Kindred Counseling Center

Welcome to **Kindred Counseling Center**! Please fill out the following forms to the best of your ability. **Please note**: if you are participating in couple, relational, or family therapy each person attending therapy will need to fill out a packet. If you have any questions, I will be happy to discuss them with you. I look forward to working with you!

☐ **Form 1: Notice of Privacy Practices**

Please read the ***Notice of Privacy Practices*** regarding HIPAA and your protected health information (PHI) carefully. I can answer any questions you may have.

☐ **Form 2: Client Agreement & Informed Consent**

Please carefully review this agreement regarding your treatment, which outlines confidentiality, payment, the 24Hr. cancellation policy, and other important practice policies. Please initial where indicated and sign the ***Client Agreement & Informed Consent*** form. If you have any questions, please discuss them with me.

☐ **Form 3: The No Surprises Act Standard Notice and Consent Documents**

In compliance with the No Surprises Act that went into effect January 1, 2022, all healthcare providers are required to notify clients of their Federal rights and protections against "surprise billing." Please be sure to carefully complete and sign ***The No Surprises Act Standard Notice and Consent Documents***.

☐ **Form 4: Client Demographic Information**

This form helps me get to know you and ensures that I can contact you, and your emergency contact, as needed. Collecting this information assists me in creating a specialized treatment plan suited to your specific needs. Please be sure to sign the ***Client Demographic Information*** form.

☐ **Form 5: Audio/Visual Consent to Record**

I occasionally record sessions for my training, research, and educational purposes. I'm happy to answer any questions you may have. Please sign the ***Audio/Visual Consent to Record*** form.

Kindred Counseling Center
kindredcounselingcenter.com | 215.622.9628
contact@kindredcounselingcenter.com

Doylestown
350 S. Main St.
Suite 306
Doylestown, PA 18901

Philadelphia
401 S. 2nd St.
Suite 401
Philadelphia, PA 19147

Notice of Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Commitment to Your Privacy

I am dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services either in paper or electronic format. This Notice of Privacy Practices ("Notice") is required by law to provide you with the legal duties and the privacy practices that I maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

By federal and state law, I am required to ensure that your PHI is kept private. This Notice explains when, why, and how I would use and/or disclose your PHI. *Use* of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is *disclosed* when I release, transfer, give, or otherwise reveal it to a third party outside of myself. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

How PHI About You May Be Used and Disclosed

I will not use or disclose your PHI without your written authorization, except as described in this Notice, required by federal and state law, or as described in the "Client Agreement and Informed Consent" document. Below you will find the different categories of possible uses and disclosures with some examples. Not every use of disclosure in a category is listed. However, all of the ways we are permitted to use and disclose PHI will fall within one of the categories.

For Treatment. I may disclose your PHI to provide and coordinate the mental health treatment and services you receive. For example, if you are also seeing a psychiatrist for medication management, I may disclose your PHI to her/him/them in order to coordinate your care. Except for in an emergency, I will always ask for your authorization in writing prior to any such consultation.

For Payment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided to you. For example, I give information about you to your health insurance plan so it will pay for your services. I might provide your PHI to billing companies, claims processing companies, and others that process health care claims for my office if you are not able to stay current with your account. In this latter instance, I will always do my best to reconcile this with you prior to involving any outside agency.

For Healthcare Operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice, improve your care, and contact you when necessary. For example, I use health information about you to manage your treatment and services.

Employees and Business Associates. There may be instances where services are provided to me by an employee or through contracts with third-party "business associates." Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, I will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of me.

Note: This federal and state law provides additional protection for certain types of health information, including **alcohol or drug abuse, mental health, and AIDS/HIV,** and may limit whether and how I may disclose information about you to others.

For Special Purposes. I am permitted/mandated under federal and state law to use or disclose you PHI without your permission when certain circumstances arise. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

- **Individuals Involved in Your Care or Payment for Your Care**. I may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, I may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.

- **Abuse, Neglect, or Domestic Violence**. I may disclose PHI if mandated by Pennsylvania child, elder, or dependent adult abuse and neglect reporting laws. For example, if I have a reasonable suspicion of child abuse or neglect, I am mandated to, and will, report this to the Pennsylvania Department of Human Services.

- **Minors/Disclosures to Parents or Legal Guardians**. If you are a minor, I may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.

- **Worker's Compensation**. I may provide PHI in order to comply with Workers' Compensation or similar programs established by law.

