BREAKTHROUGH
Christian Counseling & Alternative Education Center

Date/Submitted:

_____

Therapist:

_____ Account #: _____

Application for Services (Ages 5-17)

Minor Information
Office Use Only

Name: _____ **DOB**: ___/___/_____ **SSN:** _____ - _____ - _____ **Address**:

_____ **City/State/Zip**: _____

BioSex: _____ **Ethnicity**: _____ **Religion/Church**: _____

Age: _____ **Grade:** _____ **School:** _____

If Applicable: Phone: _____ **Email**: _____ **Appointment Reminders:** *Appointment Reminders default to email. Ask our Office Manager about texting options.* ***The individual listed in this section will hereinafter be referred to as (Minor).***

Parent/Guardian Information (1)

Name: _____ **DOB**: ___/___/_____ **Relationship to (Minor):** _____

BioSex: _____ **Ethnicity**: _____ **Phone:** _____ **Email**: _____

Preferred Contact (Circle One): Phone/Email **Emergency Contact for Minor? (Circle One):** Yes No

Marital Status: _____

If applicable - Date of Separation: _____

If applicable - Stepparent name: _____

Check if the info below is the same as (Minor).

Address: _____ **City/State/Zip**: _____

Religion/Church: _____

Appointment Reminders: *Appointment Reminders default to email. Ask our Office Manager about texting options.*

Parent/Guardian Information (2)

Name: _____ **DOB**: ___/___/_____ **Relationship to (Minor):** _____

BioSex: _____ **Ethnicity**: _____ **Phone:** _____ **Email**: _____

Preferred Contact (Circle One): Phone/Email **Emergency Contact for Minor? (Circle One):** Yes No

Marital Status: _____

If applicable - Date of Separation: _____

If applicable - Stepparent name: _____

Check if the info below is the same as (Minor).

Address: _____ **City/State/Zip**: _____

Religion/Church: _____

Appointment Reminders: *Appointment Reminders default to email. Ask our Office Manager about texting options.*

1701 E. 69th St., Ste A, Sioux Falls, SD 57108
p: 605.275.2280 | www.breakthroughsfc.org | f: 605.271.2026

Clinical History

What is the primary reason for referral/seeking services?

Description of circumstances leading up to seeking services for (Minor). Description of any mental health concerns you have for (Minor). Symptoms, Onset, Duration, Frequency, etc.

Are you currently experiencing a crisis? (Circle) Y N *If yes, please describe.*

Has (Minor) ever undergone psychiatric testing (includes testing with a school psychologist)? (Circle) Y N *If yes, please describe - Please provide dates of testing and a brief summary of results. Full results may be requested by your assigned therapist.*

Has (Minor) ever experienced a traumatic event? (Circle) Y N *If yes, please describe - Could include but not limited to the following: Physical, Emotional, or Sexual Abuse. Serious injury due to an event or natural disaster. Parental separation. Adoption (Primal Wound Trauma). Personal or Familial drug/alcohol abuse.*

Is there a history of mental illness in the family? (Circle) Y N *If yes, please describe. If minor is adopted/in foster care include biological family history as is known.*

Medical History

Please list all current and past medical conditions of (Minor).
Conditions, treatments, allergies, etc.

(Minor) Current Height: _____ (Minor) Current Weight: _____

The above information is used to calculate the client's current Body Mass Index (BMI). An individual's BMI (whether high, low, or in the normal range) can influence their mental health in many ways. If you are uncomfortable with this question, please feel free to leave blank.

Is (Minor) currently on any medication(s)? (List Below)

Medication Dosage Purpose Prescribing Physician

Please list any additional medications on separate paper.

