ENGAGE COUNSELING AND CONSULTING SERVICES

ENGAGE SERVICES
PO Box 65 Plankinton, SD 57368
Phone 605.942.7332 – Fax 605.734.8113
www.engageservices.net

NEW ADULT CLIENT INFORMATION

All information provided to Engage Counseling Services on this form or during the initial intake session will be used for counseling purposes only and is considered confidential regardless of subsequent contract for therapy services. If you have any questions about our privacy policy, please ask us at any time.

PERSONAL INFORMATION **Today's Date: ___/___ /____**

Client's Name: _____ Date of Birth___/___/___ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SSN: _____ Gender: ◯ Male ◯ Female Ethnicity: _____

Religious Affiliation_____ Employed? ◯ No ◯ Yes Where? _____
Student? ◯ Yes ◯ No School Name: _____

Education Level Completed: ◯ Grade _____ ◯ GED ◯ High School ◯ College ◯ Other _____

Relationship Status: _____ If married, # of years: _____

List in the following area any persons that are in your household or of significance to you:

Name	Relationship	Age	Occupation

Referred to Counseling by:_____

CONTACT INFORMATION

Home Phone: (_____) _____Leave Message? ◯ Yes ◯ No

Work Phone: (_____) _____ Leave Message? ◯ Yes ◯ No

Cell Phone: (_____) _____Leave Message? ◯ Yes ◯ No

Text? ◯ Yes ◯ No

Email: _____ Send Message? ◯ Yes ◯ No

Which of the above do you prefer as the primary source of contact? _____

Emergency Contact: _____ Relationship: _____ Phone: (___)_____

(By filling in the above contact I give permission to Engage to make contact in case of an emergency)

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MEDICAL INFORMATION

Primary Care Physician: _____ Clinic: _____

Primary Care Phone Number: ( ) ____ - _____

Most Recent Medical Exam: _____ History of Serious Illness ◯ Yes ◯ No

Explain: _____

Do you give consent for Engage Services to contact your primary care physician if needed: ◯ Yes ◯ No

Signature: _____ **Date:** ____/___ /____

Please list in the following area all current medication you are taking:

Medication	Reason	Dose	Frequency

Developmental Milestones - (Noticed delays: speech, walking, emotional complications, difficulty problems solving/decision making, etc.)

_____

_____

_____

HISTORY:

Mental Health/General information:

Areas of concern current/past	Current	Past	Areas of concern	Current	Past
Depression	◯	◯	Relationship/Marriage	◯	◯
Anxiety/Panic Attacks	◯	◯	Children	◯	◯
Anger	◯	◯	Academic	◯	◯
Grief	◯	◯	Job/Occupation	◯	◯
Life Change/Decision	◯	◯	Abuse/Trauma History	◯	◯
Substance/Alcohol Use	◯	◯	Sleep	◯	◯
Spiritual	◯	◯	Concentration	◯	◯
Hallucinations	◯	◯	Sexual Difficulties	◯	◯
Nutrition/Eating	◯	◯	Legal	◯	◯
Self-injurious Behavior	◯	◯	Other_____	◯	◯
Suicide	◯	◯	Other_____	◯	◯

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Please look at the following table. Place a check mark in the column which best describes how often you struggle with the following areas:

I Struggle with….	Never	Rarely	Sometimes	Frequently
1. Life is hopeless.				
2. I am lonely.				
3. No one cares about me.				
4. I am a failure.				
5. Most people don't like me.				
6. I want to die.				
7. I want to hurt someone.				
8. I am so stupid.				
9. I am going crazy.				
10. I can't concentrate.				
11. I am so depressed.				
12. God is disappointed in me.				
13. I am disappointed with God.				
14. I can't be forgiven.				
15. Why am I so different?				
16. I can't do anything right.				
17. People hear my thoughts.				
18. I have no emotions.				
19. Someone is watching me.				
20. I hear voices in my head.				
21. I am out of control.				

