



NEW CHILD CLIENT INFORMATION

All information provided to Engage Counseling Services on this form or during the initial intake session is 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 at any time.

PERSONAL INFORMATION

Client's Name: _____ Today's Date: _____
 Gender: Male Female Ethnicity: _____ Date of Birth ___/___/___ Age: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 SSN: _____ Student? Yes No School Name: _____
 Education Level Completed: Grade _____ GED High School College Other

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: _____

MINOR CONTACT INFORMATION

Home Phone: (____) _____ Leave Message? Yes No
 Cell Phone: (____) _____ Text Yes No
 Email: _____ Send Message? Yes No

IF CLIENT IS A MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION:

Guardian Name: _____ Relationship to Minor: _____
 Address: _____
 Home Phone: _____ Cell: Other: _____
 Email: _____

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

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

Date: _____ Signature: _____

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	<input type="radio"/>	<input type="radio"/>	Relationship/Marriage	<input type="radio"/>	<input type="radio"/>
Anxiety/Panic Attacks	<input type="radio"/>	<input type="radio"/>	Children	<input type="radio"/>	<input type="radio"/>
Anger	<input type="radio"/>	<input type="radio"/>	Academic	<input type="radio"/>	<input type="radio"/>
Grief	<input type="radio"/>	<input type="radio"/>	Job/Occupation	<input type="radio"/>	<input type="radio"/>
Life Change/Decision	<input type="radio"/>	<input type="radio"/>	Abuse/Trauma History	<input type="radio"/>	<input type="radio"/>
Substance/Alcohol Use	<input type="radio"/>	<input type="radio"/>	Sleep	<input type="radio"/>	<input type="radio"/>
Spiritual	<input type="radio"/>	<input type="radio"/>	Concentration	<input type="radio"/>	<input type="radio"/>
Hallucinations	<input type="radio"/>	<input type="radio"/>	Sexual Difficulties	<input type="radio"/>	<input type="radio"/>
Nutrition/Eating	<input type="radio"/>	<input type="radio"/>	Legal	<input type="radio"/>	<input type="radio"/>
Self-injurious Behavior	<input type="radio"/>	<input type="radio"/>	Other _____	<input type="radio"/>	<input type="radio"/>
Suicide	<input type="radio"/>	<input type="radio"/>	Other _____	<input type="radio"/>	<input type="radio"/>



ENGAGE SERVICES

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

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: 1 2 3 4 5 6 7 8 9 10?

Please explain: _____

Have you ever been hospitalized for emotional and/or behavioral concerns? (self-harm, suicidal ideation, etc.)

Yes No (If yes, please explain)

Explain: _____

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

Explain: _____

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
- Angry outbursts
- Excessive fear of specific places or objects
- Difficulty making friends

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, read, 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 address any of the topics you are concerned with?

Yes No (If yes, please explain): _____

Legal History:

(arrest history, sentencing, DUI occurrences, incarceration, litigation): _____

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

Yes No (If yes, please explain): _____

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 of 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 absolutely 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 absolutely 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.

Discontinuation of Therapy

While the majority of 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 particular 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, is in need of 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 understand the policy can be found at www.EngageServices.Net.

Client or Authorized Person on Behalf of the Client

Date



FINANCIAL AGREEMENT

Payments

We are committed to provide 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 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 make contact with 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

If you are unable to attend a scheduled session, it is your responsibility to let Engage Services know your intent to cancel the appointment. We reserve the right to charge \$50 if the scheduled session is not cancelled prior to 24 hours or without appropriate emergency exceptions.

Standard Fees

The standard fee for the initial Psychotherapy Evaluation is \$220 and may take the first 3 sessions. For Subsequent Psychotherapy Sessions, the standard rate is \$185. Any session not scheduled may be billed at the Crisis Psychotherapy rate of \$185 per hour. We offer a discounted rate for payment at time of service for those who do not have insurance or have not met their insurance deductible. This discounted rate is \$100 for an initial session and \$65 for subsequent sessions. For further information on Fee Schedules, visit www.EngageServices.Net

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 a documentation software that allows for billing to take place electronically. Information is stored then shared electronically with a clearinghouse that forwards the claims on to health insurance companies. Once the health insurance company has released payment, the clearinghouse sends them back to Engage Services. During this process, identifying information of the client such as name, date of birth, diagnosis and type of session is visible to employees at the clearinghouse and health insurance companies. These companies are required by law to view only the extent necessary to complete their job function and must 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 of the above. I have been given a copy of this agreement as well as understand the policy can be found at www.EngageServices.Net.

Client or Authorized Person on Behalf of the Client

____/____/____
Date



Telemental Health Informed Consent Form

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 the course of 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 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 the 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 be 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 of my questions have been answered to my satisfaction.

Client Name Signature of Client/Parent/Guardian

____/____/____
Date

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 understand the policy can be found at www.EngageServices.Net.

