Jennifer Matthews, LPCC
Jennifer@plightforlife.com
www.plightforlife.com

Welcome

Thank you for initiating the first step in your pursuit of clinical care. I look forward to establishing a collaborative dynamic as we identify the goals and trajectory of our work together. Although we will go through paperwork in our initial session, know that I am happy to review my policies and procedures at any time throughout the duration of our work together.

By initialing below, understand and agree to the information provided.

_____ _____
Client Name Date of Birth

_____
Legal Representative & Relationship to Client (for minor clients)

Disclosure Statement and Client Rights

Degrees and Credentials
I am a Licensed Professional Clinical Counselor licensed by the Minnesota Board of Behavioral Health and Therapy.

You are entitled to receive information about the method of therapy, techniques used, duration of therapy if known), and the fee structure. You may seek a second opinion from another therapist or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, and certifies the licensee, registrant, or certificate holder. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality as listed an defined by applicable MN statutes. For examples, mental health professionals are required to report suspected child and elder abuse or serious threats of harm to self or others, to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

_____Initials

Consent for Treatment of a Minor or Dependent (if applicable)

I am the legal guardian or legal representative of the client and on the client's, behalf legally authorize the practitioner to deliver mental health care services to the client. I also understand that all policies described in this statement apply to the client I represent. In signing, I recognize that information discussed during the course of treatment will be held confidential to preserve the therapeutic relationship. Signing as guardian or representative and/or providing payment for services does not entitle a guardian or representative to all clinical content. All documentation

and record keeping is property of the Therapist. Content will be disclosed based on the judgment

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of the therapist where disclosure may be beneficial for the client's wellbeing, with care and consideration always given first and foremost to client safety.

☐ N/A

_____Initials

Financial Policy and Fee Details

Jennifer is not currently affiliated with any insurance coverage plans. However, all fees are considered with thoughtfulness towards the client's ability to pay without causing undo stress. The standard fee is $150.00 per 50-minute session which is inclusive of reasonable external coordination of care and correspondence on the client's behalf. If a cancellation is not made within 24 hours prior to the scheduled appointment time, payment for that missed session is expected in full at the time of that session if possible, or within 7 days following the missed appointment. Any outstanding payments will be billed at the end of each month to the credit card each client will be asked to place on file. A phone session may be conducted within the 24-hour cancellation policy in lieu of physical presence if an unexpected situation prevents a client from being physically available for a scheduled appointment time. Payment will still be expected within 7 days of that phone session at the latest.

_____Initials

Communication/Emergency Policy & Email/Text Informed Consent

Email and text communication are not to be used for urgent mental health concerns or in-depth therapeutic exchanges. Mental health concerns must be discussed in-person or within an active exchange on a telephone call. Messages will be checked during normal office hours and sporadically outside of those office hours. Calls are not taken while in sessions and therefore on-call services are not provided.

I accept that the therapist does not provide emergency services. I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24-hour hotline support.

Ideally, sessions will be scheduled at the end of each in person visit. However, if scheduling changes need to be made at other times, these exchanges may be carried out via phone, text or email. In order to communicate via text or email, consent must be provided in recognition that neither is a secure form of communication. There is some risk that any protected health

information that may be contained in email or text may be disclosed to, or intercepted by, unauthorized third parties. All precautions will be taken to use the minimum necessary amount of protected health information to respond to your query.

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Phone and Voicemail

☐ I authorize Jennifer Matthews, LPCC to leave detailed messages at the following number:

(_____) _____- _____

Email

I grant permission to use the email address provided for the purpose of communication regarding my care. I understand that in order to secure my electronic PHI, email messages may be encrypted. Encrypted email will require an additional step to authenticate in order to view the secure email.

_____

Authorized Email Address(s)

I have read and understood the above description of the risks and responsibilities associated with electronic communication. I acknowledge that commonly used or unencrypted e-mail services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. I have been given the opportunity to discuss electronic communication with my healthcare provider and have had all my questions answered. In consideration of my desire to use electronic communication as supplement to in-person office visits with my provider, I hereby consent to electronic communication via e-mail services that may be encrypted but may at times be sent as unsecure. I understand that I may revoke my consent to communicate electronically at any time. I agree to release my provider and the practice from any and all liability that may occur due to electronic communication. I further agree to be held accountable for the responsibilities as outlined above.

_____Initials

HIPAA Notice of Privacy Practices

A signature acknowledging the receipt of these practices is a release for me to share information as provided in the HIPPA statement.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. If you have any questions or requests about this Notice, please contact me at jennifer.matthews.ignatia@gmail.com

My Practice is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental

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health information, and to request that you sign the attached written acknowledgement that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights. Protected Health Information, PHI, is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:
Permissible Uses and Disclosures Not Requiring Your Written Authorization: Your mental health information may be used and disclosed in the following ways:

- **Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In any of these instances only information necessary to complete the task will be provided.
- **Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.
- **Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.

- **Required or Permitted by Law:** Your mental health care information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the clients death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.
- **Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
- **Crimes on the premises or observed by the provider:** Crimes that are observed by the therapist or staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.
- **Business Associates:** Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to

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perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

• **Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

• **Family Members:** Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without client consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, protected health information will not be disclosed.