ISSUES CHECKLIST:

Please indicate which of the following are current issues for you. Check all that apply:

☐ Not being able to say what you really think/ feel
☐ Under too much pressure and feeling stressed
☐ Feeling down or unhappy/depressed mood
☐ Excessive anxiety or worry
☐ Feeling inferior to others
☐ Anger outbursts
☐ Excessive fear of specific places or objects
☐ Difficulty making friends

Have you or anyone in your family been diagnosed and/or treated with any mental health problems including therapy or medication for issues such as depression or anxiety?

_____

_____

Please explain the reason you feel a need for therapy?

_____

_____

What do you hope to gain from therapy?

_____

_____

_____

What have you attempted in order to gain help up to this point?

_____

_____

Have you ever had a severe emotional upset or had thoughts of suicide? ◯ **Yes** ◯ **No**
If yes, please circle the how intense those feelings currently are: Low 1 2 3 4 5 6 7 8 9 10 High
Please explain:

_____

_____

Have you ever been hospitalized for emotional and/or behavioral concerns? (self-harm, suicidal ideation, etc.) ◯ **Yes** ◯ **No** (If yes, please explain)

_____

_____

Have you ever received prior counseling? ◯ **Yes** ◯ **No** (If yes, list when and counselor(s)/location(s))

_____

_____

Please describe any alcohol or substance use/misuse over the past 6 months including frequency and amounts, legal consequences, and any other negative impacts. _____

_____

_____

List the 3 most distressing or disturbing experiences of your life you can remember:

1._____

2._____

3._____

List the 3 best moments in your life you can remember:

1._____

2._____

3._____

What are some positive things you do to impact your emotional health (exercise, reading, hobbies, etc.)?

_____

_____

Family information:

(Family of origin, relationship with parents, siblings, significant other(s): _____

_____

_____

How many supportive people (those on whom you can depend) do you currently have in your life?

○ **None** ○ **Some (1-5)** ○ **Many (5+)**

Have you ever attended a support group that addresses any of the topics you are concerned with? ○ **Yes** ○ **No** (If yes, please explain): _____

_____

Legal History:
(Arrest history, sentencing, DUI occurrences, incarceration, litigation): _____

_____

Are there any other concerns or information you would like to share?

○ **Yes** ○ **No** (If yes, please explain):

_____

_____

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STRENGTHS, NEEDS, ABILITIES, PREFERENCES (SNAP) INVENTORY

SNAP Questionnaire Instructions: Put a checkmark next to the strengths/needs/abilities/preferences that you believe you or your child has.

Client name: _____ Date: ____/___ /____

STRENGTHS

- ☐ Ability to ask for help
- ☐ Honest
- ☐ Physically Strong
- ☐ Levelheaded
- ☐ Resilient
- ☐ Responsible
- ☐ Self-reliant
- ☐ Sincere
- ☐ Humorous
- ☐ Intelligent
- ☐ Other _____
- ☐ Determined
- ☐ Articulate
- ☐ Athletic
- ☐ Well-liked by others
- ☐ Business like
- ☐ Cares about others
- ☐ Centered
- ☐ Confident
- ☐ Considerate
- ☐ Very patient
- ☐ Good social support system
- ☐ Dependable
- ☐ Dynamic
- ☐ Goal oriented
- ☐ Energetic
- ☐ Motivated
- ☐ Humble
- ☐ Flexible
- ☐ Spiritual/religious
- ☐ Courageous
- ☐ Organized
- ☐ Good Family Relationship
- ☐ Has Charisma
- ☐ Has integrity
- ☐ Enthusiastic
- ☐ Exercises regularly
- ☐ Financially stable
- ☐ Creative
- ☐ Generous