Does (Minor) have a history of substance use? (Circle) Y N *If yes, please describe - Substances used (alcohol, tobacco, prescription drug use (other than those listed above), other drug use.*

Primary Physician: _____

Clinic: _____ _____ **Phone:** _____ **Email**: _____ **Address**:

_____ **City/State/Zip**: _____

Permission to Contact? (Additional Release of Information may be requested)

Psychiatrist (If Applicable): _____

Clinic: _____ _____ **Phone:** _____ **Email**: _____ **Address**:

_____ **City/State/Zip**: _____

Permission to Contact? (Additional Release of Information may be requested)

Previous Mental Health Counselor (If Applicable): _____

Clinic: _____ _____ **Phone:** _____ **Email**: _____ **Address**:

_____ **City/State/Zip**: _____

Permission to Contact? (Additional Release of Information may be requested)

Please list any additional health professionals serving (Minor) on separate paper. Additional Release of Informations may be requested.

Family History

Is (Minor) an adopted child? (Circle) Y N *If yes, please describe - General description of adoption process, State/Agency where adoption was processed, open vs closed, history of contact with biological parents, etc.*

Does (Minor) have any siblings? (List Below)

Name	Age	Biological/Half/Adopted *In regards to (Minor)*	Living in Home *With (Minor)*
			Y N
			Y N
			Y N
			Y N

Please list any additional siblings on separate paper.

Please describe the relationship between (Minor) and parents/guardians:

Please describe the relationship between (Minor) and siblings:

Please describe the relationship between (Minor) and other significant family members:

Social History

Please list significant relationships that influence (Minor) below:
*Friendships, romantic relationships, **bullies**, etc.*

Name Age Reason for Significance *From your perspective*

Please list any additional significant relationships on separate paper.

Please describe the relationship between (Minor) and friends/peers:

Please describe the nature of (Minor's) online activity:

Church Name: _____ **Denomination:** _____ **Pastor and/or Youth Director:** _____ _____ **Phone:** _____ **Email**: _____

Address: _____ **City/State/Zip**: _____

Permission to Contact? (Additional Release of Information may be requested)
Potential consults with pastor and/or youth director regarding client's mental health in church community.

Please list (Minor's) involvement with church and/or youth group:

Besides church, what other community involvement does (Minor) have?

Early Development and Home Background (EDHB) Form—Parent/Guardian

Child's Name: _____ **Age:** ____ **Sex:** ❑ Male ❑ Female **Date:**_____

Instructions to Parent or Guardian: Questions P1-P19 ask about the early development and early and current home experiences of your child. Some questions require that you think as far back as to the birth of your child. Your response to these questions will help your child's clinician better understand and care for your child. Answer each question to the best of your knowledge or memory.

What is your relationship with the child receiving care? _____

Please choose one response (✓ or x) for each question.

	Early Development	**No**	**Yes**	**Can't Remember**	**Don't Know**
P1.	Was he/she born before he/she was due (premature)?	☐	☐	☐	☐
P2.	Were the doctors worried about his/her medical condition immediately after he/she was born?	☐	☐	☐	☐
P3.	Did he/she have to spend any time in a neonatal intensive care unit (NICU)?	☐	☐	☐	☐
P4.	Could he/she walk on his/her own by the age of 18 months?	☐	☐	☐	☐
P5.	Has he/she ever had a seizure?	☐	☐	☐	☐
P6.	Did he/she ever lose consciousness for more than a few minutes after an accident?	☐	☐	☐	☐
	Early Communication				
P7.	By the time he/she was age 2, could he/she put several words together when speaking?	☐	☐	☐	☐
P8.	Could people who didn't know him/her understand his/her speech by the time he/she reached age 4?	☐	☐	☐	☐
P9.	Have you ever been concerned about his/her hearing or eyesight?	☐	☐	☐	☐
P10.	By the time he/she was age 4, was he/she interested in playing with or being with other children?	☐	☐	☐	☐
	Home Environment				
P11.	Was there ever a time when he/she could not live at home and someone else had to look after him/her?	☐	☐		☐
P12.	Has he/she ever been admitted to the hospital for a serious illness?	☐	☐	☐	☐
P13.	Does anyone at home suffer from a serious health problem?	☐	☐		☐
P14.	Does anyone at home have a problem with depression?	☐	☐		☐
P15.	Does anyone at home regularly see a counselor, therapist, or other mental health professional?	☐	☐		☐
P16.	Does anyone at home have a problem with alcohol, drugs, or other substances?	☐	☐		☐
P17.	Would you say that the atmosphere at home is usually pretty calm?	☐	☐		☐
		Less Than Once a Month	**Between Once a Week and Once a Month**	**More Than Once a Week**	**Most Days**
P18.	How often are there fights or arguments between people at home?	☐	☐	☐	☐
P19.	How often does your child get criticized to his/her face by other family members when he/she is at home?	☐	☐	☐	☐

