

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 (DCI) and its professional staff, and you, the client. This contract must be agreed to and signed in order 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 DCI professional staff, or a student or intern who is under the supervision of a licensed professional staff member. 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 involved 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. The same is true for medications if you are seeking medication management of your symptoms. All medications have the potential for side effects, and not every medication works the same for everyone. 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 DCI 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 EAPs request information about your treatment. When you sign on with an insurance company and/or EAP, you sign a waiver or a release of information authorizing 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 made 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 the 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 you are the parent bringing your minor child for treatment, please be advised that all information requested by or shared with one parent will also be made available to the other parent, unless such parent's rights have been terminated by a court of law and such termination order has been placed in the child's client file.
10. If you are the partner in couple's therapy, any release of records must be approved and signed by both parties, and the information will be made available to both parties participating in these counseling sessions.
11. If services are funded, wholly or in any part, through State Contract or Medicaid monies, the State of South Dakota, Division of Behavioral 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.
12. 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. Similarly, if your therapist is under supervision of a licensed provider,

the supervisor will periodically review records, and you therapist may discuss your case in supervision meetings. All participants in supervision are bound by the same confidentiality standards as your therapist.

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 have a 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 Behavioral Health at the following address and phone number:

South Dakota Department of Social Services
Division of Behavioral Health
700 Governors Drive
Pierre, SD 57501

Phone: (605) 773-3123
Fax: (605) 773-7076

I have read this treatment contract and understand its terms. My signature below indicates that I 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/protected adult treated by Dakota Counseling Institute professional staff.

Parent/Legal Guardian

Date

Witness/Therapist

Date

(Please initial)

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

[Revised 5/2024]

Dakota Counseling Institute, Inc. 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 (PHI) 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, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves 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 health 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 notice,
- 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, you may contact the practice's Privacy Officer, Roswitha Konz, Clinical Director, at (605) 996-9686 or at r.konz@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, U.S. 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
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Updated February 2017

MICHELLE L. CARPENTER
Executive Director

ROSWITHA KONZ, M.A.
Clinical Director

JANAE OETKEN, CCDCIII
Clinical Supervisor



November 15, 2023

Medication Refill Requests

All refill requests need to be made Monday through Thursday. Refill requests are 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.

We recommend that you plan your refill needs carefully. You will need to plan at least 24-48 hours for your refill request to be processed. Any requests received on a Thursday or Friday will not be processed until the following Monday (or Tuesday if Monday is a holiday). Please keep in mind that any prescriptions for controlled substances will not be renewed until 2-3 days before a refill is due.

Sincerely,

A handwritten signature in black ink, appearing to be "Roswitha Konz", written over a horizontal line.

Roswitha Konz, MA, LPC, QMHP
Clinical Director

MENTAL HEALTH

910 West Havens • Mitchell, SD 57301
605-996-9686 • fax: 605-996-1624

PATHWAY

900 West Havens • Mitchell, SD 57301
605-996-3723 • fax: 605-996-1126

STEPPING STONES

901 South Miller • Mitchell, SD 57301
605-995-8180 • fax: 605-995-8183

Dakota Counseling Institute, Inc.

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- 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

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- 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 health 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 notice,
- 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, you may contact the practice's Privacy Officer, Roswitha Konz, Clinical Director, at (605) 996-9686 or at r.konz@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, U.S. 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

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Updated November 2023

Dakota Counseling Institute

Grievance Process for Persons Receiving Services Reimbursed by the South Dakota Division of Community Behavioral Health

Dakota Counseling Institute is committed to providing high quality mental health and chemical dependency services through its various programs. As is the case with any service provider, however, occasionally there will be times when a person receiving services is dissatisfied, for some reason, with the services provided by the agency. If you believe that you have a legitimate complaint regarding services provided to you, the following procedure should be followed.

For all types of services provided by Dakota Counseling Institute, first try discussing the situation or the nature of your dissatisfaction with the staff member providing services to you. Our goal is to provide the most effective services possible and we want you to be satisfied with the services you receive. 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 or Clinical Supervisor of Dakota Counseling Institute within 15 days of making your dissatisfaction known to the person providing services to you. The Clinical Director or Clinical Supervisor will respond to your complaint verbally and in writing within 15 days of receiving it.

Throughout the grievance process, if you feel a need for additional personal support, you may find it helpful to contact the National Alliance for the Mentally Ill-South Dakota at

PO Box 88808
Sioux Falls, SD 57109
605.271.1871
800.551.2531

namisd@midconetwork.com

or South Dakota Guardianship and Advocacy Program at 605.705.3025.