• **Emergencies:** In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.

• **Uses and Disclosures Requiring Your Written Authorization or Release of Information:** Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

• **Psychotherapy Notes:** Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances:

• (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) the therapist who wrote the notes uses them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring a legal action and we have to defend ourselves; and (e) certain limited circumstances defined by the law.

YOUR RIGHTS AS A CLIENT:

Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your mental health information. However, I do not always have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form.

Alternative Means of Receiving Confidential Communications: You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If seek this, it is within your clinician's discretion whether or not you are given the full record of notes or a summary. Ask your clinician for any additional information and to request this summary.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures

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the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

Copy of this Notice: You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, clients will be notified of the revised Notice and copies will be available upon request. For further information, to receive a copy of this notice, or if you believe your privacy rights may have been violated and you want to file a complaint, please contact Department of Personnel and Administration's HIPAA Compliance Officer by U.S. mail or by e-mail, as follows:

U.S. Mail:

Minnesota Department of Health
Health Regulation Division
85 East Seventh Place, Suite 300
PO Box 64900
St. Paul, Minnesota 55164-0900

You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.

_____Initials

Teletherapy Informed Consent

I consent to engage in teletherapy Jennifer Matthews, LPCC (henceforth referred to as 'the therapist'). I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

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1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general HIPPA agreement I received.
3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not be improve, and in some cases may even get worse. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
5. I accept that teletherapy does not provide emergency services. I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.
6. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
7. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.
8. I have been made aware that payment for teletherapy sessions is required prior to the scheduled session time.

_____Initials

Litigation Policy

My role as therapist is to provide counseling and support, not to address legal issues. If you are involved in a legal dispute, including divorce or custody litigation, please understand that my role as a therapist is not to make recommendations to the court concerning parenting or custody

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issues, nor to testify in court concerning an opinion or issue involved in the litigation. By signing this disclosure statement, you recognize that this involvement is beyond my scope of practice, and agree not to call me as a witness in any such litigation. Only court appointed evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans. Information discussed in therapy is meant for your exclusive use in healing and growth. Evaluations to be used for legal purposes should be obtained from a non-treating mental health professional independent of this therapy.

_____Initials

_____
Client Name (printed)

_____ _____
Client Signature Date of Consent

_____
Legal Representative Signature (if applicable)

Basic Information Sheet

Name(s) of Client(s): _____ & _____

DOB: _____ Gender: _____ Pronouns: _____

Marital Status:_____ Living Arrangements: _____

Employment/Recreation Information: _____

_____

_____

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How were you referred to me? _____

I often thank referrals for sending you my way*. Is this okay with you? ☐ Yes ☐ No

** This only applies to other providers - not friends or past clients*

Emergency Contacts

Name of one or more emergency contacts and relationship(s) to you:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

_____
Name of Client

X_____ _____
Signature of Client *OR* Legal Representative Date

X_____ _____
Signature of Therapist Date

Release of Information

I _____, hereby consent to authorize Jennifer Matthews, LPCC to *(Check all that apply):*

☐ provide ☐ obtain ☐ exchange

the following information:

☐ Entire record

☐ Record with the exclusion of: _____

with the following individual / group via fax, phone, and / or email:

Name: _____ Relationship: _____

Telephone: _____ Fax: _____

Email: _____

Address: _____

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The purpose of this disclosure is to facilitate any treatment or consultation, billing or payment, and other uses as I may define here: _____.
The designated information can be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Additionally, the content of the released information may be discussed by telephone. This consent is in effect until revoked. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place. I understand that treatment or payment cannot be conditioned on the signing of this authorization. I further understand that the potential exists for re-disclosure of my records in which case it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily and that I have received a copy of this signed authorization.

_____
Name of Client

X_____ _____
Signature of Client *OR* Legal Representative Date

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Credit Card form

PAYMENT INFORMATION

Cardholder Name: _____

Billing Address: _____

_____

Type of Card: ☐ VISA ☐ MasterCard ☐ ☐ DISCOVER

Card Number: _____

Expiration Date: _____ Security Code: _____
last 3 digits / 4 for AMEX

SERVICES

I hereby authorize the Jennifer Matthews to automatically charge the credit card listed above & per the policy listed below for the following services at the time those services are rendered unless payment is otherwise given in the form of cash or check at the time services are proved:

→Individual, couples', family, or group therapy sessions
→Missed sessions or late cancellations (as per policy)

CHARGE POLICY & AGREEMENT

As the authorized cardholder, by signing below I understand and agree to the terms set forth in this agreement, to authorize Jennifer Matthews to charge my credit card for the services defined above. I, the cardholder, agree to charges for those services without additional pre-authorization unless there is a change to the agreed upon services listed above or the fees for those services. I agree that I will not dispute these scheduled charges with my credit card company provided that they correspond with the information provided above. I further agree that in the event my credit card becomes invalid, I will provide a new and valid credit card upon request, to be charged for the payment of any outstanding balances owed. Charges made for services listed above are non-refundable.

Charges are non-refundable.

The undersigned guarantees performance of the financial provisions of this agreement

Signature of Cardholder:_____ **Date:**_____