Psychological Associates of Yankton, LLC
Taryn S. Van Gilder-Pierce, Ph.D. – Clinical Psychologist
William D. Pierce, Ph.D. – Clinical Psychologist
Alexandra Pagel, Psy.D. – Clinical Psychologist
Angela Tonsoline, Ph.D. – Counseling Psychologist

Confidential Patient Information

Identifying Information:

Patient Name:(first)_____(middle)_____(last)_____

Address:(street)_____

(city)_____(state)_____(zip)_____

Phone:(home)_____(work)_____(cell)_____

Marital Status:_____ Age: _____Date of Birth:_____

Parent/Spouse/Emergency Contact & Phone:_____

Referred by:_____

Education/Vocation:

School Name:_____

Number of Years in School/ Year in School if Still Attending: _____

Degree:_____ Field of Study:_____

Current Employer & Position:_____

Medical:

Significant Problems/Diagnoses: _____

_____

Current Medications: _____

_____

Physician:(name, phone & address)_____

_____

Psychological/Psychiatric/Substance Abuse Treatment:

Clinician:(name, address & year)_____

_____

Hospitalizations:(name of hospital & year):_____

_____

2703 Fox Run Pkwy, Suite 200, Yankton, SD 57078

(605) 665-0258

Consent for Services

Signatures below indicate agreement for the identified patient to receive services through Psychological Associates of Yankton, LLC.

Identifying Information:

Patient Name:
(first)_____(middle)_____(last)_____
Patient Signature:_____Date:_____

If a Minor Child or Protected Adult:

Parent/Guardian (1) Name: (first)_____ (last)_____
Relationship to Patient:_____
Address:_____
Phone Number:_____
Parent/Guardian (1) Signature:_____Date:_____

Parent/Guardian (2) Name:(first)_____ (last)_____
Relationship to Patient:_____
Address:_____
Phone Number:_____
Parent/Guardian (2) Signature:_____Date:_____

*__both parents/guardians must sign for consent for services. In the event of sole legal custody or guardianship, a copy of the court order must accompany this consent for services. In the state of South Dakota, a minor aged 16 years or older can consent to mental health treatment services in a temporary outpatient basis without parental consent.__

Notice of Limits of Confidentiality

I understand and agree that in general, the privacy of all communications between a patient and a psychologist or other mental health provider is protected by law, and that information about treatment can only be released to others with written permission. However, there are a few exceptions. In most legal proceedings, I have the right to prevent the provider from offering information about treatment. In some legal proceedings, a judge may order testimony from the provider if determined the issues demand it. There are some situations in which the provider is legally and ethically obligated to take action to protect the patient/myself or others from harm. Such situations include, but are not limited to: threats to self ; threats to others; abuse and/or neglect (current and/or past) of minors, the elderly, and/or a vulnerable adult individual. In the event a report(s) is necessary, the appropriate agencies and/or individuals will be contacted for the safety of all involved. The provider may seek consultation with other professionals regarding the case but will make every effort to avoid revealing identity; the consultant also is bound to keep any information received confidential. Psychological Associates of Yankton, LLC may be required to furnish information to insurance carriers concerning treatment for reimbursement purposes. Finally, Psychological Associates of Yankton, LLC also may release identifying information to a credit collection service in the event that financial obligations are not fulfilled as agreed. My signature below indicates I understand the privacy and confidentiality contingencies of treatment.

Authority of Patient/Parent/Guardian

Printed Name:_____
Signature: _____
Date: _____

Financial and Policy Consent

I, _____, understand and agree to the following:
(patient/parent/guardian)

Initial _____I understand that I am solely responsible for and will pay all monies due to Psychological Associates of Yankton, LLC for all services rendered.

Initial _____I have reviewed a copy of the professional fees for services. I understand insurance reimbursement may vary from actual claims made for services and that my responsibility for fees depends upon insurance determination and/or self-pay agreement. I can call my insurance carrier for verification. As a courtesy, Psychological Associates of Yankton, LLC will gather this information for you and provide a summary of benefits

Initial _____I understand and agree that unless the patient is uninsured or other arrangements are made in writing, Psychological Associates of Yankton, LLC will submit a claim for medically necessary services to the insurance carrier on file.