- **Lawsuits and Disputes**. If you are involved in a lawsuit or a legal dispute, I may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process. I may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. I will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.

- **Public Health**. I may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.

- **Food and Drug Administration (FDA)**. I may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

- **Health Oversight Activities**. I may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. For example, when compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

- **Law Enforcement**. Subject to certain conditions, I may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. I may disclose your PHI for law enforcement purposes as authorized or required by law or in response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about a death resulting from criminal conduct; about crimes on the premises or against a member of our workforce; and in emergency circumstance, to report a crime, the location, victims, or the identity, description, or location of the perpetrator of a crime.

- **United States Department of Health and Human Services**. Under federal law, I am required to disclose your PHI to the U.S. Department of Health and Human Services to determine if I am in compliance with federal laws and regulations regarding the privacy of health information.

- **Research**. In certain circumstances, we may use or disclose your PHI for research purposes. However, before disclosing your PHI, the research project must be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.

- **Coroners, Medical Examiners, and Funeral Directors**. I may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death, or other duties as authorized by law. I may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.

- **Organ or Tissue Procurement Organizations**. Consistent with applicable law, I may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, baking, or transplantation of organs for the purpose of tissue donation and transplant.

- **Notification**. I may use or disclose your PHI to assist in a disaster relief effort so that your family, personal representative, or friends may be notified about your condition, status, and location.

- **Correctional Institutions**. If you are, or become, an inmate of a correctional institution, I may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

- **To Avert a Serious Threat to Health or Safety**. I may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, I may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.

- **Military and Veterans**. If you are a member of the armed forces, I may release PHI about you as required by military command authorities. I may also release PHI about foreign military personnel to the appropriate military authority.

- **National Security, Intelligence Activities, and Protective Services for the President and Others**. I may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law.

- **As Required by Law**. I must disclose your PHI when required to do so by federal or state law.

- **Treatment Alternatives**. I may use and disclose PHI to tell you about or recommend possible alternative treatments, therapies, health care providers, or settings of care that may be of interest to you.

- **Health-Related Benefits and Services**. I may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you. I am permitted to contact you, without prior authorization, to provide information about alternative or other health-related benefits and services that you may need or that may be of interest to you.

- **Appointment Reminders**. I may use or disclose PHI to provide you with appointment reminders (e.g. voicemail messages, postcards, or letters). You have a right, as explained below, to request restrictions or limitations on the PHI I disclose.

Other Uses and Disclosures of PHI

Your Authorization. I will obtain your written authorization before using or disclosing your PHI for purposes other than those described above (or as otherwise permitted or required by law). If you chose to authorize use or disclosure, you can later revoke that authorization by notifying me in writing of your decision. Your revocation will become effective upon my receipt of your written notice. You understand that I am unable to take back any disclosures I have already made with your permission, I will continue to comply with laws that require certain disclosures, and I am required to retain records of the care that I have provided to you.

- **Psychotherapy Notes**. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use of disclosure is:
    - For my use in treating you.
    - For use in training or supervising mental health practitioners to help them improve their skills in group, joint, couple, family, or individual counseling or therapy.
    - For my use in defending myself in legal proceedings instituted by you.
    - For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
    - Required by law and the use or disclosure is limited to the requirements of such law.
    - Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
    - Required by a coroner who is performing duties authorized by law.
    - Required to help avert a serious threat to the health and safety of others.

- **Marketing Health-Related Services**. As a psychotherapist, I will not use or disclose your PHI for marketing communications/purposes without your written authorization, and only as permitted by law.

- **Sale of PHI**. I will not sell your PHI without your written authorization, and only as permitted by law**.** I may contact you for fundraising efforts, but you can tell me not to contact you again.

Changes to This Notice

The terms of this notice apply to all records containing your PHI that are created or retained by myself. Please note that I reserve the right to revise or amend this Notice. Any revision or amendment will be effective for all of your records that I have created or maintained in the past and for any of your records that I may create or maintain in the future. I will have a copy of the current Notice in the office in a visible location at all times, on my website, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of the Notice.

Your Health Information Privacy Rights

You have privacy rights under federal and state laws that protect your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think that your rights are being denied or your health information isn't being protected. Providers and health insurers who are required to follow federal and state privacy laws must comply with the following rights:

To Request Restrictions on Certain Uses and Disclosures of PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or my operations with your health insurer. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make, or which are necessary to administer my business.