David Shaffer, F.R.C.P., F.R.C., Psych.

Current School: _____ **Phone:** _____ **Email**: _____ **Address**:

_____ **City/State/Zip**: _____

Permission to Contact? (Additional Release of Information may be requested.
Potential consults with school counselors, school social workers, administrative staff, learning center staff, etc.

Please list other schools attended:

School City Dates Attended Permission to Contact? (Circle) Y/N Y N

Y N

Please list any additional schools attended on separate paper. Additional Release of Informations may be requested for schools above, and for additional schools listed separately.

What concerns (if any) do you have for (Minor's) educational needs?
IEP or 504 Information. Learning disability description.

What is (Minor's) favorite subject in school?

What are (Minor's) academic strengths/interests/achievements?

Are you interested in learning about Breakthrough Alternative Education? (Circle) Y N *If yes, for what reason?*

**Breakthrough Alternative Education is a program designed for individuals whose mental health is prohibiting them from being successful in a traditional classroom. Breakthrough Education is not limited to students who have lower grades. The program focuses on surrounding the student with care in all areas of their life from a mental health perspective. Breakthrough Education is not a Special Education or a Behavior Program.*

Please list all previous mental health placements, services, and/or interventions and the reason for services/placement. *Examples: Avera Behavioral Health, Residential Treatment Centers, etc.*

Placement Name City Dates Attended Permission to Contact? (Circle) Y/N Y N

Y N

Please list any additional placements attended on separate paper. Additional Release of Informations may be requested for placements above, and for additional placements listed separately.

Does (Minor) have any past or present legal problems? (Circle) Y N If yes, please describe.

Does anyone in the family have past or present legal problems? (Circle) Y N If yes, please describe.

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ Male ☐ Female **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS**, how much (or how often) has your child...	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS**, has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS**, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

SNAP/Other Information

Please list (Minor's) Strengths, Needs, Abilities, and Preferences:
Hobbies, interests, talents, extracurriculars, future plans, etc.

Please list any other important information you would like the counselor to know:

What are your short-term goals for (Minor)?

What are your long-term goals for (Minor)?

Referral Information (If Applicable)

How did you hear about Breakthrough?

Name of Referral Source: _____ Referral Source Agency (If Applicable):

_____ **Relationship to Minor: _____ Phone: _____ Email**:

_____ Permission to Contact? (Additional Release of Information may be requested.

Insurance

Please attach a copy/picture of both the front and back of your insurance card.

I would prefer copies be made at the intake session.
I am considering private pay options at this time.

Ask our Office Manager about payment plans, community funding/scholarships, and private pay options.

Insurance Carrier:

_____ ID Number:

_____ Group Number: _____ Policy

Holder: _____ Relationship to Client: _____

DOB: ___/___/_____ **SSN:** _____ - _____ - _____

Therapist Preference

We will do our best to match (Minor) and your family with a therapist who meets your preferences. This is not guaranteed.

We would like a therapist who specializes in the following:

Academic Concerns
Adoption
Anxiety
Behavior Analysis
Coping Skills
Depression
Divorce/Separation
Family Systems
Identity
Parent Coaching
Psychoeducation
Self-Harm
Sexual Abuse/Assault
Social/Emotional
Spirituality
Trauma Informed Care
Other: _____

Additional Notes:

Therapy Techniques

Breakthrough therapists are trained to use a variety of approaches during sessions. Combined with Person-Centered Talk Therapy, the following techniques may be used with (Minor). If you have any questions or concerns regarding any item listed below please consult with your therapist prior to initialing.

