Family Solutions Center
6116 S. Lyncrest Ave. Suite 101
Sioux Falls, SD 57108-2576
(605)339-0880

NEW CLIENT INFORMATION

CLIENT

Name _____Date: _____

Address _____

_____Zip Code _____

Home Phone (____)_____Work Phone (____)_____
Cell Phone (____)_____ I give permission to leave messages_yes__no

Date of Birth _____age_____male _____female_____

Civil Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

SPOUSE/PARENT (if client is a minor child)

Name _____

Address (if different than client) _____

_____Zip Code _____

EMPLOYMENT OF RESPONSIBLE PARTY

Employer _____ Occupation _____

Address _____ Phone (____)_____

BILLING NAME/RESPONSIBILITY (if other than client)

Name _____ Relation to client _____

Address _____ Phone (____)_____

INSURANCE INFORMATION

Name of Company _____

Please supply insurance card for copying

Date of Birth of policy holder _____

INSURANCE AUTHORIZATION

I hereby authorize Family Solutions Center to release necessary information to insurance carriers concerning my diagnosis and treatment in order to process my claims. I hereby authorize direct payment to Family Solutions Center from insurance carriers for services rendered if my account in not paid in full. I permit a copy of this authorization to be used in place of the original.

Signature of Client or Gaurdian _____

Date _____

(over)

HEALTH INFORMATION

My present health is ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List any significant health concerns _____

Are you currently under the care of a physician? ☐ Yes ☐ No
If 'yes', for what? _____

Are you taking medications at this time? ☐ Yes ☐ No
If 'yes', list drugs, dosage, schedule:

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Do you smoke? ☐ Yes ☐ No Packs per day? _____ How long? _____years

Have you ever smoked? ☐ Yes ☐ No

Do you use alcoholic beverages? ☐ Yes ☐ No
If 'yes', how often? _____

Have you ever received or are you now receiving Family Therapy, Psychological, or Psychiatric counseling? ☐ Yes ☐ No

Referred by _____ Family Doctor _____

PHYSICIAN AUTHORIZATION

If your physician referred you, it is helpful for your therapist at Family Solutions Center to be able to confer with your personal physician regarding your diagnosis and treatment.

I give my permission for my therapist at Family Solutions Center to release records and/or information about my treatment to my physician for the purpose of treatment, planning, and coordinating psychotherapy with my physical health care needs. I may withdraw this consent at anytime in writing or verbally by advising Family Solutions Center.

☐ Yes I AUTHORIZE this release. ☐ No, I DO NOT.

Client Signature _____ Date_____

Physician _____
(if different than above)

Consent withdrawn on _____

Fee Schedule:

Initial Intake	$165.00
20-30min. Session	$75.00
50-60min.Session	$125.00

Many insurance companies provide some coverage for mental health treatment. However, you, and not your insurance company are responsible for the full payment of your bill. Therefore, it is very important that you find out exactly what your policy covers. You can do that by referring to your policy handbook or calling the 800 number on your insurance card.

You are expected to pay your full fee at the time of service unless you are certain that your insurance will cover a percentage of your fee. In that case, you are expected to pay your co-pay or co-insurance, and whatever deductible you may have.

You will be sent a monthly bill that reflects your charges, what you have paid and what your insurance company has paid. You are expected to pay your balance in timely manner. Interest will accrue at the rate of 1.25% monthly (15% annual) on the unpaid balance after 90 days from the initial billing date. If your bill is delinquent and suitable arrangements for payment have not been agreed to, Family Solutions Center has the option of using legal means to secure payment, including collection agencies of small claims court. If legal options must be used, you will forfeit your right to confidentiality to the extent necessary to process the legal claim against you.

About this contract
Please take the opportunity to discuss any and all questions and concerns you have regarding this contract with your therapist. A copy of this agreement will be kept in your clinical record. You will also be provided a copy for your personal records.

My signature below indicates that I have read the information in this document and agree to abide by its terms during my professional relationship with my therapist.

Signature of Client (parent if client is a minor):_____
Date:_____

Signature of Therapist:_____Date:_____