To Access PHI. In general, you have the right to see your PHI that is in my possession, with the exception of "psychotherapy notes," or to get copies of it; however, you must request it in writing. If I do not have your PHI, but know who does, you will be advised how you can get it. You will receive a response from me within 30 days of receiving your written request. Under certain circumstances, I may feel I must deny your request, but if it do, I will give you, in writing, the reasons for the denial. I will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged a reasonable fee per page and the fees associated with supplies and postage. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

To Request Confidential Communication. You have the right to ask me to contact you in a specific way (e.g. home or office phone) or the send mail to a different address. I will accommodate all reasonable requests.

To Choose Someone to Act for You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. I will make sure the person has this authority and can act for you before I take any action.

To Obtain an Email or Paper Copy of the Notice Upon Request. You may request a copy of the current Notice at any time. You have the right to get this notice by email and/or paper copy. The most current version of this Notice is also available on my website.

To Request an Amendment of PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information (by adding a note) or add the missing information. Requests must be made in writing and identify: (a) which information you seek

to amend, (b) what corrections you would like to make, and (c) why the information needs to be amended. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than me. Denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial will be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

To Receive an Accounting of Disclosures. You have the right to request an accounting of your PHI disclosures. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The time period for the accounting of disclosures must be limited to less than 6 years prior to the date of the request. I will respond in writing within 60 days of receipt of your request. I will provide one accounting list per 12-month period free of charge, but you may be charged for the cost of any subsequent accountings. I will notify you in advance of the cost involved, and you may choose to withdraw or modify your request at that time.

To Notification in the Event of a Breach. You have a right to be notified of an impermissible use or disclosure that compromises the security or privacy of your PHI. I will provide notice to you as soon as is reasonably possible and no later than sixty (60) calendar days after discovery of the breach and in accordance with federal and state law.

To File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with the privacy officer, listed below. You may also send a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be penalized in any way for filing a complaint. However, if you file a complaint, our professional ethics and board rules may require us to terminate our therapeutic relationship with you and refer you to other providers.

Please discuss any questions or concerns with your therapist. Your signature on the "***Client Agreement and Informed Consent***" (provided to you separately) indicates that you have read and understood this document.

If you want more information about our privacy practices or have questions or concerns, please contact me. Submit all written requests to our Privacy Officer at the addresses listed at the top of this notice or via the methods below.

Privacy Officer: Meghan Jerry, LMFT, 267.603.1624, meghan@kindredcounselingcenter.com

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Kindred Counseling Center
kindredcounselingcenter.com | 215.622.9628
contact@kindredcounselingcenter.com

Meghan B. Jerry, MFT, LLC
Tax ID: 81-2964599
NPI#: 1245783018
PA License #: MF001145

Doylestown
350 S. Main St.
Suite 306
Doylestown, PA 18901

Philadelphia
401 S. 2nd St.
Suite 401
Philadelphia, PA 19147

Welcome to **Kindred Counseling Center**! I am very pleased that you have selected me to be your therapist, and I am sincerely looking forward to working with you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Client Agreement & Informed Consent

I ask that you review, initial, and sign this document where indicated. When you sign this document, it will represent an agreement between us. The policies outlined in this agreement apply to both in-person and telehealth sessions. The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important to have a clear understanding about how this relationship will work, and what the client and therapist can expect. Successful therapy requires a commitment by both the therapist and the client. **Please carefully review, initial the bottom of each page (including the last page), and sign this document where indicated to indicate that you agree, acknowledge, and understand:**

Privacy Notice (See "*Notice of Privacy Practices*")

By initialing and signing below you acknowledge that you have received and read the ***Notice of Privacy Practices*** document explaining confidentiality and the limits of privacy. Please bring any questions you have to my attention and we will discuss them.

Therapist & License Information

Therapist: Meghan Jerry, Licensed Marriage & Family Therapist (PA License #MF001145)
Supervisor: Thomas Wood, PhD, LCSW, CST (PA License #CW017447)

I am a highly specialized therapist dedicated to helping people gain greater insight and create greater joy in their lives. I provide services for individuals, families, and all types of relationships. My unique practice is coupled with supervision from other highly trained and specialized therapists who function independently but are benefited by the strength of a group skill set. Your records may be shared with the supervisor noted above for purposes of consultation, collaboration, and supervision. Any information shared will be held in strict confidence by the therapist and supervisor.