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

Department of Social Services
Division of Behavioral Health
Kneip Building
700 Governor's Drive
Pierre, SD 57501
Phone: 605.367.5236
Fax: 605.367.5239

Updated November 2023

Dakota Counseling Institute, Inc. Client Rights

Clients' rights (67:62:07:01). Dakota Counseling Institute will ensure that client's rights are fully protected. DCI will give each client, the client's parent if the client is under 18 years of age, or the client's guardian, if any, a copy of the client's rights and responsibilities in writing, or in an accessible format, during the intake process and will discuss the rights and responsibilities with the client or the client's parent, guardian or advocate.

The client's rights and responsibilities statement will be posted in a place accessible to clients. Copies are also available in locations where clients can access them without making a request to center staff. In addition, DCI makes the client's rights and responsibilities statements available to the division. DCI will provide services to each client in a manner that is responsive to the client's need in the areas of age, gender, social support, cultural orientation, psychological characteristics, sexual orientation, physical situation, and spiritual beliefs.

Guaranteed rights (67:62:07:02). Dakota Counseling Institute will ensure that a client's rights guaranteed under the constitution and laws of the United States and the State of South Dakota are protected, including:

- The right to refuse extraordinary treatment as provided in SDCL 27A-12-3.22;
- The right to be free of any exploitation or abuse;
- The right to seek and have access to legal counsel;
- The right to have access to an advocate as defined in subdivision 67:62:01(2) or an employee of the state's designated protection and advocacy system;
- The right to confidentiality of all records, correspondence, and information relating to assessment, diagnosis, and treatment pursuant to SDCL 27A-12-26 and the security and privacy of HIPAA, 45 C.F.R., Parts 160 and 164 (September 26, 2016); and
- The right to participate in decision making, related to treatment, to the greatest extent possible.

Updated November 2023

PARENTAL INFORMATION SHEET

CHILD: _____ TODAY'S DATE: _____

CHILD LIVES WITH: _____

(NAME)

(STREET ADDRESS)

(STATE/ZIP)

(TELEPHONE)

(RELATIONSHIP TO CHILD)

BIOLOGICAL
FATHER:

(NAME)

(STREET ADDRESS)

(STATE/ZIP)

(TELEPHONE)

BIOLOGICAL
MOTHER:

(NAME)

(STREET ADDRESS)

(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

910 West Havens
Mitchell SD 57301

DAKOTA COUNSELING INSTITUTE

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 | ☐ Sensitive to rejection |
| ☐ Unable to work quietly at home | ☐ Complains a lot about stomach aches/headaches |
| ☐ Unable to work quietly at school | ☐ Wishes he/she was not there. |
| ☐ Difficulty concentrating, | ☐ "I wish I was dead." "You'd be better off without |
| ☐ Difficulty finishing tasks | ☐ me, if I was gone." |
| ☐ Requires lots of supervision | ☐ Any self destructive acts such as cutting, |
| ☐ Often disobeys parent or teacher | ☐ scratching, or picking |
| ☐ Often fidgets/always on the go | ☐ Overdose |
| ☐ Difficulty getting along with other children | ☐ Physically aggressive |
| ☐ Impulsive - acts without thinking | ☐ Verbally aggressive and threatening |
| ☐ Gets into fights | ☐ Destructive to property or objects |
| ☐ Lies frequently | ☐ Fearful of school |
| ☐ Runs away | ☐ Fearful of the dark |
| ☐ Truant from school | ☐ Fearful of strangers |
| ☐ Takes things that don't belong to him/her | ☐ Fearful of animals |
| ☐ Plays with matches/sets fires | ☐ Fearful of public speaking |
| ☐ Cruelty to animals | ☐ Fearful of leaving home |
| ☐ Cruelty to others | ☐ Other fears _____ |
| ☐ Fails to take responsibility for own behavior | ☐ Generally worried |
| ☐ Often loses temper | ☐ Worry about something happening to him/her |
| ☐ Often argues with adults/authority figures | ☐ Afraid of being apart from you |
| ☐ Often does not follow rules | ☐ Extremely shy |
| ☐ Rebellious | ☐ Worry about things before they happen |
| ☐ Swears/uses obscene language | ☐ Perfectionist |
| ☐ Often blames others for his/her mistakes | ☐ Re-occurring thoughts, acts, or images |
| ☐ Loss of interest in activities | ☐ Doing the same thing over and over again |
| ☐ Decreased energy | ☐ Hoarding |
| ☐ Significant weight loss/gain | ☐ Checking over and over |
| ☐ Cannot be cheered up | ☐ Frequently washes hands |
| ☐ Sleeping too little/too much | ☐ Excessive fear of germs |
| ☐ Down on self/worthless/guilty | ☐ Alcohol or drug abuse |
| ☐ Unable to have fun | ☐ Any known or suspected physical or sexual abuse |
| ☐ Withdrawal from parents | ☐ Any sexual play or acting out - touching of self or others |
| ☐ Withdrawal from friends | ☐ Nightmares |
| ☐ Change from school performance | ☐ Hearing voices (auditory hallucinations) |
| | ☐ Seeing object/persons others do not see (visual hallucinations) |

