Sioux Falls Wellness Counseling, Inc.
3508 S. Minnesota Ave #100
Sioux Falls, SD 57105
Phone: 605-610-9228

Informed Consent Form

Psychotherapy has benefits and risks. You may get worse before you get better. You may experience anxiety, nervousness, depression, painful memories, confusion, and changes in your relationships.

Confidentiality

As per the following laws, all information shared in the therapy session will remain confidential: Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R., Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and SD Codified Law 19-13-21.1. The limits to confidentiality are listed below:

1. You sign a written release of information
2. I am ordered by the court to release information
3. You/your child present a danger to self or others as mandated by State and Federal Laws
4. There is a suspicion of abuse, neglect, or threat of physical or mental harm to self or others.

Emergencies

I am available by appointment only. I will return phone calls during regular business hours. If you are receiving care at the time of my extended vacations, I will give you the name of a colleague to contact if needed. In case of emergency, please call 988 (mental health crisis line), 911, Avera Hospital, Sanford Hospital or your primary care physician.

Access to Additional Documents (please check each box; found at siouxfallswellness.com)

(___)I have reviewed the HIPPA brochure and compliance procedures and have been offered a copy.

(___) I have been given access to the Client Information brochure and been offered a copy.

(___) I have been given access to the Confidentiality in Therapy handout and been offered a copy.

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Financial Agreement

Payment is due at the time of service. If you utilize insurance, your co-payment is due at the time of service. Only necessary information will be provided to the insurance company. I hereby authorize Sioux Falls Wellness Counseling to furnish information to insurance carriers concerning my illness and treatments. I understand that my insurance may not reimburse for my condition/diagnosis; if this is deemed to be the case, I understand I would be responsible for full fee. I understand that it is my responsibility to pay for all services incurred by myself/my dependents.

I agree to provide a credit card to be kept on file on Jituzu software. I authorize *Sioux Falls Wellness Counseling* to charge any fees for applicable professional counseling services (to include all applicable insurance co-pays, deductibles, and coinsurance, as well as fee for missed sessions per cancellation policy) to the credit card provided.

Late Cancellation/No-Show Policy

If you are unable to make the scheduled appointment, you agree to call the counselor at minimum 24 hours before the appointment time. If you do not contact the counselor's office at least 24 hours before your appointment to cancel, you agree to pay the counselor $75 for the missed appointment.

Initial Intake Session $250

Session fee (50-55 minutes) $210 (30 or 45 minute sessions will be prorated)

______ This is the minimal amount I am required to pay at time of session **or**

______ Insurance Co-pay/Deductible/Coinsurance

My signature below signifies my informed and voluntary consent to enter therapy (and/or have my child/ren enter therapy). By signing below, I acknowledge and agree to all policies and information in this two-page *Informed Consent* form. I affirm that before becoming a client of Sioux Falls Wellness Counseling, I was given sufficient information to understand the nature of therapy, including possible risks and benefits, and also the nature of confidentiality. I understand the office's policies and procedures and cancellation policy. I have been provided the opportunity to ask questions and have had my questions answered to my satisfaction. I understand that I can ask questions and raise concerns about treatment at any time.

(Client/Guardian) Signature____________________________________Date___________

Signature of Therapist Rita Hansen:______________________________Date__________

Transfer Plan

Clinician Incapacitation or Termination of Practice

Sioux Falls Wellness Counseling, Inc		Barbara RA Christensen II Inc
Rita Hansen MA, NCC, LPC-MH, LAC, QMHP		MS, NCC, LPC, LPC-MH, LAC, QMHP
3508 S. Minnesota Ave #100	to	6809 S. Minnesota Ave #102
Sioux Falls SD 57105		Sioux Falls SD 57108
Phone: 605-610-9228		
Fax: (605) 496-9989		Phone/Fax: (605) 362-5803

I, Rita Hansen, MA, NCC, LPC-MH, LAC, QMHP, in the event of my death, disability, retirement or inability to provide counseling services appoint Barbara RA Christensen MS, NCC, LPC, LPC-MH, LAC, QMHP as custodian to provide those services and possess and maintain my clinical records for a period of ten (10) years. Barbara RA Christensen is named in this informed consent document and I have provided my custodian with the necessary means to execute this transfer plan.

The duties of custodian will include, but not be limited to:

1. Notification of all active clients of my inability to practice and offer counseling or referral services.
2. Notification of all active clients that the custodian has possession of the client financial records
3. Respond to requests for information in consideration with state laws, HIPPA guidelines and code of ethics.
4. Possess and maintain all clinical records for a period of ten (10) years or at minimum within guidelines of the laws and statutes within SD as well as federally.
5. After ten (10) years, or the required time, shred all records according to legal guidelines.

Record Keeping

Rita Hansen stores client files in two ways:

1. Originals of intake paperwork is stored in a locked file cabinet behind a locked office door.
2. Progress notes, treatment plans, demographic and insurance information are stored electronically through My Clients Plus, which is encrypted and HIPAA compliant.

By signing this, I understand the transfer plan as stated above and how my client records are stored.

Signed by client and/or guardian/parent:____Date:________________

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Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Rita Hansen, there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:
people in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages; your employer, if you use your work email to communicate with Rita Hansen; third parties on the Internet such as server administrators and others who monitor internet traffic. If there are people in your life that you don't want accessing these communications, please talk with Rita Hansen about ways to keep your communications safe and confidential. Rita Hansen has entered into agreement with her email and phone provider that they will comply with HIPAA. Despite this, confidentiality of email and text communication cannot be guaranteed.

I consent to allow Rita Hansen to use unsecured email and mobile phone text messaging to transmit to me the protected health information related to the scheduling of appointments and billing/payment.
I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time. I have been given the option to communicate through a more secure client portal rather than standard email and texts.

I do______ do not______give permission to be reached by email
I do______ do not______give permission to be reached by text
I do______ do not______choose to communicate through the client portal*

*The portal allows for online scheduling, online payments and more secure (encrypted) messaging.

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ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE

If you wish, you may pay fees electronically using any of the following services:

- *Intuit*
- *Jitizu client portal*

Please Be Aware of the Following:

We have a duty to uphold your confidentiality, and thus we wish to make sure that your use of the above payment services is done as securely and privately as possible. After using any of the above services to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include our business name, and would indicate that you have paid for a therapy session.

In addition to these possible emails or text messages, payments made by credit card will appear on your credit card statement as being made to *Sioux Falls Wellness Counseling*. Please consider who might have access to your statements before making payments by credit card.

____________________________________ __________________

(Signature of client) Date

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