My initials below give consent for (Minor) and assigned therapist to work together on (Minor)'s mental health using the following therapy techniques. I understand that I can adjust these permissions at any time. I understand that any therapy technique can result in (Minor) feeling emotional, tired, and may present as irritable after a therapy session.

Therapy Technique	Initials	Date
Brain Spotting - *psychotherapy that uses spots in a person's visual field to help them process through feelings and past events..*		
Cognitive Behavioral Therapy (CBT) - *talking therapy that can help a person manage their problems by changing the way they think and behave.*		
Eye Movement Desensitization and Reprocessing (EMDR) - *psychotherapy that enables a person to heal from the emotional distress that is the result of difficult life experiences.*		
Mind/Body/Spirit Connection - *an active therapy that uses different body stretches to activate relaxation in the body while calming the mind and integrating Christian prayer.*		

By signing below I (we) state that the information stated on this Breakthrough Application for Services is accurate to the best of my (our) knowledge.

_____ _____ _____ Client's
Printed Name Parent/Guardian's Printed Name Parent/Guardian's Printed Name

_____ _____ _____
Parent/Guardian's Signature Parent/Guardian's Signature Date

BREAKTHROUGH
Christian Counseling & Alternative Education Center

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Breakthrough Christian Counseling and Alternative Education Center, LLC (the "Practice") is committed to protecting your privacy. The Practice is required by federal law to maintain the privacy of Protected Health Information ("PHI"), which is information that identifies or could be used to identify you. The Practice is required to provide you with this Notice of Privacy Practices (this "Notice"), which explains the Practice's legal duties and privacy practices and your rights regarding PHI that we collect and maintain.

Your Rights

Your rights (and the rights of your child) regarding PHI are explained below. To exercise these rights, please submit a written request to the Practice at the address noted below.

- **To inspect and copy PHI**
  - ○ You can ask for an electronic or paper copy of PHI. The Practice may charge you a reasonable fee. ○ The Practice may deny your request if it believes the disclosure will endanger your life, your child's life, or another person's life. You may have a right to have this decision reviewed.
- **To amend PHI**
  - ○ You can ask to correct PHI you believe is incorrect or incomplete. The Practice may require you to make your request in writing and provide a reason for the request.
  - ○ The Practice may deny your request. The Practice will send a written explanation for the denial and allow you to submit a written statement of disagreement.
- **To request confidential communications**
  - ○ You can ask the Practice to contact you in a specific way. The Practice will say "yes" to all reasonable requests per medical standards.
- **To limit what is used or shared**
  - ○ You can ask the Practice not to use or share PHI for treatment, payment, or business operations. The Practice is not required to agree if it would affect your and your child's care.
  - ○ If you pay for a service or health care item out-of-pocket in full, you can ask the Practice not to share PHI with your health insurer.
  - ○ You can ask for the Practice not to share your PHI with family members or friends by stating the specific restriction requested and to whom you want the restriction to apply..
- **To obtain a list of those with whom your PHI has been shared**
  - ○ You can ask for a list, called an accounting, of the times your health information has been shared. You can receive one accounting every 12 months at no charge, but you may be charged a reasonable fee if you ask for one more frequently.
- **To receive a copy of this Notice**
  - ○ You can ask for a paper copy of this Notice, even if you agreed to receive the Notice electronically. ●

To choose someone to act for you or your child

  - ○ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights.
- **To file a complaint if you feel your rights are violated**
  - ○ You can file a complaint by contacting the Practice using the following information

    Breakthrough Christian Counseling and Alternative Education Center
    1701 E 69th St, Suite A
    Sioux Falls, SD 57108
    Clinical Director: Krysta Winter
    P: 605-275-2280 / F: 605-271-2026

Your Rights and Complaint information continued on the following page.

