**SPIRALS COUNSELING, L.L.C.**
**Lynell Rice Brinkworth, MA, LMFT, QMHP**
623 Quincy Street, Suite 102 Rapid City, SD 57701
(605) 381-5277

Client name_____Referred By_____

Home phone_____Okay to call? Yes No Leave message? Yes No
Cell #_____Okay to call? Yes No Leave message? Yes No
Work #_____Okay to call? Yes No Leave message? Yes No
E-mail_____ Okay to E-mail? Yes No
Education completed_____

Family Members / Relationships / Age / Birthdate / Employment or school / Education

1. _____
2. _____
3. _____
4. _____
5. _____

Chief complaint (client's own words)_____
_____
What would you like to accomplish through therapy?_____
_____

Relationship status: S M SEP DIV W Live-in # Marriages_____ Religion_____

Previous marriages/living together (Name, Dates, How ended, # children)

1. _____
2. _____

Relevant Legal History_____
_____

Significant physical/medical problems_____
Physicians_____
Medications (include dosages)_____
Past/Present Psychotropic Medications (include dosages)_____

Has there been previous psychiatric care or counseling? YES NO
Dates Reasons Reason for termination
_____
_____

Has there been past or present substance abuse treatment? YES NO
Dates Type Successful Completion?
_____
_____

Person to contact in case of emergency:
_____
Name Address City/State/Zip Phone

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Office Policies, Procedures, Fee Agreement, and Informed Consent

THERAPY PROCESS: I am a Licensed Marriage & Family Therapist, providing therapeutic counseling services intended to diagnose and improve mental health and interpersonal relationships. Psychotherapy may include diagnostic services; individual, group, marital, or family therapy. Counseling is a process in which we talk about things in life. There are varying degrees of success and a lot of the success depends on what is revealed. I encourage you to share your thoughts and feelings to get clarity. I will sometimes give feedback, direction or guidance. At times the process may become uncomfortable because of things which come up; when it does, it is important to bring into the session all of your emotions to feel improvement. I also help clients to develop and integrate their own sense of spirituality or faith into their lives. Together, you and I will decide on frequency and types of treatment. Maximum benefits occur with regular attendance. Participation in counseling is voluntary.

While psychotherapy may vastly improve the quality of your life, it is also an expensive process. The duration of therapy is affected by the nature of your concerns and what your goals are. It is important that you feel that you are benefiting from treatment. If at any time you feel that you are not getting what you want or need out of therapy, I urge you to discuss this with me so that we can find a solution for your concerns.

CONFIDENTIALITY: All information disclosed to me in counseling sessions is confidential and may not be revealed to anyone without your written permission.

Exceptions to confidentiality are where disclosure is required by law and when therapists are required by their professional license, and legal and ethical guidelines to take action to protect its citizens from harm. Disclosure may be required in the following circumstances: (1) where there is a reasonable suspicion of child or elder abuse, (2) a client presents a danger of violence to others or a client is likely to harm himself/herself (3) pursuant to a legal proceeding. If it is determined that consultation with a colleague is in your best interest, this will be discussed with you. If it is necessary to contact you via phone, I will be discreet. If you have concerns about confidentiality or legal concerns, please seek legal counsel. It is important for you to understand that by utilizing your health insurance, I am required to provide them with certain information regarding services that are provided. I am required to provide a clinical diagnosis and sometimes a treatment plan or copies of your records. I make every effort to release only the minimum information requested. By signing this agreement, you agree that I can provide requested information to your insurance carrier for purposes of reimbursement.

If you fail to keep current on your bill, I have the right to utilize a collection agency or small claims court to obtain payment. This will require me to disclose confidential information. Typically, information released includes the client's name, nature of services provided, and the amount due.

By utilizing electronically transmitted communications (cell phone, e-mail, webcam, World Wide Web), I understand that my confidentiality may be compromised due to the limited ability to control all aspects of this technology. Please limit the disclosure of personal information to face-to-face conversations. Social Media of any kind is not part of the therapeutic process and no invitations will be accepted.

CONFIDENTIALITY OF MINORS: It is my priority to provide your child with the best services possible and keep them safe first and foremost. It is essential that youth, especially teenagers, are guaranteed that their information is confidential for them to freely express themselves and obtain the most out of their counseling sessions. The law may allow parents who have children under the age of 18, who are not emancipated to have access to their treatment information. I like to work with both the parent and youth to compromise on providing the parent with general information about their child's progress and attendance. More information may be shared with the child's permission. I will notify parents immediately if I have concerns that their child is in danger of harming themselves or someone else.

RECORDS: The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Since these are professional records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to an information request. Records are kept for approximately 7 years.