Dakota Counseling Institute's Psychiatric Care and Prescription Policy

Dakota Counseling Institute is committed to provide medication management for psychiatric symptoms to as many people and in as timely of a manner as is possible within our budgetary and staffing constraints. The following prescription policy is intended to streamline certain prescription procedures in order to make them easily understandable to both clients and providers. In addition these policies aim to reduce time providers spend in administrative and paperwork tasks in order to make as much time as possible available to directly serve our clients.

Please read the following policy statements carefully and ask your provider to explain any parts that are unclear to you. Once you understand each part, please **place your initials by each statement** indicating that you understand and agree to each:

___ At the end of each appointment a follow-up appointment will be scheduled for you if medication was prescribed for you. If you agree to the course of treatment, you will consistently attend all follow-up appointments that are scheduled for you, and will only reschedule when absolutely necessary. Please be aware that **ALL PATIENTS MUST ATTEND AT LEAST ONE MEDICATION REVIEW APPOINTMENT EVERY SIX MONTHS AT A MINIMUM** in order to maintain a provider relationship. This means that your prescriptions will not be refilled if it has been longer than six months since your last appointment. Do not wait until the last moment to schedule follow-up appointments as our providers are booked many weeks in advance.

___ Once you and your provider have agreed on a course of medication management for your symptoms, you commit to follow your provider's instructions and to not change dosages or times of administration unless instructed to do so by your provider.

___ While under the care of one of our providers, you are making a commitment to not accept prescriptions from other providers for any controlled or psychotropic medications unless you have first fully informed and discussed this with our psychiatric provider. You hereby give permission to Dakota Counseling Institute to contact and exchange information with all your other medical providers involved in your care

___ You agree to have your medical care coordinated by **one primary care provider** of your choice. Your psychiatric provider at Dakota Counseling will maintain contact with your primary provider as needed and/or requested by your primary care provider.

___ While receiving psychiatric care from Dakota Counseling Institute, you agree to **use only one pharmacy** for your prescriptions unless otherwise discussed with your provider. You will inform Dakota Counseling Institute immediately of any change of pharmacy or of primary care provider.

___ My primary care provider is _____

___ The pharmacy I use is _____

___ All medication refills need to be requested from your pharmacy. Your pharmacy will take care of contacting us and getting refill authorization. **DO NOT LEAVE REQUESTS FOR REFILLS ON OUR ANSWERING MACHINE AS YOU WILL BE REDIRECTED TO CALL YOUR PHARMACY -- NO EXCEPTIONS.**

___ Plan ahead and make your refill requests in a timely manner. Refill requests will be handled as soon as possible, usually within two to three business days.

___ As required by State Law, refills of controlled medications will be given for 30 days at a time, at the most. **There will be no early prescriptions or replacement of lost, stolen, or contaminated prescriptions.** Please be careful to not open your medication container near the toilet, sink, or other water source to safeguard against your medications getting wet or otherwise getting contaminated or destroyed. Keep all medications in a safe place and out of reach and sight of others to minimize the possibility of theft of your medications.

___ You are responsible for keeping your medications safe. Failure to do so will result in going without your medications until they are due to be refilled.

___ If we become aware that you have sold or traded your medications we will not renew these prescriptions. We will work with you to address your symptoms with non-controlled medications as best as possible, and provide you with referral for substance abuse treatment if indicated.

___ Any apparent alterations to prescriptions by unauthorized parties will be reported to law enforcement immediately.

___ In order to make as much appointment time available as possible, all phone calls and requests for call backs from providers will be handled by our registered nurse, who will relay any and all patient concerns to the providers, and return patient phone calls with providers' instructions.

By signing this document you agree to the terms of Dakota Counseling Institute's Psychiatric Care and Prescription Policy.

