CLIENT INFORMATION

Name _____ Date _____
First Last MI

_____
Address City State Zip

_____ _____ _____ Sex: ☐Female ☐Male
Social Security Number Birth Date Age

_____ _____ _____
Home Telephone Daytime Telephone Cell Phone

Employer _____ Job Title _____

Marital Status: ☐Single ☐Married ☐2nd Marriage ☐Significant Other ☐Separated ☐Divorced ☐Widowed

Who referred you to our office? ☐Friend ☐Family Member ☐Co-worker ☐Other, _____

SPOUSE/SIGNIFICANT OTHER INFORMATION

☐NA
Name _____

Address _____ DOB _____ Age _____
Street/Box #/Apt#

_____ Cell Phone _____
City State/Zip

Social Security Number _____ Home Phone _____

Employment _____ Work Phone _____

Children(s) Names	Age	Step
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No

REASON FOR COUNSELING

☐Marriage	☐Separation	☐Divorce	☐Greif/Loss	☐Parenting	☐Depression	☐Anxiety
☐Alcohol	☐Career/Job	☐Mood	☐Anger	☐Loneliness	☐Isolating	☐Spiritual
☐Sleep	☐Childhood	☐Failure	☐Financial	☐Inferiority	☐Legal	☐Risk Taking

Paul Ritter Counseling & Training, LLC
2210 W. Brown Place Sioux Falls, SD 57105
605-336-1974

CONSULTATION

Signature (indicates your written permission allowing me to consult with other qualified therapists as needed) _____ Date _____

Name of Primary Physician _____ ☐ NA

List the names of any medication you are presently taking _____ ☐ NA

Signature (if you wish to have Paul Ritter consult w/your physician) _____ Date _____

PAYMENT INFORMATION

Insurance:

- Is precertification required? ☐Yes ☐No
- Please provide your insurance card to the front desk for copying
- We will submit an insurance claim for you if you wish. Paul Ritter, LLC does not accept responsibility for collecting insurance claims or negotiating a settlement in a disputed claim. The professional services performed at this office are charged to you, not to your insurance company. Therefore, if there is a problem in payment by your insurance company, you will be responsible for prompt payment.
- It is expected that the client will at a minimum will make a co-payment (prior/following a session)
- It will be to your advantage to make a payment promptly as a 1.0% finance charge will be assessed on all balances exceeding 60 days.

I hereby authorize Paul Ritter, LLC to furnish information to insurance carriers concerning my treatments and hereby assign to the therapist all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature _____ Date _____

Cash/No Insurance/Not Provider:

Initial Assessment & Consultation	$150
Individual Therapy, 50 minute session	$140
Couples Therapy, 80 minute session	$150
Sliding Scale Fee (based on income, request form at front desk)	$50-125
If I am not a provider for your insurance company	$40

Appointment/Attendance Guidelines:

- You may be charged for failure to appear for your scheduled appointments and/or phone calls.
- Appointments not cancelled 24 hours in advance are considered failed appointments.
- Insurance does not cover failed appointments.

I have read and understand the payment information. Fees associated with therapy will be paid by:

Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

- The Notice of Privacy Practices/HIPPA describes how my health information may be used or disclosed and outlines my rights with respect to such information. I understand that I should read it carefully and am aware that the Notice may be changed at any time.
- I am aware that the Notice of Privacy Practices is openly posted in the waiting room of Paul Ritter Counseling & Training/Family Service Inc.
- In addition, I can request a copy of the Privacy Polices at any time.
- I am aware that if I have any concerns related to the Notice of Privacy Practices, I can contact Dan Deal, Privacy Policy Coordinator at 605-336-1974.

- If you would like a copy of the Notice of Privacy Practices please note: ☐Yes ☐ No

_____ _____
Client Signature Date

_____ _____
Client or Legal Guardian Signature (if client is under 18 years of age) Date

RELIGIOUS IDENTIFICATION

☐NA

☐Catholic ☐Islamic ☐Jewish ☐Protestant ☐Atheist ☐Agnostic ☐Other:_____

Which church, synagogue, or temples are you involved? _____

ADDITIONAL INFORMATION

☐NA
Please list any additional information that you feel would be important:

_____

_____

_____

_____

_____

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