I have particular expertise in relationships and sexuality issues; however, I work with many psychological issues including persons experiencing affairs, anxiety disorders, mood disorders, adjustment disorders, life challenging illness (self or others), bereavement, trauma, divorce, marital, family, or relationship problems, assertiveness issues, anger management, career adjustment or indecision, and other mental health disorders and issues as described in the Diagnostic and Statistical Manual of the American Psychiatric Association.

I am licensed to practice in Pennsylvania. **PA law requires you to be in PA at the time we meet** (including telehealth services), otherwise I am not legally able to provide services to you.

Understanding Psychotherapy Services

Psychotherapy is difficult to describe in general terms. A therapist helps clients with mental, emotional, cognitive, and behavioral difficulties. Psychotherapy is intended to help clients reach a better understanding of specific problems or increased self-awareness. It is also intended to work toward improvement of the identified problems, offer support in problem solving, provide some symptom relief, and improvement in coping with daily life activities. Your progress in psychotherapy and its outcome depends upon many factors including but not limited to your level of motivation and desire to change, the effort you put forth in following through with agreed upon therapeutic tasks outside of session, keeping your appointments, and your willingness to be open with me as we work together. Approaches and techniques vary depending on the problems you have identified, who you are as a person and what special qualities you bring to the therapy, and the training and professional experience I have. You have a right to ask me about the approach I am using and you may decline to answer questions posed by me. In addition, there are different modalities of therapy (individual, couple, family, and group) that may be suitable for you. In some instances, an evaluation for medication may be recommended, and a referral to a psychiatrist or other medical professional with prescribing privileges may be made.

Therapy has both benefits and risks associated with it. Risks include intermittent feelings of discomfort (such as sadness, guilt, anxiety, or anger) during and after some sessions as problems are brought to the surface. You may be asked to recall difficult and unpleasant aspects of your personal and family history in order to loosen the grip of these past events on your life now. Some of the changes you make as a result of psychotherapy may not be welcomed by other people in your life. This may result in some strain in your relationships with partners, family and others. Sometimes, it is also possible for a client's problems to worsen immediately after beginning therapy. Most of these risks are to be expected when people are making important changes in their lives. On the beneficial side, therapy has been shown to produce improvements in individual psychological health, communication and problem-solving skills, and relationship satisfaction. It can be helpful in resolving specific problems and can lead to improved relationships with significant others in your life.

There are no guarantees about what you may experience during therapy or how therapy may affect you; you agree no promises have been made as to the results of treatment or of any procedures provided by me. You understand that you are fully responsible for your own participation in any and all exercises and activities suggested by me. You agree not to hold me legally responsible for the effect of these exercises on you, either during the session or later.

Scope of Practice. You understand that I will not practice outside my scope of practice. I will NOT:

- perform social studies or custody evaluations
- provide recommendations regarding possession, custody, access to, or visitation with minor children
- provide medication or medical advice
- provide legal advice

Role of Diagnosis. At times I may need to diagnose a client to aid in the treatment process (or for insurance reimbursement purposes). If the need for diagnosis arises, I use the Diagnostic and Statistical Manual (5th Edition) published by the American Psychiatric Association (2013) to assist in coding any diagnosis appropriate to your situation. This coding serves the purpose of providing a framework upon which I can view your

situation and plan treatment. In the event a diagnosis is appropriate, I will inform you of the diagnosis rendered. Please speak with me about any questions or concerns you have regarding your diagnosis.

Confidentiality

Information revealed during therapy will be kept strictly confidential pursuant to the laws and regulations promulgated by the Pennsylvania State Board listed below. There are exceptions to this, however.

The limits to confidentiality in therapy include the following:

- If you waive the rights to privilege or sign a "Release of Information" form, I will comply with your authorization. In couple or family therapy, I will not disclose confidential information about treatment unless all persons who participated in the treatment provide their written authorization to release such information.

- If I believe you are a danger to yourself or to other persons, I will contact medical or law enforcement personnel, and/or I may choose to contact a friend or family member if appropriate.

- If you disclose information that leads me to suspect that a minor, elderly, or disabled person is being abused or neglected, I am required by law to notify authorities and I will comply with this requirement.

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without your written authorization. However, if my records are subpoenaed or if a judge issues a court order for my records, I am legally obligated to comply. In the case of a subpoena, I will contact you so you (and/or your attorneys) can take steps to contest the subpoena. If you do nothing to contest the subpoena after being notified by me, I will obey the subpoena. You agree to furnish me with any request to contest the subpoena and notify me immediately of its outcome. If I receive a signed, valid court order, other legal proceeding, statute, or investigation by a municipal, state or federal agency that requires disclosure of your information, I will obey the court order or the law.