(Patient)

(Date)

(Provider)

(Date)

Division of Behavioral Health
Family Mental Health Disorder Outcome Tool

Client STARS ID: | | | | | | | | | | | | | | | |

Date: _____

Tool Type:

- | | |
|------------------------------------|---------------------------------|
| ☐ Initial | ☐ Family |
| ☐ Update | |
| ☐ Discharge | |

1. Would you say that in general your child's mental health is:

- | | | | | |
|------------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| ☐ Excellent | ☐ Very Good | ☐ Good | ☐ Fair | ☐ Poor |
|------------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|

2. What is your child's employment status?

- | | | |
|--|---|--|
| ☐ Employed full time (35+ hours per week) | ☐ Employed part time | ☐ Homemaker |
| ☐ Student | ☐ Retired | ☐ Other (specify) |
| ☐ Disabled | ☐ Unemployed | |

3. Which of the following best describes your child's current residential status?

- | | | |
|---|---|---|
| ☐ Independent, living in a private residence | ☐ Homeless | ☐ Dependent, living in a private residence |
| ☐ Residential Care (group home, rehabilitation center, agency-operated care) | ☐ Foster Home/ Foster Care | ☐ Institutional setting (24/7 care by skilled/specialized staff/doctors) |
| ☐ Other (specify) | ☐ Crisis Residence | ☐ Jail/Correctional Facility |

4. What is your child's highest education level completed?

(12= GED and High School diploma or self-contained special ed classes)

- a. If enrolled in school, has your child attended school at any time in the past 3 months? ☐ Yes ☐ No ☐ Refused

5. Please answer the following questions based on the past 30 days:

- a. Has your child been arrested? ☐ Yes ☐ No ☐ Refused

- b. Did you have enough money to meet your child's needs? ☐ Yes ☐ No ☐ Refused

- c. Have you been satisfied with the conditions of your child's living space? ☐ Yes ☐ No ☐ Refused

- d. In the past 30 days, has your child felt...

- | | |
|--|---|
| i. Nervous? | ☐ Yes ☐ No ☐ Refused |
| ii. Hopeless? | ☐ Yes ☐ No ☐ Refused |
| iii. Restless or fidgety? | ☐ Yes ☐ No ☐ Refused |
| iv. So depressed that nothing could cheer your child up? | ☐ Yes ☐ No ☐ Refused |
| v. That everything is an effort? | ☐ Yes ☐ No ☐ Refused |
| vi. Worthless? | ☐ Yes ☐ No ☐ Refused |
| vii. Bothered by psychological or emotional problems? | ☐ Yes ☐ No ☐ Refused |

Division of Behavioral Health
Family Mental Health Disorder Outcome Tool

6. Please answer the following questions based on the past 6 months:

a. Has your child spent time in a facility for:

- | | |
|--|---|
| i. Detoxification/Inpatient or Residential Substance Use Disorder Treatment? | ☐ Yes ☐ No ☐ Refused |
| ii. Mental Health Care? | ☐ Yes ☐ No ☐ Refused |
| iii. Any illness, injury, or surgery to the human body? | ☐ Yes ☐ No ☐ Refused |

- b. Has your child spent time in a correctional facility including jail/prison/detention (because of an arrest, parole, or probation violation)?** ☐ Yes ☐ No ☐ Refused

- c. Has your child had suicidal thoughts?** ☐ Yes ☐ No ☐ Refused

7. Please indicate your level of agreement or disagreement with the statements by checking the choice that best represents your feelings or opinion for your child over the past 6 months.

Response Options

Strongly disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable	Refused
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Domain: Social Connectedness Questions a-g

- | | |
|--|--|
| a. My child is happy with the friendships they have, their friends will listen and understand them when talking. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| b. My child has people with whom they can do enjoyable things. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| c. I feel my child belongs in the community. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| d. In a crisis, my child would have the support they need from family or friends. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| e. My child has people that they are comfortable talking with. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| f. My child has family or friends that are supportive of their recovery. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| g. My child generally accomplishes what they set out to do. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

Domain: Functioning Questions h-q

- | | |
|---|--|
| h. My child does things that are more meaningful to them. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| i. My child can take care of their needs. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| j. My child can handle things when they go wrong. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |
| k. My child can do things that they want to do. | ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

Division of Behavioral Health
Family Mental Health Disorder Outcome Tool

Please indicate your level of agreement or disagreement with the statements by checking the choice that best represents your feelings or opinion for your child over the past 6 months.	Response Options						
	Strongly disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable	Refused
l. My child gets along with family, friends, and other people.	☐	☐	☐	☐	☐	☐	☐
m. My child can deal with crisis.	☐	☐	☐	☐	☐	☐	☐
n. My child does well in social situations.	☐	☐	☐	☐	☐	☐	☐
o. My child does well in school and/or work.	☐	☐	☐	☐	☐	☐	☐
p. My child's symptoms are not bothering them as much.	☐	☐	☐	☐	☐	☐	☐
q. My child's housing situation is a safe place to live.	☐	☐	☐	☐	☐	☐	☐