_____ Date

Client or Authorized Person on Behalf of the Client



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



Client Refusal

_____ / ____ / ____

Signature Date

Administrative Signature

_____ / ____ / ____

Signature Date

Minor Child Therapy Consent Agreement

(Print Child's Name)

____/____/____
(Date Of Birth)

It is an honor to have you trust Engage Counseling Services with the opportunity to work with your child. Prior to beginning treatment, it is important for you to understand our approach to child therapy and agree to some rules about your child's confidentiality during his/her treatment. The information herein is in addition to the information contained in the Informed Consent and Disclosure.

Parent Authorization for Minor's Mental Health Treatment

To authorize mental health treatment for your child, parental consent is required. If the parents of the child have an intact marriage, the consent of one parent is sufficient. However, if you are separated or divorced from the child's other parent, consent from both parents is required along with a copy of the most recent custody decree that establishes custody rights of you and the other parent. Exceptions for both signatures include if you are widowed; if you are an unmarried mother in a custody dispute; if you are a single mother without any custody agreement; or if custody paperwork specifically gives you the sole right to make decisions.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that we are meeting with your child. We believe that all parents have the right to be involved in their child's mental health treatment.

Zone of Privacy

Therapy is most effective when a trusting relationship exists between the therapist and a child. Privacy is especially important in securing and maintaining that trust. It is necessary for children to establish a "zone of privacy" with their therapist that allows them to feel free to discuss personal matters. Therefore, it is our policy to provide you with general information about the treatment of your child, but we will not share with you what your child has disclosed to us without your child's consent. However, if we ever believe that your child has been abused or is at serious risk of harming him/herself or another, we will inform you. This "zone of privacy" extends to information contained in treatment records as well. By signing this agreement, you are waiving your right of access to your child's treatment records. We will be happy to provide a written treatment summary upon request.

The "zone of privacy" or "confidentiality" *cannot be maintained* when:

- Your child tells me they plan to cause serious harm or death to themselves, and we believe they have the intent and ability to carry out this threat in the very near future.
- Your child tells me they plan to cause serious harm or death to someone else, and we believe they have the intent and ability to carry out this threat in the near future.
- Your child tells me, or we otherwise learn that it appears your child is being neglected or abused-- physically, sexually, or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, we are [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.
- We are ordered by a court to disclose information.



In other situations, even though we have agreed to keep your child’s treatment information confidential, we may believe that it is important for you to know about a particular situation that is going on in your child’s life. In these situations, we will encourage your child to tell you, we will help your child tell you, or we will tell you directly. Also, when meeting with you, we may sometimes describe your child’s problems in general terms, without using specifics, to help you know how to be more helpful to your child.

Parent/Guardian Agreement Not to Use Minor’s Therapy Information/Records in Custody Litigation

When we agree to treat your child, your child’s mental health becomes our primary concern. Our responsibility to your child may include addressing parenting and family concerns, but it does not include providing testimony for child custody/visitation proceedings. By signing this document, you agree that neither you nor your attorneys will seek to subpoena our records, ask us to testify in court whether in person or by affidavit, refer to things we have said in any court petition, or to provide letters or documentation expressing our opinion about parental fitness or custody/visitation arrangements.

This agreement may not prevent a judge from requiring my testimony. If we are required to testify, we are ethically bound *not* to give my opinion about either parent’s custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, we will provide information to them as needed (after releases are signed), but we will not make any recommendation about the final decision. Furthermore, if we are required to appear in court as a witness, the party responsible for my participation agrees to reimburse me at the current rate per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Thank you for your understanding and cooperation. If you have any questions about the information contained in this contract, please discuss them with me prior to signing below. Your signature indicates legally-binding agreement with the terms set forth in this contract.

Parent #1 Print Name: _____

Parent/Guardian: _____ Date: ____/____/____
Signature

Parent #2 (If available) Print Name: _____

Parent/Guardian: _____ Date: ____/____/____
Signature

Therapist: _____ Date: ____/____/____
Signature



Custodial Parents/Guardian Signature

____/____/____

(Print Child's Name)

(Date Of Birth)

Parent #1

I _____, give my authorization to Engage Counseling Services to provide counseling services for to the above minor client. I attest the following is my legal responsibility with this minor child and will promise to let Engage Services know if legal status changes.

Check on of the following:

- Custodial Parent Non-Custodial Parent Dual Custody Other _____

Parent/Guardian: _____ Date: ____/____/____

Signature

Parent #2 (If available)

I _____, give my authorization to Engage Counseling Services to provide counseling services for to the above minor client. I attest the following is my legal responsibility with this minor child and will promise to let Engage Services know if legal status changes.

Check on of the following:

- Custodial Parent Non-Custodial Parent Dual Custody Other _____

Parent/Guardian: _____ Date: ____/____/____

Signature

Receipt of divorce or custody degree. Date received: ____/____/____

Minor Child: _____ Date: ____/____/____

Signature

Therapist: _____ Date: ____/____/____

Signature