

PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Jennifer E. Morris, M.A. LPC NCC
17344 W 12 Mile Rd, Suite 209, Southfield MI, 48076
248-327-4643

Professional Disclosure Statement

Professional Qualifications

I am a graduate from The Chicago School of Professional Psychology, with a Master of Arts degree in Clinical Counseling. My formal education in counseling has prepared me to work with adolescents, adults, couples, families, and psychotherapy groups. I am a member of the American Counseling Association and the Michigan Mental Health Counselor's Association. I have participated in conferences, workshops, and seminars to further my knowledge and gain additional training in the field of counseling.

Experience

In my master's program and ten-month internship in Chicago, IL, I received supervision in counseling individuals, adolescents, families, and co-facilitating groups. I also have one and a half years of experience as a School Counselor working with adolescents at a therapeutic day school near Chicago, one and a half years working at Wayne State University's Counseling and Psychological Services, and private practice since 2015. The experience I gained during my internship, as a school counselor, and at the private practice, equipped me to effectively provide therapy for individuals with psychological, social, and emotional challenges.

Process of Counseling

Individuals generally seek counseling because they desire a change for their lives. As a first step in counseling, you and I will explore your feelings and concerns to determine what decisions or changes you want to make. After we both understand your needs and goals, I will assist you in creating ways to meet these goals to achieve the best possible results.

Philosophy Statement

The theories that guide my approach to counseling are Cognitive Behavioral and Adlerian. This means that a collaborative approach will be used to identify feelings of inadequacy, other belief systems from your upbringing, and ways your cognitions (thoughts and beliefs) impact your feelings or behaviors. I am also committed to the goal of providing you with unconditional support to facilitate self-acceptance and teaching you the process of effective decision-making so that you can meet these challenges when they arise for you in the future.

Informed Consent

Counseling Relationship

During the time we work together, we will meet weekly, bi-weekly or as scheduled with each session lasting approximately 50 minutes for individuals or couples. Group sessions may vary according to the size and type of group work that is needed. Our contact will be limited to the professional counseling sessions that you arrange with me, except in the case of an emergency. You will be best served if our relationship remains professional and our sessions concentrate exclusively on your goals and concerns.

Client Rights

The number of counseling sessions varies depending on the needs of the client and/or insurance recommendations. As a client (or parent of a minor) you may end our counseling relationship at any time, although I do ask that you participate in a termination session. You also have the right to refuse or discuss any of my counseling techniques or suggestions that you believe might not be helpful.

My services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time, or for any reason you are dissatisfied with my services, please let me know. In the event that a client would like to file a complaint regarding my counseling services, a written complaint should be sent to the following location:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Legal Affairs Division, Allegations Section
P.O. Box 30670
Lansing, MI 48909
(517) 241-0205

Appointments and Cancellation

In the private practice setting, your session has been reserved for you. I require 48-hour notice of cancellation so that your time may be given to someone else. You will be charged your full session fee for appointments canceled with less than 48-hour notice or for missed appointments. With exception, four designated holiday weeks throughout the year will require eight days of advanced notice for cancellation or will result in a full session appointment fee. Holiday time policy to be provided at intake or the beginning of each calendar year. Additionally, arriving to appointments more than 15 minutes past the scheduled time will be considered a late cancellation and the client will be charged for the full session fee out of pocket without services rendered.

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Fees

In return for a previously agreed upon fee, I agree to provide counseling services for you. The fee for each session will be due and must be paid at the time services are rendered. If the fee presents a hardship to you, please inform me prior to the beginning of our counseling relationship. I currently charge a set fee for private pay or as determined by insurance policy. In the event that your insurance retroactively recoups an insurance claim, the client is responsible to pay for the difference out of pocket. There is a \$100 fee for each written verification or documentation of therapeutic services rendered to you. In the event of a judge signed legal subpoena, you are responsible for compensating time spent in court totaling \$1,000 per day.

Records of Confidentiality

I will keep our conversations in the strictest of confidence; however, I may consult with colleagues from time to time on how to better service you. This is done without exposing your identity at all times. In addition, the following limitations and exceptions do exist:

- a) You give me written permission to disclose our conversations to someone else
- b) I have reasonable suspicion that you are a threat to yourself or someone else
- c) You disclose abuse or neglect of a child, elderly or disabled person, or if you have been sexually abused yourself
- d) You disclose sexual contact with another mental health professional
- e) I am ordered by the court to disclose information
- f) You involve me in a lawsuit and I need to release specific information
- g) I learn that you are infected with a potentially life-threatening illness that could be transmitted to a specific uninformed person

By signing below, you are indicating that you read and understand this statement and that any questions you had were answered to your satisfaction. By my signature below, I verify accuracy of this statement and acknowledge my commitment to conform to its specifications.

