

**1801 E. Kemp Ave. \* Watertown, SD 57201  
 (605) 753-5520**

**Client Information Form**

All information will be held in the strictest confidence according to the confidentiality standards of my profession and this practice.

**(Please Print)**

Client Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Work Phone \_\_\_\_\_ Years Employed \_\_\_\_\_ Occupation \_\_\_\_\_

School Name and Address \_\_\_\_\_ Year in School \_\_\_\_\_

(if Full or Part-time Student)

Family Physician and Address \_\_\_\_\_

Person to Contact in Emergency \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**Parent/Guardian Information (if minor)**

Mother \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Street City State

Employer and Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Father \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Street City State

Employer and Address \_\_\_\_\_ Work Phone \_\_\_\_\_

**Spouse Information (if applicable)**

Name \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ E-mail \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Street City State

Employer and Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Significant Relationship Status: \_\_\_\_\_ Single \_\_\_\_\_ Engaged \_\_\_\_\_ Married \_\_\_\_\_ Separated  
 \_\_\_\_\_ Divorced \_\_\_\_\_ Remarried \_\_\_\_\_ Committed Relationship \_\_\_\_\_ Widowed

**How did you hear about Dakota Counseling & Mediation?** \_\_\_\_\_

**ADDITIONAL INTAKE INFORMATION**

**Family Members/Others Living in Household:**

Name	Relationship	Age	DOB	School/Occupation

In your own words, state the nature of your concerns and how long they have been present:

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Is there a history of any mental health problems with family members? If so, please list:

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Are you currently taking medication? \_\_\_\_\_ If yes, what, how much and with what results:

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On the scale below, indicate the severity of your concerns:

- \_\_\_\_\_ Mildly upsetting
- \_\_\_\_\_ Moderately severe
- \_\_\_\_\_ Very severe
- \_\_\_\_\_ Extremely severe
- \_\_\_\_\_ Incapacitating

With whom have you previously consulted and what were the results?

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*My practice is committed to providing the best treatment for my clients. In order for me to achieve that goal, it is necessary for treatment to be consistent. My policy is to charge \$50.00 for missed appointments. Please cancel at least 24 hours in advance. Failure of notification may result in delayed and/or interrupted scheduling of your regularly preferred appointment time.*

## **Dakota Counseling & Mediation** **Informed Consent for Services**

### **Confidentiality:**

I understand that all information disclosed within sessions is confidential and may not be revealed to anyone outside Dakota Counseling & Mediation without my written permission. The only exception is in situation where disclosure is required by law:

- 1) If I present an imminent threat of harm to myself or to others.
- 2) When there is an indication of abuse of a child or dependent adult
- 3) By court subpoena
- 4) Information regarding diagnosis, treatment plan, etc. will be provided to insurance companies unless otherwise specified.

### **Benefits and Risks:**

There are benefits and risks that may occur as a result of counseling. The process may involve the risk of remembering unpleasant events and may arouse strong emotional feelings. The benefits may include: 1) improved ability to handle stressful situations; 2) enhanced personal development such as a clearer understanding of self, values and goals; and 3) improved interpersonal relationships. Taking personal responsibility for working with these issues may lead to greater growth.

### **Appointments:**

If you are unable to keep an appointment, please call the office at 753-5520 to reschedule as soon as possible. If I cannot keep an appointment time with you, I will attempt to contact you as soon as possible. Appointments that are not canceled or rescheduled at least 24 hours in advance will be charged at a rate of \$50.00 per session.

### **Consent to Services**

**I have read the above conditions of counseling services. I accept these conditions and give my consent to receive services from Dakota Counseling & Mediation. I have had the opportunity to discuss this information with my counselor.**

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Client or Legal Guardian Signature

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Date

**INSURED/RESPONSIBLE PARTY INFORMATION**  
**(Please complete this section regardless of insurance coverage.)**

Full Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Primary Insurance Company and Address \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_ Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_

Name of Secondary Insurance Company and Address (if applicable) \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_ Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_

Is Pre-authorization required? \_\_\_\_\_ YES \_\_\_\_\_ NO

*Pre-authorization will be YOUR responsibility. Dakota Counseling & Mediation will provide your insurance company with necessary treatment information when requested by the insurance company.*

**OFFICE BILLING AND INSURANCE POLICY**

Thank you for choosing me as your counselor. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment.

The fee per individual therapy session (50 minutes) is \$105.00.

The fee per couples therapy session is (90 minutes) is \$160.00 (Not covered by insurance)

It is your responsibility to pay any deductible amount, co-pay, co-insurance, or any other balance not paid by your insurance on the day of service. An extended payment plan is available if needed. This practice also accepts VISA and Mastercard. There will be a \$40.00 charge for all returned checks.

1. I authorize the release of any necessary information to my insurance company(s) for claims and processing. All information will be held in the strictest confidence according to the confidentiality standards of my profession and this practice.
2. I understand that I am responsible for the full amount of my bill for services provided.
3. Missed appointments/Late cancellations will be charged at a rate of \$50.00. This charge must be paid at the beginning of the next appointment.
4. Minor Clients: The parents or guardians of a minor are responsible for full payment. *For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or payment is sent with the minor.*
5. I authorize direct payment to my service provider.
6. I hereby permit a copy of this to be used in place of an original.
7. I certify that all information is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature of Client or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dakota Counseling & Mediation Witness Signature

\_\_\_\_\_  
Date