

**STRONGHOLD COUNSELING SERVICES, INC.**  
**DISCLOSURE AND FINANCIAL CONTRACT**

Thank you for choosing Stronghold Counseling Services, Inc. (SCS, Inc.) as your mental health care provider. We are committed to your therapy being successful. Please understand that payment of your bill is considered a part of your therapy. The following is a statement of our Disclosure and Financial Contract which we require you read and sign prior to any therapy. Clients must complete our Information and Insurance form(s) before seeing the therapist.

***Our Mission***

At Stronghold our attempt is to respond to the needs of our clients in the Sioux Falls area by providing professional assessment and therapy services as well as individual, couples, family, and group therapy. Our hope is to create the best possible context for creating change by providing quality counseling service that is informed and girded by a Biblical gracefilled perspective.

***Our Philosophy***

Our clinical philosophy stresses the importance of attaining knowledge and insight; and making positive, responsible choices. In an atmosphere of warmth, respect, freedom, and God's grace, the reliance on the use of defense diminishes and people begin to heal and change. Our staff employs an integrated model (one that balances contemporary psychology with sound biblical truths and principles) to help our clients begin to self-assess. This model seems to further facilitate the process of recognizing, accepting and dealing with their problems. Because problems affect people in all areas of their lives and all different kinds of people, our staff utilizes a team approach to each individual and family served.

***Our Team***

A highly trained team cares for each client from initial to final session. The team varies according to client needs, but Stronghold's staff is willing to coordinate and cooperate with a wide variety of professionals and specialists, including physicians, psychiatrists, psychologists, substance abuse counselors, court service workers, probation officers, family therapists, and social workers.

Each client's therapist will, with the Stronghold team, meet on a regular basis as needed to discuss the client's progress and to plan the therapy required to address the client's personal recovery needs. This coordination and team effort insures that the best possible therapy is afforded in as timely and efficient a manner as possible.

***Regarding Insurance***

We may accept assignment of insurance benefits after your second visit; however, we do require your co-pay to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. We need you to complete the SCS, Inc., insurance area and sign it. We will file your insurance claim for you. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If there is not insurance coverage, full payment is to be paid at the time of service unless other arrangements have been set up with your counselor.

**All co-pays and deductibles are your responsibility.** Some insurance companies require pre-certification. Please check with your insurance company. **We ask that a payment be made at time of service.** (Initial X \_\_\_\_)

***Usual and Customary Rates***

SCS, Inc. is committed to providing the best therapy for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

***Testing***

Psychological testing may be done. These testing charges will vary. Most insurance companies will pay a portion of the charges. You are responsible for what is not covered by your insurance company.

***Adult/Minor Clients***

Adult clients are responsible for payment at time of service. The parent/guardian accompanying a minor client is responsible for payment at the time of service. Unless it is an emergency, parent/guardian must accompany minor clients to first initial intake or service will be denied.

Please Read Both Sides

**Missed Appointments and Cancelled Appointments / Notification of Next Appointment**

Unless you notify SCS, Inc. of cancelled therapy sessions at least 24 hours in advance, our policy is to charge a \$40.00 fee for the missed session. This policy will apply to all cancellations where we have less than 24 hours notice, unless another client fills your scheduled time. We understand there are extenuating circumstances that may prevent you from giving us the necessary 24-hour notice; if this is the case we invite you to discuss this with our secretary or financial administrator. (Initial X \_\_\_\_\_)

*Unless you request otherwise, Stronghold Counseling will make a reminder call prior to your next scheduled appointment.*

**Confidentiality**

Confidentiality is a key part of the counseling relationship. It is not, however, absolute. Each therapist will discuss the ethical and legal limits of confidentiality. Some of these limits include (1) determination that the client is a danger to self or others; (2) disclosure of abuse; (3) an order by the court to disclose information; and (4) if otherwise required by law to disclose information if part of the case record is intended to be used for supervision, training, or research purposes, your therapist will discuss this with you and obtain written release to do so. Confidentiality of information and records are strictly maintained. No information and/or records are released without client's prior consent *and* signature on written release form, unless otherwise required by law.

**Referrals**

Should you or your therapist believe that a referral would be appropriate during the course of the counseling relationship; the therapist will take the responsibility of identifying referral services and assist in making the referral. Referrals may be made for a number of reasons, including yours or your therapist identifying any source of conflict in the relationship, you need which requires a greater degree of expertise or a different area of counseling specialization, or a need for medical or psychiatric attention. Referrals will be discussed openly and the transfer completed to the best of our ability.

**Professional Boundaries**

The counseling relationship is a professional relationship. It should not, therefore, become a social or business relationship at any time. This would be detrimental to the purposes of counseling and would contaminate the process. As such we would request that our clients not discuss any invitations, events, and not solicit us for business. We will do the same. If we encounter clients' outside of the counseling setting, we will not acknowledge the existence of any relationship. (Initial X \_\_\_\_\_)

**Licensing Board**

The name, address, and phone number of the state agency is:  
South Dakota Board of Counselor Examiners  
P O Box 1222  
Sioux Falls, SD 57101-1822  
605-331-2927

If a conflict arises in the course of the counseling relationship it is our desire to discuss this with you as a part of the counseling process. It is our desire to provide services in a professional manner consistent with accepted legal and ethical standards. If you are dissatisfied or have a complaint we would request that you discuss the issue with your therapist. If he/she is not able to resolve the concerns, you have the right to contact the licensing agency noted above.

**Informed Consent**

I affirm that prior to becoming a client; I was given sufficient information to understand the nature of counseling. The information included the nature of the agency, the counselor's professional identity, possible risks and benefits of counseling, nature of confidentiality including legal and ethical limits, and alternative treatments available. My signature below affirms my informed and voluntary consent to receive counseling. (Initial X \_\_\_\_\_)

**Minor Client**

I affirm that I am the legal guardian of \_\_\_\_\_. With an understanding of the above information and conditions, I do grant permission for my child to participate in counseling.

X \_\_\_\_\_ / \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Client (Parent if Client is Minor)

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Therapist