Initial _____I understand and agree that submission to insurance carrier does not guarantee the insurance carrier will pay for the services.

Initial _____I understand and agree that Psychological Associates of Yankton, LLC may resubmit denied insurance claims. However, denied claims can become my responsibility to pursue.

Initial _____I understand and agree that if the insurance claim(s) is/are denied, regardless of reason, the monies owed will be billed to me and I am responsible for all payments.

Initial _____I understand and agree to pay Psychological Associates of Yankton, LLC my co-payment or cost share at the beginning of each appointment unless other written arrangements are made.

Initial _____I understand and agree that I am responsible for notifying Psychological Associates of Yankton, LLC of any and all updates to my current address and insurance information. Failure to provide accurate information will result in appointment fees being billed and paid by myself**.**

Initial _____I understand and agree that I am responsible for payment of missed appointments, which are defined as: (1) appointments not canceled 24 hours in advance; or (2) appointments not attended without notice of 24-hour cancellation. For cancellation purposes, Psychological Associates of Yankton, LLC's regular business hours are (Monday-Thursday 8:30am-5:00pm – excluding federal holidays**).**

Initial _____I understand and agree to pay Psychological Associates of Yankton, LLC for missed appointments the value of the entirety of therapeutic or testing service fees as defined by my insurance carrier's fee schedule, or if uninsured, the entirety of the agreed upon fee for services.

Initial _____I understand and agree Psychological Associates of Yankton, LLC reserves the right to cancel all future appointments if there are three or more missed appointments as defined above.

Initial _____I understand and agree that if all future appointments are canceled, and I would like to continue services, I am responsible for contacting to arrange continued services. I understand and agree that the original appointment date(s) and/or time(s) may not be available and that the reengagement in standing appointment times may not be allowed.

Initial _____I understand and agree to maintain credit card information on file. I agree to update my credit card on file as necessary. My signature below acknowledges that this information is kept in office, with permission to charge for payments, insurance copayment, charges denied by insurance, or missed appointments. I understand I can opt to pay for the balance of my account on the date of service in cash or check. In certain circumstances, an alternate written payment agreement can be made in advance. A convenience charge of 2.85 percent (swipe) and 3.78 percent (manual) will be added for Credit or Debit cards**.**
Credit Card Information: Number_____ Expiration date_____
Name as printed on card _____CVC Code_____ Zip Code_____
Signature:_____ Date_____

Primary Insurance:
Carrier Name: _____
Insured Name:_____ Date of Birth: _____
Member Number:_____ Group Number:_____
Place of Employment:_____
Secondary Insurance:
Carrier Name: _____
Insured Name:_____ Date of Birth: _____
Member Number:_____ Group Number:_____
Place of Employment:_____
***please provide a photo copy of the front and back of each insurance card**

Initial _____I hereby authorize Psychological Associates of Yankton, LLC to furnish information to insurance carriers concerning my treatment for reimbursement purposes.

Initial _____ Any monies received from insurance carrier(s) over and above my indebtedness will be refunded to me when my bill is paid in full.

Initial _____ If I do not provide a credit card, pay off the entire balance, or pay according to agreement a $4 service fee will be added for bills issued each billing cycle, which ends on the 15th of each month. Additionally, 2% interest will be added to my amount. A $25 penalty will be charged and interest increased to 10% if no payment is made during any billing cycle**.** A convenience charge of 3.78 percent will be added for Credit/Debit cards payments**.**

Initial _____I authorize my name, address, phone numbers and balances owed to be released to Credit Collection Services if I do not fulfill my financial obligations as agreed. I understand that I am responsible for all payments to Credit Collections Services if my account is released.

Initial _____I acknowledge my receipt of a copy of Psychological Associates of Yankton, LLC Notice of Privacy Practices Version 1 according to HIPPA.

I acknowledge that I have read all of the above information and been given an opportunity to ask questions.
I acknowledge that any and all questions and/or concerns have been resolved to my satisfaction.

Authority of Patient/Parent/Guardian

Printed Name:_____
Signature: _____
Date: _____

Authority of Psychological Associates of Yankton, LLC
Printed Name:_____
Signature: _____
Date: _____