- If you file a lawsuit or a complaint against me for any reason related to your therapy, I am allowed to use your confidential information to defend myself.

- If you are seeking out-of-network reimbursement from your insurance company the following may be requested: type of services, dates/times of services, diagnosis, treatment plans, description of impairment, progress of therapy, case notes, and summaries. Most insurance companies require a clinical diagnosis to reimburse for treatment. Some may require additional clinical information to support payment. Information collected by an insurance company will become part of the company's files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their possession. If you elect to use your insurance coverage for out-of-network reimbursement, you have evaluated the stated risks and elected to proceed.

- If financial collection procedures are required, client name, contact information, outstanding fees, and dates of unpaid services will be disclosed to the collection agency.

- Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often

involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor client with the parent or guardian. Clients who are minors and their parents/guardians are urged to discuss any questions or concerns that they have on this topic with me.

- Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy. Telehealth services may also put your information at risk. If you choose to communicate with me using these methods, it can compromise your privacy.

- Sexual contact between a client and the client's mental health provider is against the law. If I learn of previous sexual exploitation by a mental health provider, I am required to report it to the district attorney in the county of the alleged exploitation and the appropriate licensing board of the provider.

- I utilize supervision and peer case consultation in order to provide the highest levels of care. In this setting, every effort is made to protect your confidentiality. The other therapists in these settings will also uphold the strictest standards of confidentiality.

- I utilize a "no-secrets" policy when conducting couple or family therapy. This means that in couple or family therapy I am permitted to use information obtained in an individual session when working with other members of the relationship/family. I will not "out" the secret with your partner or family, however, I will work with you on an extended individual basis to enable you to make the necessary disclosure as soon as possible with focus given to the barriers preventing this disclosure. Should you opt to not share the secret with your partner or family then I will discontinue my participation in your case as your treatment provider and will provide referrals to other therapists who may continue the couple or family therapy process. Please address any concerns you have about the "no secrets" policy with me.

- Your records are maintained in a web-based system. This means that your records are stored online in a secure, encrypted, HIPAA compliant system that is backed up to ensure records are not lost due to technical problems. As with any record keeping method, every foreseeable precaution has been taken to protect privacy, but there are no guarantees. Please address any concerns you have about this with me.

By initialing and signing below you are giving me permission to contact your emergency contact in the event of an emergency and for me to reveal any information necessary to attempt to prevent a life-endangering event.

By initialing and signing below, you acknowledge that you have been advised of these limits to confidentiality and potential risks.

Professional Relationship

Our relationship has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other way, we would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests. In order to offer all of my clients the best care, my judgment needs to be unselfish and focused on your needs. This is why your relationship with me must remain professional in nature.

Due to the importance of confidentiality and the importance of minimizing dual relationships, I will not accept friend or contact requests from current or former clients on any social networking site (e.g. Facebook, Instagram, LinkedIn).

If we happen to encounter each other outside of the professional setting, I will not address you unless you address me first. I am happy to return a friendly greeting but will allow you to take the initiative if you would prefer to do so. It is acceptable for you to not engage with me if you choose not to. This is for the protection of your privacy.

I will not attend events that you might invite me to, such as family gatherings, parties, or weddings. This is to protect your privacy and prevent us from entering into a dual-relationship.

Initial Assessment

Our first session, and possibly the first few sessions, will involve an assessment of your therapy needs and goals. There are several possible outcomes of this initial assessment, as it is an opportunity for us to decide if working together may be beneficial for you.

If my therapeutic approach appears to fit with your individual goals, I will offer you some first impressions of what our work will include if you decide to continue with therapy. I encourage you to evaluate this information, along with your own opinions of whether you feel comfortable working with me, in deciding whether to continue with therapy. If you have any questions about my procedures during the initial assessment, or at any point in subsequent treatment, please bring them to my attention.

Therapy involves a large commitment of time, energy, and resources; it is important to be careful about the therapist you select. If you decide to continue with treatment, then we will move toward scheduling therapy sessions. After our initial assessment, if you believe that you would be more comfortable working with another therapist or believe that another therapist may be better suited to assist you with your specific concerns, I will be happy to provide referrals. Occasionally, after the initial assessment period I may determine I am not the best fit for your unique needs. I will communicate this with you clearly and will provide appropriate referrals.