- **To file a complaint if you feel your rights are violated - Continued**

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- The Practice will not retaliate against you for filing a complaint.

- **To opt out of receiving fundraising communications**
  - The Practice may contact you for fundraising efforts, but you can ask not to be contacted again.

Our Uses and Disclosures

1. Routine Uses and Disclosures of PHI

a. The Practice is permitted under federal law to use and disclose PHI, without your written authorization, for certain routine uses and disclosures, such as those made for treatment, payment, and the operation of our business. The Practice typically uses or shares your (child's) health information in the following ways: i. To treat you

1. The Practice can use and share PHI with other professionals who are treating you (your child). Example: Your primary care doctor asks about your (child's) mental health treatment.

ii. To run the health care operations

1. The Practice can use and share PHI to run the business, improve your (child's) care, and contact you. Example: The Practice uses PHI to send you appointment reminders if you choose.

iii. To bill for your services

1. The Practice can use and share PHI to bill and get payment from health plans or other entities. Example: The Practice gives PHI to your health insurance plan so it will pay for your (child's) services.

2. Uses and Disclosures of PHI That May Be Made Without Your Authorization or Opportunity to Object. a. The Practice may use or disclose PHI without your authorization or an opportunity for you to object, including:

i. To help with public health and safety issues

1. Public health: To prevent the spread of disease, assist in product recalls, and report adverse reactions to medication.
2. Required by the Secretary of Health and Human Services: We may be required to disclose your (child's) PHI to the Secretary of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.
3. Health oversight: For audits, investigations, and inspections by government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
4. Serious threat to health or safety: To prevent a serious and imminent threat.

ii. Abuse or Neglect: To report abuse, neglect, or domestic violence.

iii. To comply with law, law enforcement, or other government requests

1. Required by law: If required by federal, state or local law.
2. Judicial and administrative proceedings: To respond to a court order, subpoena, or discovery request.
3. Law enforcement: For law locate and identify you or disclose information about a victim of a crime
4. Specialized Government Functions: For military or national security concerns, including intelligence, protective services for heads of state, or your security clearance.
5. National security and intelligence activities: For intelligence, counterintelligence, protection of the President, other authorized persons or foreign heads of state, for purpose of determining your own security clearance and other national security activities authorized by law.
6. Workers' Compensation: To comply with workers' compensation laws or support claims.

iv. To comply with other requests

1. Coroners and Funeral Directors: To perform their legally authorized duties.
2. Organ Donation: For organ donation or transplantation.
3. Research: For research that has been approved by an institutional review board.
4. Inmates: The Practice created or received your PHI in the course of providing care.
5. Business Associates: To organizations that perform functions, activities or services on our behalf.

Our Uses and Disclosures - Continued

3. Uses and Disclosures of PHI That May Be Made With Your Authorization or Opportunity to Object

Unless you object, the Practice may disclose PHI:

a. To your family, friends, or others if PHI directly relates to that person's involvement in your care. If it is in your best interest because you are unable to state your preference.

4. Uses and Disclosures of PHI Based Upon Your Written Authorization

a. The Practice must obtain your written authorization to use and/or disclose PHI for the following purposes: Marketing, sale of PHI, and psychotherapy notes.

b. You may revoke your authorization, at any time, by contacting the Practice in writing, using the information above. The Practice will not use or share PHI other than as described in Notice unless you give your permission in writing.

Our Responsibilities

- The Practice is required by law to maintain the privacy and security of PHI.
- The Practice is required to abide by the terms of this Notice currently in effect. Where more stringent state or federal law governs PHI, the Practice will abide by the more stringent law.
- The Practice reserves the right to amend Notice. All changes are applicable to PHI collected and maintained by the Practice. Should the Practice make changes, you may obtain a revised Notice by requesting a copy from the Practice, using the information above, or by viewing a copy on the website https://breakthroughsfc.org/resources/. • The Practice will inform you if PHI is compromised in a breach.

