PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Jennifer E. Morris, M.A. LPC NCC
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248-923-1408

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) 373-9196

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.

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. 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) 923-1408

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 or canceled less than 48 hours in advance, and any late, collections, and or attorney fees (if any) if this account is unpaid.

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: _____

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: _____

_____

_____