Printed Name of Client or Child

Date

Signature of Client or Legal Guardian

Signature of Counselor

JENNIFER MORRIS MENTAL HEALTH COUNSELING, LLC
17344 W 12 MILE RD, SUITE 209
Southfield, MI 48076
(248) 327-4643

I hereby give consent to EAP, evaluation, and/or treatment services for

_____ Myself

_____ My legal dependent: _____ (relationship)

I understand that a record of my evaluation/treatment will be kept, and if health insurance pays for any portion of fees charged, the record may be reviewed by my insurance company, if requested. Only those items of information that are allowed under federal (HIPPA) regulations will be furnished. I authorize the release of information necessary to process insurance claims, and I authorize payment for services to Jennifer Morris Mental Health Counseling, LLC.

Except as noted above in the Privacy Notice, or in the event of a medical emergency or court order, my record is strictly confidential and will not be released to anyone without my written consent.

I agree to be responsible for payment for all services received at Jennifer Morris Mental Health Counseling, LLC, to myself, my spouse, and/or my legal dependent that are not paid by insurance, including deductibles, co-payments, a fee for appointments not kept, my arrival to appointments later than 15 minutes past the scheduled time, or cancellations less than 48 hours in advance, and any late, collections, and or attorney fees (if any) if this account is unpaid, including patient responsibility for any retroactively recouped insurance payments. With exception, four designated holiday weeks throughout the year will require eight days of advanced notice for cancellation or will result in a full session appointment fee.

I understand that the services provided by my therapist are based on currently accepted mental health practices and that the outcome cannot be guaranteed. I also understand that no representation is made by my therapist that they are treating or are responsible for diagnosing any physical medical problem. I agree to consult my physician regarding all physical health matters.

My signature indicates that I have been given a copy of Jennifer Morris Mental Health Counseling's Privacy Notice which details the potential uses and disclosures of my record, as well as materials concerning Code of Ethics, Client Rights and Responsibilities, and policy on prevention and control of infectious disease.

Signature

Date

Witness

CREDIT CARD TRANSACTIONS FORM

Date of service (s): Missed appointment/late cancel

Therapist: Jennifer Morris

Client's name: _____

Name on the card: _____

Credit Card Number: _____

Security Number (3 on the back or 4 on front (amex) of card): _____

Expiration date: _____

Amount to be charged: _____

☐ VISA ☐ MasterCard ☐ DISCOVER ☐ AMEX

Address of the credit card billing statement:

E-mail address for payment receipt (if desired):

Client's signature: _____ Date: _____

Date_____

NEW CLIENT INFORMATION

Legal Name_____ Cell Phone #_____

Preferred Name_____ E-Mail_____

Address_____ Other Phone #_____

City_____ State_____ Zip_____

Birth Date_____ Age_____ Sex Assigned_____

Gender Identity/Pronouns_____ Sexual Orientation_____

Race (ethnicity)_____ Education Completed_____

Employer/address_____ Approx. income_____

Referred by_____ Religion_____

Others in Home: (Name)	(Relationship)	(Age)	(Employer or School)
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Nearest Relatives: (Name)	(Relationship)	(Address)	(Phone #)
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Jennifer Morris Mental Health Counseling, LLC

Notify in Case of Emergency: _____

Medical History or Therapy History: _____

Developmental History: _____

Current Medications	Dose/Frequency	Prescribing Physician & Phone
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_____	_____	_____
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_____	_____	_____
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Other Medications During Previous Six Months: _____

History of Allergies/Adverse Reactions/Ineffective meds: _____

Family Physician & Phone: _____

Change of Address or Contact Information: _____

Notice of Policies and Practices to Protect the Privacy of Your Health Information

A. Uses and Disclosures Requiring Your Consent

Jennifer Morris Mental Health Counseling, LLC may use or disclose your protected health information (PHI) for purposes of treatment, payment, or health care operations with your consent.

- “PHI” is information in your health record that could identify you.
- “use” refers to activities inside Jennifer Morris Mental Health Counseling, LLC.
- “disclose” refers to activities outside Jennifer Morris Mental Health Counseling, LLC, e.g. releasing information about you.
- “treatment” is providing, coordinating, or managing your health care, e.g. consulting with a family physician or previous therapist.
- “payment” is fees, direct or third-party paid for your health care, including disclosure of your PHI to a health insurer for payment or to determine eligibility or benefits.
- “Health care operations” are activities related to clinic practice, such as utilization review, quality assurance, and audits.

B. Uses and Disclosures Requiring Authorization

Jennifer Morris Mental Health Counseling, LLC may use or disclose your PHI outside of treatment, payment, or health care operations only with your authorization.

“Authorization” is written permission to release specific information that is not a part of your record, e.g., a summary of our contacts or Therapist’s Notes (if any), which have been made about your sessions and kept separate from your health record.

