Jones Counseling Services
jenjones7337@gmail.com
602-354-0259

Welcome! It is a pleasure to have you or your family member as a Client and your treatment will be as therapeutically productive as possible. The specifics of the treatment goals and the steps to achieve these goals will be discussed at your first appointment. Your willingness to participate and understand your treatment goals is essential for the best benefit and productivity in therapy.

Benefits and Risks to Therapy: Psychotherapy is not easily described. It varies depending on the purposes and personalities of the client and therapist. Many different methods may be used to deal with the problems and these will be discussed in the treatment planning. Psychotherapy can have benefits and risks. Benefits may include but not limited to: reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, increase in interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Therapy will involve talking about difficult topics and you may temporarily experience more emotional pain. There is no guarantee that therapy will help any or all of the benefits listed above and will usually take more than a few sessions of hard work to notice any sort of change. If during your psychotherapy session the Therapist assessment derives at conclusion that a referral is needed due to psychopathologies outside of the Therapist's scope of practice then two-three referrals will be given.

Professional Consultation: Consultation is an important component of a healthy psychotherapy practice. As such the Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, the Therapist will not reveal any personally identifying information regarding the Client.

Consent for treatment and client rights: I have chosen to receive treatment services with Jones Counseling Services and employees therein. My choice has been voluntary and I understand I may terminate therapy at any time. I understand that information given to my Therapist will not be shared with any source outside of the counseling center, except where required by law (for example danger to self or others or suspected child abuse), if I consent in writing, or if in my benefits-covered treatment and the claim payer requires information. I understand that there is no guarantee that therapy will help me to feel better. Psychotherapy is a cooperative effort between my Therapist and me, I will work with my Therapist in a cooperative manner to being relief to my issues.

> **Your Rights:** *To* be treated with respect from your personal dignity and for the privacy – regardless of race, color, religion, sex, age, physical or mental handicap or national origin. *To* participate in decisions involving your behavioral health care (on in the behavioral health care of dependents), be informed regarding your behavioral health issues, treatment and prognosis in terms that you can understand. *To* have reasonable access to behavioral healthcare services and

information about charges for which you will be responsible for. *To* make an informed decision whether to accept for refuse treatment.

Confidentiality: Information about all the work done within the therapeutic relationship is confidential, including my records regarding our work together. Who you are, what you say, and what you do will be held in the strictest confidence and the greatest respect with the following exceptions*: Intent to Harm Yourself or Another.* If you state the intention to harm a reasonably identifiable victim, I will/must report it to that person and their local police. If you have s serious place to harm or kill yourself, confidentiality will be broken in order to ensure your safety. *Child Abuse:* If there is a report of any ongoing physical, sexual, emotional abuse or neglect for a child, there will be a report made to Child Protective Services in the child's local area. *Dependent/Elder Abuse:* If there were a report of dependent adult or elder abuse, this would be reported to the Adult Protective Services in that person's local area. *Collections*: If payment was not made for three months or more, and no other arrangements have been made, your name may be given to a collections agency to attempt remittance and you will be responsible for the fees of the collection agency. *A signed letter of release of confidentiality. A court of law may subpoena records. Professional Consultation.* **Note: Before any of these reports are made, you will be notified if reasonable and possible.**

Video/Audio Recording: This is prohibited unless approved prior to appointment time by all parties with signatures obtained on the Release and Permission to Record Session form.

Termination: You have the right to terminate treatment at any time. It is recommended that there be at least four sessions prior to termination for closure. I may terminate treatment with you if payment is not made, a refusal to follow therapeutic recommendations (medication management, sobriety), or if I do not specialize or am trained in the modality that would be in the best interest of the Client.

Accessibility: If time and attention is needed between session and it is outside of normal business hours please call **Empact Crisis Line at 480-487-1500 or, Maricopa Crisis Line at 602-222-9444 or, go to local emergency room or call 911.**

Client Litigation: The Therapist will not voluntarily participate in any litigation, or custody dispute in which the Client and another individual, or entity, are parties. The Therapist has a policy of no communication with the Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be sued in the Client's

legal matter. The Therapist will generally not provide records or testimony unless compelled to do so. Should the Therapist be subpoenaed, or ordered by a court of law to

appear as a witness in an action involving the Client, the Client agrees to reimburse the Therapist for any time spent for preparation, travel, or the time when the Therapist has made self available for such an appearance at the Therapist's usual and customary hourly rate of $130.00, plus travel time and all incurred expenses.

Payment and Fees: The fee you are quoted is comparable to most of the Therapists in the surrounding area. A credit card is kept on file and will be used to collect session fees and to bring Client's account into good standing (zero balance). The Client is expected to pay at the time services are rendered. It is asked that you pay at the end of each session by exact cash, major credit card or check. **Make checks payable to Jennifer Jones.** The usual and customary fee for services is $130.00 for initial assessment and session*; $130.00 for a 45-55 minute session*; $150.00 for couples for a 45-55 minute session*; $40.00 for groups and lectures*; $50.00 per ten minutes for additional paperwork (insurance, letters etc) and phone calls (with Client or with third parties)*; $60.00 for Late Cancellation or Missed Appointments. Ask provider for other fees if applicable. **Note: *therapist reserves the right to periodically adjust fees.**

Insurance: If you have other insurance you will be responsible for submitting a billing statement directly to your insurance company for reimbursement and that full payment of the fee for services provided will be paid at each session. The Therapist will provide the Client with a super bill (via paper or electronic) which the Client can submit to the third-party reimbursement by your insurance company. The Client is responsible for verifying and understanding the limits of your coverage, as well as your co-payments and deductibles. If you have Medicare as your primary, you will be responsible for full session fee, and if is your responsibility to submit superbill to Medicare and your secondary insurance for reimbursement (if applicable).