NEEDS

- ☐ Advanced Directives
- ☐ Social Supports
- ☐ Public assistance
- ☐ Relaxation skills
- ☐ Boundary Setting
- ☐ Domestic Violence Counseling
- ☐ Stress reduction
- ☐ Time Management
- ☐ To improve trust
- ☐ Impulse Control
- ☐ Other_____
- ☐ Grief Counseling
- ☐ Abuse/Trauma Counseling
- ☐ Values clarification
- ☐ Anger Management
- ☐ Employment
- ☐ HIV/AIDS Counseling
- ☐ Education Assistance
- ☐ Eliminate Hallucinations
- ☐ Improved social skills
- ☐ Financial Counseling
- ☐ Increase Motivation
- ☐ Help with negatives in life
- ☐ Transportation help
- ☐ Help with bipolar highs/lows
- ☐ Learn to have fun
- ☐ Housing/Shelter
- ☐ Improved honesty
- ☐ Improved relationships
- ☐ Medical Consultation
- ☐ Medication education
- ☐ Relapse Prevention
- ☐ Increase self-esteem
- ☐ Insomnia relief
- ☐ Spiritual Support
- ☐ Learn to read
- ☐ Learn to say "no"
- ☐ Legal assistance
- ☐ To understand diagnosis

ABILITIES

- ☐ Time management
- ☐ Artistic
- ☐ Assertive in a positive way
- ☐ Problem solving skills
- ☐ Public Speaking
- ☐ Successful at school
- ☐ Takes all medications
- ☐ Computer literate
- ☐ Creative
- ☐ Employable/always works
- ☐ Follows directions
- ☐ Auto mechanic
- ☐ Can read well
- ☐ Volunteer work
- ☐ Good with people
- ☐ Has GED/Diploma
- ☐ Athletic
- ☐ Homemaking skills
- ☐ Good driver
- ☐ Good parenting skills
- ☐ Other _____
- ☐ Manages money well
- ☐ Organized
- ☐ Has empathy toward others
- ☐ Keeps appointments
- ☐ Makes friends easily

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PREFERANCES

☐ AM Appointments
☐ PM Appointments
☐ Female Therapist
☐ Male Therapist
☐ Specific age of therapist
☐ Spiritual Guidance Independently
☐ Therapy in home
☐ Therapy in office
☐ Therapy in school
☐ Group therapy
☐ Family therapy
☐ Individual Therapy
☐ Hearing-impaired services
☐ Sight-impaired services
☐ Spanish Speaking services
☐ Atypical antipsychotics
☐ No written/reading assignments
☐ Other_____

Client signature: _____ **Date: ____/___ /____**

Legal Guardian signature: _____ **Date: ____/___ /____**

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INFORMED CONSENT AND DISCLOSURE

Counseling Approach & Philosophy

The role of a counselor is to provide an environment of safety, trust, and mutual respect from which he/she and the client can cooperatively explore their world together. He/she will help the client to discover new perspectives and options from which they may choose to change their life situation according to the goals they establish. People become healthy and hopeful when they learn to balance their need for personal growth alongside fulfilling their responsibility to others. Our counselors are motivated by a very simple philosophy: Everyone is a person of value, everyone has an issue they struggle with, and every problem has a solution.

Benefits & Risks of Therapy

While the effects of counseling therapy have generally proven to be beneficial, there are some risks to consider. For example, some clients will experience uncomfortable feelings, and may, for a time, feel worse as they begin to work on sensitive areas of their lives or recall unpleasant memories. These feelings could possibly affect the client's life outside the counseling office. Others in the client's life may have a negative view of counseling which might create distance in their relationship. Any doubts or concerns the client has should be discussed prior to therapy, and if possible, should be alleviated in order to minimize the potential risks and maximize the benefits of therapy. Additionally, there may be options to counseling, such as support groups and/or self-help books, which may help to provide the results the client is seeking. Feel free to discuss any of these with the therapist.

