Amy Roth MS, NCC, LPC-MH
1500 S. Sycamore Ave, Ste 200, Sioux Falls, SD 57110
605.838.8545

Client Information

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY**

Client first name MI Last name Date

Address City State Zip code

Phone: home work cell

Email (optional)

Client's DOB Age Gender Message ok and preferred method to contact

Name of Spouse/Guardian Phone

Address City State Zip code

Person responsible for payment (please print name) Social Security #

X

Signature of person responsible for payment (*must be signed for services the begin*)

EMERGENCY INFORMATION
In case of emergency, contact:

Name (First and Last) Relationship

Phone: home work cell

Address City Sate Zip code

Primary Care Physician Phone

Address City State Zip code

Psychiatrist Phone

Address City State Zip code

Other physician(s) Phone

Current Medications:

Allergies:

Employment Information (If client is child, use parent's employment)

Client/guardian: place	Phone
Spouse: place	Phone

Insurance Information:

Primary insurance	Secondary Insurance
Phone	Phone
Contract/ID#	Contract/ID#
Group/Acct#	Group/Acct#
Subscriber	Subscriber
Subscriber DOB	Subscriber DOB
Client's relationship to subscriber	Client's relationship to subscriber
co-pay/deductible amount	co-pay/deductible amount

Referral source:
How did you hear about our clinic (of from whom)?

Journey Therapy at The Barn, LLC ♦ Journey Therapy and Consulting, LLC ♦ Journey Therapy Neurofeedback Clinic

1500 S Sycamore Ave, Ste 200, Sioux Falls, SD 57100 ♦ 605-351-1545

HIPAA Acknowledgment

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by looking on our website or using the above contact information.

Communication with Family and Friends

Journey Therapy at The Barn, LLC, Journey Therapy and Consulting, LLC, Tammy Lias, James Cady, and Amy Roth (hereinafter referred to as Journey Therapy) may share billing and general appointment information with the following individuals who are involved in the client's care.

Release to:_____ Relationship:_____

Release to:_____ Relationship:_____

Assignment of Insurance Benefits

I hereby assign all payments for therapy services rendered by Journey Therapy including Medicaid, private insurance, and other healthcare coverage to Journey Therapy. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, including any amount not covered by my insurance company. I authorize Journey Therapy to furnish medical information necessary to process insurance claims for me or my covered dependents.

Wireless Communications

I hereby agree to email or text reminders being sent to me for my appointments and messages left on my phone regarding appointments. ☐ DECLINE

I hereby agree that by providing my contact information of email address and/or phone number, I am granting my consent and understanding that when commuting via email, voicemail, text, or instant message these messages may be printed and placed in my file. ☐ DECLINE

No Show/Late Cancellation FEES

I understand that if I cancel o the day of (late cancel) or do not show for my scheduled session that there will be a fee applied to my account of $50. This fee will need to be paid by me prior to the next scheduled appointment. If there are 3 no shows in a row, the fee will need to be paid in full prior to scheduling any future session. Sessions canceled 24 hours prior to scheduled session time are not subject to this fee.

Consent to Treatment

I consent to treatment with Journey Therapy

Patient Legal Name (Print only)

Date of Birth

Date and time signed

Patient, Parent, or Legal Representative Signature

Relationship to Client

Amy Roth MS, NCC, LPC-MH
1500 S Sycamore Ave, Ste 200, Sioux Falls, SD 57110
605.838.8545

ACKNOWLEDGEMENTS OF RECEIPT OF PRIVACY PRACTICE

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. The most recent version will always be at my website at www.journeysupport.net in the Forms section. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at the phone number above. If you have any questions about my NOtice of Privacy Practices, please contact me at the address and/or phone number above

I acknowledge receipt of the Notice of Privacy Practices of Journey Therapy at The Barn, LLC, Amy Roth MS, NCC, LPC-MH.

Signature of patient/parent/conservator/guardian date

Signature of patient/parent/conservator/guardian date

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I made good faith attempts to obtain my patient's acknowledgement of his or her receipt of my NOtice of Privacy Practices, including (describe good faith attempts).

However, because of the above reasons, I was unable to obtain my person’s acknowledgement.

Signature of provider date

Client Rights

As a recipient of services at our facility, we would like to inform you of your rights as a patient. The information contained here explains your rights and the process of complaining if you believe your rights have been violated.

YOUR RIGHTS AS A PATIENT

1. Complaints. We will investigate your complaints.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil rights. Your civil rights are protected by federal and state laws.
4. Cultural/spiritual/gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment. You have the right to take part in formulating of your treatment plan.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
8. Availability of records. You have the right to obtain a copy and/or inspect your protected health information; however, we may deny access to certain records. If so we will discuss this cediscion with you.
9. Amendment of records. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. Medical/legal advice. You may discuss your treatment with your doctor or attorney.
11. Disclosures. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

YOUR RIGHTS TO RECEIVE INFORMATION

1. Medications use in your treatment. No medications will be prescribed by this therapist.
2. Costs of services. Wei will inform you of how much you will pay.
3. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our clinic.
4. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.
5. Policy changes.

OUR ETHICAL OBLIGATIONS

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will appropriately end services or refer clients to other programs when appropriate.
6. We willealuate our personalities limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
7. We respect various institutional managerial policies bue will help to improve such policies if the best interest of the client is served.

PATIENT'S RESPONSIBILITIES

1. You are responsible for our financial obligations to the clinic as outlined in the Payment Contract for Services.
2. You are responsible for following policies of the clinic.
3. You are responsible to treat staff and fellow patients in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.

WHAT TO DO IF YOU BELIEVE YOUR RIGHTS HAVE BEEN VIOLATED

If you believe that your patient rights have been violated, contact our Recipient's Rights Adviser or Clinic Director.