C. Uses and Disclosures Without Consent or Authorization

Therapists are required by law to disclose your PHI to the appropriate authorities without your consent or authorization under the following circumstances:

- Child Abuse (if there is reasonable cause to suspect child abuse or neglect).
- Adult/Domestic Abuse (if there is reasonable cause to suspect criminal abuse of an adult).
- Health Oversight activities (with a subpoena or other lawful request from the Michigan Department of Health or the Board of Psychology).
- Judicial/Administrative Proceedings [if you are involved in a court proceeding and information is requested about your diagnosis or treatment or the records thereof, such information is privileged and will not be released without your authorization or a court order; however, the privilege does not apply when you are being evaluated by a third party or where evaluation is court ordered].

- Serious Threat to Health or Safety (if you communicate a threat of physical violence against yourself or a reasonably identifiable other person and you have the apparent intent and ability to carry out that threat in the foreseeable future). A therapist must take steps permitted by law to prevent the threatened harm to yourself or the other person.
- Worker's Compensation. (If asked, a therapist must comply with laws relating to Worker's Compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault).

D. Patient's Rights

- You may request restrictions on certain uses and disclosures of PHI; however, your request may be denied.
- You may request and receive confidential communications of PHI by alternative means or at an alternative location, e.g., should you not want a family member to know your relationship with Jennifer Morris Mental Health Counseling, LLC, you may request bills be sent to another address.
- You may request to inspect and/or obtain a copy of PHI in your record. In some rare cases your request may be denied (and in some cases the decision may be reviewed) but the therapist will discuss the request/ denial process if you ask.
- If you believe the PHI in your record is incorrect, you have the right to request that it be amended. Your request may be denied if the therapist believes you are mistaken, but the therapist will discuss the request/denial process if you ask.
- You have the right to request and receive an accounting of disclosures of your PHI.

E. Therapist's Duties

Under provisions of the Health Insurance Portability and Accountability Act (HIPPA), Jennifer Morris Mental Health Counseling, LLC, is required to maintain the privacy of your PHI and to provide you with this privacy notice, effective April 14, 2003. If any policy or practice described herein is revised, the therapist will notify you at your first visit after the revision.

F. Questions or Complaints

If you believe your privacy rights have been violated, you may make a written complaint to Jennifer Morris, M.A. LPC NCC, owner of Jennifer Morris Mental Health Counseling, LLC, at the address at the top of the page, and she will respond within seven days of receiving it.

If you have questions about this notice, disagree with a decision, or have some other concern about the privacy of your PHI, you may contact the Michigan Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, Legal Affairs Division, Allegations Section, P.O. Box 30670, Lansing, MI 48909, (517) 373-9196.

Jennifer Morris Mental Health Counseling, LLC, will not retaliate against you for exercising your privacy rights.

Infectious Disease Policy

We need your help to maintain the healthiest possible environment at Jennifer Morris Mental Health Counseling, LLC.

Infectious diseases may be communicated in the air or by contact with the skin or body fluids of an infected person. Most infections can be controlled, i.e. prevented from spreading, if we take simple, intelligent precautions.

Washing our hands with soap eliminates most communicable infections. The most common are bronchitis, flu, common cold, measles, mumps, chicken pox, meningitis, hepatitis A, whooping cough, cytomegalovirus, strep throat, tuberculosis, and scarlet fever. Clients and staff are urged to wash their hands after using the toilet, after coughing or sneezing, or after cleaning up messes.

Since it is impossible to know for certain whether someone is positive for a communicable virus/disease, we will treat every accident/bio-spill as if it were a contagious one. Therefore, all instances should be handled with rubber gloves, cautious disposal, de-contamination, and hand-washing, as detailed below. We have decided it is unreasonably intrusive to ask clients to reveal their HIV status, but if such information has been confided, it will be treated confidentially.

If a client or staff bleeds or comes into contact with the blood of someone else, the contact area should be washed thoroughly as soon as possible. Unless there is visible blood, other body fluids (such as saliva, vomit, urine, feces, or nasal mucous) are not likely to spread serious disease, but they should still be attended to as detailed below. It is urged that clients and staff not come to Jennifer Morris Mental Health Counseling, LLC with contagious illness, but if this occurs, encourages clients to tell their therapist so that precautionary measures can be taken to prevent contagion.

Contaminated objects such as carpeting, furniture, or clothing must be washed to reduce contagion. Use rubber gloves and bio-wipes for clean-up. (They are stored in the first-aid chest in the business office). Wash blood-soiled objects with cold water (hot water makes blood bind to cloth), and then with one part bleach/10 parts water solution that is mixed just before use. Any object which would be discolored if washed with bleach should be washed with detergent instead. All bio-wipes, paper towels, Kleenex, etc. used to wipe up body fluids should be disposed of in a plastic bag and a twist-tie that says, "Caution Bio Waste".

Details of any bio-spill or potential infection contact should be reported to Jennifer Morris, M.A. LPC NCC, for writing up as an incident. Prompt testing for HIV or Hepatitis B (at the expense of the person who was exposed) is recommended following a potential contact.

Sanitary napkins should be placed in a plastic bag before disposal.

Thank you for your cooperation!