

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)

(___) 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.

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 Simple Practice 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) \$230 (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.

Transfer Plan

Clinician Incapacitation or Termination of Practice

Sioux Falls Wellness Counseling, Inc

Rita Hansen MA, NCC, LPC-MH, LAC, QMHP

3508 S. Minnesota Ave #100 to

Sioux Falls SD 57105

Phone: 605-610-9228

Fax: (605) 496-9989

Barbara RA Christensen II Inc

MS, NCC, LPC, LPC-MH, LAC, QMHP

6809 S. Minnesota Ave #102

Sioux Falls SD 57108

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 Simple Practice, which is encrypted and HIPAA compliant.

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