Jennifer Morris Mental Health Counseling, LLC

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)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Nearest Relatives: (Name) (Relationship) (Address) (Phone #)

_____ _____ _____ _____

_____ _____ _____ _____

Notify in Case of Emergency: _____

Medical History or Therapy History: _____

_____

_____

_____

Developmental History: _____

_____

Current Medications	Dose/Frequency	Prescribing Physician & Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Medications During Previous Six Months: _____

_____

History of Allergies/Adverse Reactions/Ineffective meds: _____

_____

Family Physician & Phone: _____

Change of Address or Contact Information: _____

_____

_____

JENNIFER MORRIS MENTAL HEALTH COUNSELING, LLC
29532 SOUTHFIELD RD, SUITE 115
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

_____
Jennifer Morris, M.A. LPC NCC

PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Jennifer E. Morris, M.A. LPC NCC
29532 Southfield Rd, Suite 115, 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.

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

Telementalhealth Consent Forms

Telehealth services are online therapy sessions conducted via a HIPAA compliant, secure, platform through video and/or audio connection. By signing this form you understand and agree that:

1. I understand that the video-conferencing technology that will be used to facilitate therapy services will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

2. I understand that a telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my provider is available to answer potential questions in regard to this procedure. This includes but is not limited to: risks, benefits and any practical alternatives.

CONSENT TO USE THE TELEHEALTH VIA DOXY.ME

Telehealth on Doxy.Me is the technology service we will use to conduct telehealth videoconferencing appointments. Your therapist will provide the access link to attend sessions on Doxy.me. By signing this document, I acknowledge:

1. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911 or visit the nearest emergency room.

2. Though my provider and I may be in direct, virtual contact through the Telementalhealth session, Doxy.me does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. Doxy.me facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

4. I do not assume that my provider has access to any or all of the technical information in the Doxy.me telehealthservice – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information on the doxy.me telehealth service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

· That I have read or had this form read and/or had this form explained to me
· That I fully understand its contents including the risks and benefits of the procedure(s).
· That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING THE LINES BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____
Client Name Client Signature

_____ _____
Date Counselor Signature

_____ _____
Parent/Guardian Signature (if applicable)

Jennifer Morris Mental Health Counseling, LLC

Addendum to Consent Forms

This letter is to inform clients of policy changes currently in effect for Jennifer Morris Mental Health Counseling, LLC. Clients must now provide 8 days of notice prior to canceling an appointment scheduled during holiday weeks. Failure to provide 8 days cancellation notice during designated holiday weeks will result in a charge of the full billed amount. All late cancel or no-show fees will be exacted on the same day using the credit card on file unless otherwise previously agreed upon between client and therapist. Holiday weeks include Thanksgiving, Christmas, New Year's, and July 4th. Jennifer Morris Mental Health Counseling, LLC, has the right to use the credit card provided to exact any outstanding balance as fees are incurred. 48-hour cancellation notice still applies outside of those designated holiday weeks. Clients are responsible for updating the credit card on file. Jennifer Morris Mental Health Counseling, LLC, may refuse scheduling new appointments until the prior balance is paid. In the event a client arrives 15 minutes or more past the scheduled appointment time, the client may be charged for the full session fee without services rendered. Additionally, if cancellations become a pattern, therapy may be discontinued in order to accommodate clients on the wait list. Appointments will be offered on a first come first served basis, giving precedence to weekly recurring appointments. Lastly, if you are using your health insurance plan to cover the cost of sessions, your rates change annually in accordance with the price set by your plan. Clients using Blue Cross Blue Shield or Blue Care Network insurances can expect their cost to go up effective on July 1st of every year. You may notice an increase in the out-of-pocket amount collected per session. If you pay a co-insurance of the amount billed (a percentage), then it will increase accordingly. If you have a set copay then the increase will not change the amount you pay. In the event an insurance policy retroactively recoups claim payment, clients are responsible to pay the difference to Jennifer Morris Mental Health Counseling, LLC. Please do not hesitate to inquire with questions, comments, or concerns. Jennifer Morris Mental Health Counseling, LLC, appreciates your cooperation and understanding in order to efficiently provide continued support to the community. Your signature indicates that you understand and will comply to the changes listed above:

Client Name (Printed)	Client Signature
Date	Counselor Signature

Jennifer Morris Mental Health Counseling, LLC

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 of 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.

Jennifer Morris Mental Health Counseling, LLC

CREDIT CARD TRANSACTIONS FORM

Client's Name:_____

Name on card (if different): _____

Amount to be Charged:

Copay/Co-insurance amount:_____

Full session amounts are charged the same day for all missed, late canceled, or late arrival appointments

Personal Card Number: _____

Security Number: _____

Expiration Date: _____

_____VISA _____MasterCard _____DISCOVER _____AMEX

Billing Address: _____

_____

HSA or FSA Card # if applicable: _____

Security Number: _____

Expiration Date: _____

_____VISA _____MasterCard _____DISCOVER _____AMEX

Billing Address: _____

_____

Receipts available upon request

Payer Signature: _____ Date: _____

29532 Southfield Rd Suite 115, Southfield, MI 48076 248-327-4643 JMMHC@JMMHC.COM