This Notice is effective on 4/7/2022.

_____ _____ Client's Printed Name Parent/Guardian's Printed Name

NA if Client 18+

_____ _____ Signature of Parent/Guardian **or** 18+ Client Date

BREAKTHROUGH
Christian Counseling & Alternative Education Center

Consent for Services

Services Provided
Breakthrough is a Christian-based organization that offers a variety of therapy, treatment, and educational services based on individualized programs for the client. The pieces of this program are assembled, monitored, assessed, and provided by a team of professional therapists, education staff, and administration that seeks to carry out the mission of Breakthrough.

Psychotherapy
Psychotherapy has risks and benefits. These may include discussions of personal challenges which can elicit uncomfortable feelings and thoughts. Psychotherapy has potential benefits such as healthier interpersonal relationships, improved academic performance, solutions to specific problems, and decreased distress. There is no assurance of these risks and benefits.

Fees for Service
See the fee agreement page for an understanding of programming costs.

Confidentiality
Per professional ethical standards and state and federal law, all services provided by Breakthrough are kept confidential except as noted below and in the *Notice of Privacy Practices* form.

- Consultation with appropriate staff and supervision
- Records with other client medical and school providers, with a Release of Information form
- If the client is likely to harm themselves or others
- If the client has been or is likely to be harmed by others
- Valid court order from a judge

Counseling sessions will not be audio recorded or videotaped without client and applicable (client is under the age of 18) parental consent.

Please be aware that email may not be private or confidential. Your counselor will not communicate therapeutic information via email without encryption services, unless requested.

Counselors and other staff will not accept requests for connecting or messaging on social media sites. It is not part of our practice to search for clients/families on social media or other websites. The exception to this would be for the bulleted reasons above, ensuring client and other's safety and welfare.

Location-based services, such as on a smartphone or computer, may compromise your privacy while at Breakthrough.

Right to Records
Parents/guardians have the right to a copy of and to review their child's records. 18+ clients have the right to a copy of their own records. Records may not be examined that have been shared with Breakthrough by other organizations. Parts of the record may be redacted before viewed if it is determined by the therapist that the sharing of information would be harmful to the mental health of the client.

Transportation and Building Safety
Breakthrough Counseling, LLC does not provide transportation or escort clients to and from Sioux Falls Christian schools and/or other organizations. The exception to this policy (Breakthrough Volunteering) will require additional permissions. There may be times where the Breakthrough front desk is not staffed. Clients and parents/guardians are welcome to wait in the lobby for their therapist whether or not the front desk is staffed. We request that individuals under the age of 10 not wait in the lobby without the supervision of a parent/guardian regardless if the Breakthrough front desk is staffed.

Emergency/Crisis Situations
Breakthrough Counseling, LLC is NOT a medical emergency or crisis intervention facility. In the event of an emergency or crisis between scheduled appointments, go to the nearest emergency room or seek help by calling the South Dakota Suicide Prevention HELPLine at 605.339.4357 or the Suicide Crisis Center 24-Hour Line at 800.273.8255, or call 911 if it is a life-threatening situation.

In the event of a medical emergency or crisis situation while the client is at Breakthrough, we will contact the appropriate services and the parent, guardian, and/or emergency contact.

Psychiatric Consults and Medication
Breakthrough does not retain a psychiatrist on staff, nor do we prescribe or dispense medications. Breakthrough can provide you with a psychiatric referral if deemed necessary. You may sign a release to enable Breakthrough to consult with a psychiatrist.

Missed Appointment Policy

No shows and/or cancellations within 24 business hours will result in a non-refundable missed appointment fee of $125. Three missed appointments that accrue a fee may result in losing a regularly scheduled appointment time or termination of services. Fees are not charged if cancellation occurs due to inclement weather or illness. If sessions are affected by weather conditions, clients may be offered a Telehealth session. A fee will not be charged if a client declines the Telehealth option. Scheduling conflicts such as school activities or other appointments should be communicated to the Breakthrough Office Manager at least 24 business hours in advance to avoid being charged a fee.