Cancellation: The Client is responsible for full payment of any missed session(s) not cancelled at least 24 hours in advance by call/text to 602-354-0259 or email jenjones7337@gmail.com. Not confirming your appointment when the 24 hour reminder is sent does not meet criteria for a formal cancellation. A phone call, text message or email is required to formally cancel your session and guarantee you will not be charged $60.00. If running late, your Therapist will wait 15 minutes and the session will not be extended. Otherwise, the credit card you have on file will be used for missed or late cancellations which will incur a charge of $60.00 (see Payments and Fees section above).

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Acknowledgment: By signing below, the Client acknowledges that he/she has reviewed and fully understands the terms and conditions of the agreement. The Client has discussed such terms and conditions with the Therapist and has had any questions with regards to its terms and conditions answered to the Client's satisfaction. The Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with the Therapist. Moreover the Client agrees to hold the Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. The Client understands that he/she is financially responsible to the Therapist for all change.

_____
Client Name

_____
Signature of Client (or authorized representative) Date

_____
Name of Responsible Party (if other than client) please print

_____
Signature of Responsible Party (if other than client) Date

_____
Name of Responsible Party (if other than client) please print

_____
Signature of Responsible Party (if other than client) Date

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Client Information

Welcome! Please fill out the following.

Name _____ Age_____ DOB_____

SSN_____ Marital Status: Married Divorced Single Separated

Name of spouse/partner: _____

Parent(s) (if client is a minor): _____

Referral Source: _____

Address/City/State/Zip_____

Home Number _____ Ok to call?_____ Leave message? _____

Cell Number _____ Ok to call? _____ Leave message? _____

Email address_____

Employer _____ Job Title_____

Employer Address/City/State/Zip_____

_____

Emergency Contact _____

Number_____ Relationship_____

List of doctors, therapists, or other health care providers who are important to you in your life network:

Name:_____Profession/Title_____

Address_____ Phone Number_____

Name:_____Profession/Title_____

Address_____ Phone Number_____

Name:_____Profession/Title_____

Address_____ Phone Number_____

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List all medications or over the counter

Medication Name	Dosage	Used for	Prescribed by

List all mood altering substances used (cigarettes, alcohol, marijuana, etc)

Substance or Process	Began Using	Amount used on a daily/weekly/monthly	Last Use

What is the reason you are seeking counseling at this time? _____
_____
_____

What is your goal in counseling? _____
_____
_____

What are your hobbies? _____
_____
_____

Who is in your support system?
_____
_____
_____

Do you identify with having trauma in your past?
_____
_____
_____

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Who would you identify as your primary relationship?

_____

_____

_____

What are the strengths of your relationship?

_____

_____

_____

Where does your relationship need improvement?

_____

_____

_____

What have you tried in the past that worked or did not work? _____

_____

_____

What are your coping skills? _____

_____

_____

What are your strengths? _____

_____

_____

Other information you think should be included?_____

_____

_____

_____

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Financial Agreement

_____ I understand that it is my responsibility as the Client to notify the office or Therapist 24 hours prior to my scheduled appointment if I am unable to keep the scheduled appointment, and will be billed a $60.00 fee using the credit card listed below. Not confirming my appointment with the 24 hour reminder does not meet criteria for a formal cancellation and I will be charged full session fee. Insurance will not cover missed or late cancelations.

_____ I understand that it is my responsibility as the Client for the full session fee at the time of the session and that I, the Client, am responsible for submitting a super bill to insurance company for out-of-network reimbursement.

_____ I understand the fee schedule as follows and in previous section labeled "Payments and Fees" and the Therapist reserves the right to adjust the fee schedule. Also that a collection agency at my, the Client's, expense may be used to collect unpaid debt. $130.00 for Initial Assessment/Session; $130.00 for Individual Session; $150.00 for Couples Session; $40.00 for Groups and Lectures; $50.00 for additional paperwork, phone calls to third parties or phone sessions that exceed ten minutes; $40.00 for returned checks.

_____ I understand that the credit card listed below will be used for missed/cancelled sessions, completed sessions, or to bring my account into good standing (zero balance).

Credit Card Authorization

Name as it appears on card: _____

Billing address for card: _____

Type of card (circle one): Visa MasterCard Discover

Card #_____ EXP: _____

3 digit code on back of card _____

_____
Client Name

_____
Signature of Client (or authorized representative) Date

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Notice of Privacy Practices Acknowledgement

I have received a copy of the latest guidelines related to disclosure and privacy of my **PROTECTED HEALTH INFORMATION (PHI).** These guidelines went into effect on February 25, 2012.

Signature _____ **Date** ____-____-____

Signature _____ **Date** ____-____-____
(Guardian if client is a minor)

Signature _____ **Date** ____-____-____
(Guardian if client is a minor)

[This documented activity will be kept on file]