Confidentiality

All counseling therapy is confidential within the exceptions provided by law. The therapist is otherwise unwilling and unavailable to offer support or testimony in court or legal situations of any kind unless compelled by law. The therapist may consult with other professionals or supervisors on client issues, however, identifying details are kept strictly confidential, unless you sign a specific written release. While wireless telephone communication is reasonably private, it is not guaranteed to be secure. Because our business phone is cellular, you should be aware of this while discussing therapy related issues in detail on the phone. Any correspondence via e-mail or text is likewise not guaranteed to be private, so reasonable precautions are advised. Unavoidable dual relationships will be discussed in therapy to decide on a mutually satisfactory approach.

While the therapist strives to be confidential as much as possible, there are certain situations in which confidentiality will not be able to be maintained. (1.) When necessary, the therapist will share information with parents regarding a child's individual therapy sessions in order to help parents to meet the child's needs, promote positive behavior, and increase optimal benefit. (2.) The therapist will not keep secrets in therapy when more than one person is involved in treatment. When treating a couple or family in therapy, the therapist views the entire family unit as the client in therapy. (3.) The Client or authorized person for the client has signed Releases of Information to important individuals in the client's life that will allow the therapist to talk with others regarding the client. (4.) If the therapist has reason to believe that a child client, or another child whose identifying information has been given, has experienced or is at risk of experiencing physical abuse, sexual abuse, emotional abuse, neglect, exploitation, the therapist is required by law to report this information to Child Protection Services.
(5.) The therapist is required by law to protect those who are the anticipated victims of physical harm or death. If anyone makes a claim that he or she plans to harm him/herself or another person, the therapist is required by law to take every step possible to protect these individuals from potential harm.

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Discontinuation of Therapy

While most therapy experiences are positive and beneficial to both the client and the therapist, there are times when the therapy process is not proving to be beneficial for the client, and possibly harmful to the therapist. The therapist reserves the right to ask any client or family to leave therapy if they believe that the continuation of therapy services with this therapist is not beneficial to the client. A client as well can request termination of services or consideration of changing to another available therapist. A client automatically is terminated from therapeutic care if not seen in a six-week time period.

Risks of Withdrawing from Therapy

Therapy is a process. If the client chooses to leave therapy during the process and has not learned necessary coping skills, there is a risk of harm. It is best to discuss these feelings with the therapist so that so that together the therapist and client can decide what is in the best interests of the client at that time.

Consent for Treatment of a Minor

If I am not the client, but I am signing as the authorized person for the client (guardian or parent), I hereby authorize the therapist and whomever they designate as their assistants to administer treatment of my child as necessary. An additional consent for treatment of a minor child will also be required.

Emergencies

If you, or the client you are authorized to sign for, needs emergency psychological help at a time when a therapist is not available, it is your responsibility to call 911 or another support service.

If you have any questions about this, please do not hesitate to ask.

_____

Client name

My Signature below signifies that I have read and understand all the above. I have been given a copy of this Informed Consent as well as an understanding of the policy can be found at www.EngageServices.Net.

_____ _____/_____/_____

Client or Authorized Person on Behalf of the Client **Date**

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FINANCIAL AGREEMENT

Payments
We are committed to providing you with the best possible care. Co-pays/Co-insurance/Cash Discounts are due at the time of service unless another agreement has been reached between you and Engage Services. We accept cash, checks, and credit/debit cards. Any amount not paid by a third party is expected to be paid by you within 30 days of the invoice to avoid a finance charge. Any account balances outstanding after ninety days will be subject to administrative review and can be considered for submission to a collection agency. Please contact the business office to inquire about payment plans and discount rates.

Other services
There is no charge for brief phone calls. However, calls requiring more than 10 minutes may be charged to the closet quarter hour at the Crisis Psychotherapy rate at the discretion of the therapist. Any legal appearances or professional work outside of normal therapeutic commitments will also be billed at this rate.

Cancellations and Missed Appointments
If you are unable to attend a scheduled session, it is your responsibility to let Engage Services know your intent to cancel your scheduled appointment. We reserve the right to charge a **$25 cancellation fee** if the scheduled session is not cancelled prior to 24 hours before the session or is without appropriate emergency exceptions. Any missed appointments will be assessed a **$75 missed appointment fee**. A complete fee schedule will be provided by request. Emergency exceptions will be considered on a per-needed basis.