Defamation

By signing this form, you agree that you (and your child) will not make defamatory comments about Breakthrough or staff. In the event that defamatory remarks are made, you further consent to allowing Breakthrough to use confidential information as is necessary to rebut, defend against, or prosecute claims for the defamation.

Minor Assent

During the intake session your therapist will read the "Minor Assent Form" out loud to all attendees. The minor assent form is for youth to understand their rights as a minor client. A copy of this form can be located on the Breakthrough website.

Consent to Treatment

By signing below, I agree to allow myself/my child to enter the Breakthrough program. I understand I have the right not to sign this form. My signature below indicates I have read and discussed this agreement; it does not indicate that I am waiving any of my (child's) rights. I understand I can choose to discuss my concerns with the counselor before I/my child begins therapy. I understand that after therapy begins I have the right to withdraw my consent to my (child's) therapy at any time, for any reason. However, I will make every effort to discuss my concerns with the therapist or Breakthrough administration before ending the treatment program.

I understand that no specific promises have been made to me by the therapist or Breakthrough staff about the results of my (child's) enrollment in the program. I understand that violation of the policies above may result in the termination of my (child's) services.

Complete the box below if client is a Minor

I, _____, parent/guardian for
_____, (Parent/Guardian's Printed Name) (Client's Printed Name)

agree to allow my child to enter into psychotherapy at Breakthrough Counseling, LLC in accord with the policies outlined above.

Complete the box below if client is 18 years of age or older

I, _____, agree to enter into psychotherapy at Breakthrough Counseling LLC (Client's Printed Name)

in accord with the policies outlined above.

_____ _____ _____
Parent/Guardian's **OR** 18+ Client Printed Name Signature Date

_____ _____ _____ Therapist
Printed Name Signature Date

_____ _____ _____ Clinical
Director Printed Name Signature Date

BREAKTHRO
Christian Counseling & Alternative Edu

This client qualifies for community funding from:

_____

___ Staff: _____ Date:

Fee Agreement

Office Use Only

Please read carefully and initial all of the following information before signing this document. Only one guardian's initials and signature are required to proceed with services.

For more information visit breakthroughsfc.org/resources/billingandfees

Initial 1 Initial 2

_____ _____ **I (we) understand that I am ultimately responsible for the payment of Breakthrough Counseling, LLC services for myself and/or the Minor noted on this document.**

When entering care at Breakthrough Counseling, LLC, clients may choose to use insurance or private pay for clinical services. Clients are responsible for checking with their specific insurance plans to ask about coverage for mental health services. Certain services at Breakthrough are unable to be sent to insurance such as alternative education tuition, interventions, and therapist correspondence. At times, clients receive community funding or private scholarships. A signed Fee Agreement is required for all individuals receiving services at Breakthrough regardless of funding source.

_____ _____ **I (we) understand that if more than one therapy service is necessary on one day, I will be billed a direct rate of $1/minute for each additional service.**

The above statement typically affects clients enrolled in Breakthrough alternative education. In the majority of situations, clients only receiving outpatient services will not have more than one session per day. Direct billing for extra sessions results in saving over 50% on average. If a client does not use insurance, an intervention code with the $1/minute rate still applies for additional sessions.

_____ _____ **I (we) understand that Breakthrough charges for therapist time spent on casework outside of session at a rate of $0.50 per minute or per therapist sent email.**

Therapist time spent on casework outside of session is tracked to determine client level of care and to ensure therapists are adequately attending to client and family needs. Each client's level of care is continually evaluated to ensure they are receiving appropriate services.