TELEPHONE CALLS AND EMERGENCIES: Office hours are between 8:00 a.m. and 5:00 p.m. If you need to contact me between sessions, please leave a message and I will return your call within 24 hours, with the exception of weekends and holidays. All calls are handled by confidential voicemail. If there is an emergency, and I am unavailable, contact your family physician, emergency room/urgent care, or Crisis Care Center.

CANCELLATIONS: Since the scheduling of an appointment involves the reservation of time specifically for you, you will be expected to pay for it unless you provide a minimum of 24-hours notice of cancellation. An exception may be made when circumstances are beyond your control. Insurance companies do not provide reimbursement for cancelled sessions. You will not be charged for your missed appointment if you can reschedule within the same week.

PAYMENT FOR SERVICES: My hourly fees are listed below:

| **Initial Session** | **Individual** | **Family/Couple** |
|---|---|---|
| $160 | $150 | $150 |

Each session will be between 45-55 minutes. Payment is due at the time of the session, although other billing arrangements may be made on a case-by-case basis. Teletherapy is billed as a regular session and may not be covered by insurance.

As a courtesy to my clients, I will bill your insurance company, however, you, (not your insurance company) are responsible for full payment of my fees. I will accept a client's co-pay amount once the insurance has been established and is flowing smoothly.

Failure to keep current on your bill, or to make a written alternative plan may result in the termination of therapy. If a client has not made payments, or other written arrangements, you agree that all costs of collection of the fee set forth in this contract, including Lynell Rice Brinkworth's time conferring with attorneys, drafting correspondence, or appearing in court shall be payable to at the rate of $150 per hour. In addition, any attorney's fees incurred while enforcing this agreement shall be recoverable.

Any account that has a returned check will have a $35 service charge added to the bill.

CONTRACT AGREEMENT: I agree that, in signing this policies, procedures, and fee agreement, I have read and fully understand the terms contained herein. Fees are due at the time of scheduled session, unless other arrangements are made in advance. This fee may be renegotiated in a new fee agreement from time to time as my personal financial situation may change. Further, I am aware that in the event of nonpayment, my account may be turned over to a collections agency. If I choose to utilize my health insurance, I agree that payment may be made directly to Spirals Counseling, LLC/Lynell Rice Brinkworth, MA, LMFT, QMHP.

In signing, I am agreeing to the above terms of the counseling relationship.

| | | | |
|---|---|---|---|
| Signature of Client/Guardian | Date | Signature of Minor/Client | Date |
| Signature of Client/Guardian | Date | Lynell Rice Brinkworth, MA, LMFT, QMHP | Date |

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## Notice of Privacy Practices

The following is a summary of my privacy policy, which is based on the federal law HIPAA (Health Insurance Portability and Accountability Act) governing patient privacy and my own high standard of patient confidentiality.

**Uses and Disclosures:** I believe you have a right to know what I do with the health information that is gathered about you as a client in my practice. I want to assure you that I am properly safeguarding your important information. Once you have signed this form, I may use your health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. In addition, I may be required to disclose information to comply with state or federal laws. Examples include, but are not limited to, report of abuse to a minor, court orders, or imminent danger to yourself or others. However, generally I will ask for your written authorization before using or disclosing identifiable health information about you.

**Your Rights: As a client this statement provides for equality of opportunity and treatment regardless of race, age, color, sex, national origin and ancestry.** You have a right to inspect and request your protected health information. However, under law you may not necessarily have copies of the following records including, but not limited to, psychotherapy and psychiatric progress notes. You have the right to request a restriction of your protected health information. You have a right to receive an accounting of certain disclosures I have made of your protected health information. Any of the above requests must be made in writing and I will discuss the process with you upon request. Please allow reasonable time to allow me to respond to the request and/or to compile the information.

**My Duties:** I am required by law to protect the privacy of your information, provide this notice about my information practices, follow the information practices that are described in this notice, and seek your acknowledgment of receipt of this notice. I also reserve the right to amend the policies described in this notice and am required to abide by these terms unless I notify you of any changes. You can also request a copy at any time and I will provide you with a copy with any revisions.

**Concerns**: If you have questions or concerns about the privacy practices, please discuss it with me. You may also send a written complaint to the South Dakota Board of Counselor Examiners. I support your right to the privacy of your health information.

If you have concerns about your privacy rights, feel your rights have been violated and wish to file a compliant with me, please submit your written complaint to Spirals Counseling, LLC Attn: Lynell Rice Brinkworth, 623 Quincy Street, Suite 102, Rapid City, SD 57701

**Your signature acknowledges that you have read this agreement and agree to its terms. It also serves as acknowledgment that you have received the Notice of Privacy Practices.**

I, _____ have ready the Notice of Privacy Practices.

Print Name:_____

Signature of Client:_____Date:_____

Signature of Parent/Guardian/Custodian:_____Date:_____