Standard Fees
The standard fee for the initial Psychotherapy Evaluation is $300. For Subsequent Psychotherapy Sessions, the standard rate is $250. We offer a discounted and sliding fee rate **for payment at time of service** for those who do not have insurance or have not met their insurance deductible. A discount cash price and sliding fee are available for approved clients upon request. All accounts will be required to have a credit/debit card on file which will be charged at check in prior to the session and per the missed/cancelled appointment agreement. The client is required to make sure debit/credit cards on file are current and funded. (Call for information on discounts and sliding fee.) ***By signing this form, the client is giving permission to charge the card on file for the above agreed upon amounts. Discount pricing will not be allowed to carry a balance on the account.***

Insurance
Processing your insurance claims and tracking reimbursement is a benefit we provide to you. If you have medical insurance providing coverage for mental health counseling, we can assist in processing claims and tracking reimbursement. *Remember, you are ultimately responsible for any cost not covered by the insurance plan.*

Insurance Information **Copy of Insurance Card provided:** ◯ **Yes** ◯ **No**

Insurance Company _____ Phone Number _____

ID Number _____ Group Number _____

Policy Holder_____ Policy Holder DOB _____/_____/_____

Policy Holder Employer _____ Policy Holder Phone _____

Client's relationship to Policy Holder _____

Authorization for Health Insurance Claims
Engage Services utilizes documentation software that allows for billing to take place electronically. Information is stored then shared electronically with a clearinghouse that forwards the claims to your health insurance company. During this process, identifying information of the client such as name, date of birth, diagnosis and type of session is visible to health insurance companies. These companies are required by law to maintain confidentiality. *By signing below*, the client or authorized person on behalf of the client, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of the client. It also serves as my signature authorizing Engage Services to process claims without obtaining my signature on each submission.

My Signature below signifies that I have read and understand all the above. I have been given a copy of this agreement as well as understand the policy can be found at www.EngageServices.Net.

_____ _____/_____/_____

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TELEMENTAL HEALTH INFORMED CONSENT

I _____ [name of patient(s)] hereby consent to engaging in Telemental health with Engage Services LLC as part of my psychotherapy. I understand that "Telemental health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications. I understand that Telemental health also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in South Dakota or outside of South Dakota.
I understand that I have the following rights with respect to Telemental health:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical and mental health information also apply to Telemental Health. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self and/or an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

In case of emergency my location is: _____

and contact information for local emergency services is: _____

I understand the therapist may contact my emergency contact and/or appropriate authorities in case of emergency.

I also understand that the dissemination of any personally identifiable images or information from Telemental Health interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from Telemental health. These may include, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or limited ability to respond to emergencies.

In addition, I understand that Telemental health-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g., face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from Telemental health, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical and mental health information and copies of medical records in accordance with South Dakota law. I have read and understand the information provided above. I have discussed it with my psychotherapist, and all my questions have been answered to my satisfaction.

_____

Client Name

_____ ____/___ /____

Signature of Client/Parent/Guardian **Date**

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HIPAA ACKNOWLEDGEMENT FORM

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish. Our current Privacy Policy can also be found at www.engageservices.net.

My signature below signifies that I have received a copy of the Engage Counseling Services' HIPAA Notice of Privacy Practices as well as understanding the policy can be found at www.EngageServices.Net.

SIGN HERE if you were offered a privacy policy.

_____ ____/____/____

Client or Authorized Person on Behalf of the Client **Date**

Only sign below if you refuse to accept the privacy policy.

Client Refusal to accept Privacy Policy (Counseling service cannot be provided without agreement.)

_____ ___/___ /____

Signature **Date**

_____ ___/___ /____

Administrative Signature **Date**