_____ _____ **I (we) understand that client session time is designated to address client mental health and that questions related to insurance, billing, scheduling, community funding, and paperwork need to be directed to the Breakthrough Office Manager at no additional charge.**

Concerns about client mental health, behaviors, and therapy services should be directed to the client therapist. If a question or concern is directed to the office manager that should be sent to the therapist, the office manager will pass the information to the therapist who will then respond; accruing the appropriate fee. Breakthrough does its best to respond to all correspondence within 48 business hours. In the case of an emergency or crisis, the best thing to do is call 911 or Behavioral Urgent Care.

_____ _____ **I (we) have read the below missed appointment policy and understand that community funding and/or private scholarships do not cover missed appointment fees.**

No shows and/or cancellations within 24 business hours will result in a non-refundable missed appointment fee of $125. Three missed appointments that accrue a fee may result in losing a regularly scheduled appointment time or termination of services. Fees are not charged if cancellation occurs due to inclement weather or illness. If sessions are affected by weather conditions, clients may be offered a Telehealth session. A fee will not be charged if a client declines the Telehealth option. Scheduling conflicts such as school activities or other appointments should be communicated to the Breakthrough Office Manager at least 24 business hours in advance to avoid being charged a fee. ***Clinical Appointments remain scheduled when Breakthrough Education is closed unless an exception has been communicated (Federal Holidays).***

_____ _____ **I (we) understand that all fees are due within 15 days of receiving the monthly billing statements and that I may be charged an additional late fee if payment is not received within the allotted time given.**

Breakthrough accepts payment in the following forms: cash, check, or credit card. Checks should be made payable to Breakthrough Counseling, LLC.

_____ _____ **I (we) understand that if I at any point receive community funding or a private scholarship I am still required to select either private pay or insurance billing for if/when funding ends.**

Breakthrough does its best to notify clients when funding is close to ending.

Fee Agreement - Continued

Breakthrough Counseling, LLC clinical session rates are as follows.

This is not a comprehensive list of clinical services provided, and additional services may be billed.

Insurance

- *90791 Psychosocial Intake - $250*
- *90837 Individual Therapy 60 minutes - $225*
- *90846 Family Therapy w/o client - $150*
- *90847 Family Therapy w/client - $225*

- *90849 Parent Group Therapy - $30*
- *90853 Group Youth Therapy - $50*

Select one of the payment options listed below (Required)

Private Pay

- *Psychosocial Intake - $150*
- *Individual and Family Psychotherapy - $125*
- *Family Psychotherapy w/o client - $100*
- *Youth or Parent Group Therapy - To be determined per scheduled group.*

Options for Payment

A selection is required to begin services. Breakthrough staff will indicate on the previous page if you are to receive community funding. A selection is still required for if/when community funding expires.

Insurance - bill insurance company, with potential copay

By selecting this option I agree to provide Breakthrough Counseling, LLC current images of the client's insurance card (front and back) and to provide updated images/information with any insurance changes.

Private Pay

By selecting this option I agree to be billed privately by Breakthrough Counseling, LLC.

If Insurance was selected:

_____ _____ I (we) understand that Breakthrough Counseling, LLC does not accept all insurance providers, but will do its best to work with the responsible party to determine an agreeable program cost.

_____ _____ I (we) agree to allow Breakthrough Counseling, LLC…

…to bill my insurance directly for services provided, per the Fee Agreement and Consent for Services forms;
…to release client medical records, per the Notice of Privacy Practices;
…to assign all of my rights to claims and payment by my insurance to Breakthrough;
…to assist with the claims process as required by Breakthrough or my insurance provider.

_____ _____ I (we) understand that if my insurance plan requires I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until that amount has been met and I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

Prior to signing please select one of the required payment options listed and ensure you have read/initialed all information on the first page of this document as well as the insurance clauses above (if applicable). Only one guardian's initials and signature are required to proceed with services.

Please inquire with any questions or concerns prior to signing.

For more information visit breakthroughsfc.org/resources/billingandfees

Minor Client Printed Name (If Applicable): _____

_____ _____ _____

Parent/Guardian Printed Name (If Applicable) Signature Date

_____ _____ _____

Parent/Guardian OR 18+ Client Printed Name Signature Date