Therapy Session and Attendance

Typically, sessions are 50 minutes and are scheduled to occur one time per week, at the same time and day if possible. However, longer or more frequent sessions may be recommended depending on the nature and severity of your concerns. The duration of therapy (length of time you are in treatment) varies from client to client and is dependent on several factors, including but not limited to, client goals, severity of symptoms, client engagement, and systemic factors (e.g. support systems). We will work together to identify specific goals for therapy, such as symptom reduction, behavioral change, improved communication and/or interpersonal skills. Goals will in all likelihood change as the therapy progresses and should be renegotiated accordingly. The therapeutic approach used will vary and you agree to discuss any questions or concerns about therapy with me. You understand that consistent attendance greatly contributes to a successful outcome.

You understand that treatment offered by me is of a voluntary nature, except when mandated by the court, and may be ended by you at any time. When treatment is mandated by the court, it is your responsibility to share the court order with me at the outset of treatment, so that the purpose and terms of the therapy can be clarified, including how communications and information about the therapy are to be shared.

Couple/Family Therapy. If you are receiving couple or family therapy, and one party of the couple or family can't attend the scheduled session and the other party shows up for individual therapy to avoid a missed session fee, therapy will not be offered and a late cancel fee at **full session price** will be charged to your credit card on file. Occasionally, I might recommend individual sessions, called breakout sessions, during couple or family therapy; however, this decision to change treatment protocol needs to be discussed as a group and agreed upon in advance of the scheduled appointment.

Late Arrival. If you are **later than 20 minutes** to a session your appointment will be rescheduled, given a late cancel status, and a **full session fee** will be charged to your credit card on file. On-time arrival is very important to ensure that you receive a solid therapeutic service. If you submit for out-of-network reimbursement no reimbursement will be made by insurance companies for no-shows and canceled appointments no matter what the reason. If you are late I will still end our session at the scheduled time (50 minutes from the start of the scheduled appointment time) out of respect for clients scheduled following your appointment.

Substance Use. Use of any substance affects your ability to notice and access your emotions and thoughts, affects your mood, and also colors your mindfulness while you communicate and can affect the boundaries of your work. Because of this, I request that drinking and recreational drugs not be used for 8 hours prior to sessions. **Due to the impact, this creates, I will end the therapy session if I believe you are attending therapy under the influence, a late cancel fee will be charged, and you understand insurance will not reimburse a session that did not occur due to substance use.**

Fees & Insurance

The fee per session is $200/50mins. **Payment is due at the time of service**, unless other arrangements have been made with me in advance. You agree to pay the full fee at the time of service. If payment for the services you receive is not made, I will not schedule another session, may stop your treatment, and may use a collection agency to recover payment. You understand that if a collection agency is used, I will have to disclose part of your record (e.g. name, contact information, dates of service, outstanding fees) to the agency.

I use the HIPAA-compliant platform, Ivy Pay, to collect payment. By initialing and signing below, you authorize the storage of your credit card information on this platform. You may also pay for services with a personal check or cash, with the exception for telehealth and court related fees. If you pay with cash, I cannot provide change and any overage will be applied as a credit to your account. **Regardless of your preferred method of payment, you agree to provide a credit card for payment of "late cancel" and "no-show" fees and by initialing and signing below, authorize me to charge your credit card for these fees**. If your card is declined, you agree to provide alternative card information to me immediately after session. Any returned check will be charged a $25 processing and return fee IN ADDITION to any additional bank fees accrued due to a check submitted which cannot be cashed. These fees will be charged to your credit card on file. You agree any "insufficient funds" fees charged to you by your financial or banking institution due to payments made to me are NOT the responsibility of myself or **Kindred Counseling Center**.

Fees are reviewed annually and subject to increase. If fees change in the future, I will provide you with notice, verbally and in writing, 30 days in advance. If you cannot afford the new fee, I will provide referrals.

Additional Services & Fees. If together we determine that an extended session, longer than one hour is needed, it should be understood that any extra time will NOT be reimbursable by your insurance company and

you are solely responsible for this additional cost. The rates for extended time are pro-rated at the regular session fee.

In addition to therapy appointments, I may charge for other professional services you request, at full session price; although I will pro-rate the hourly cost at the regular session price for periods of work less than one hour. For fees related to litigation/court-related services please see the section titled "Litigation Policy and Fees for Court-Related Services" below. It is understood, if you request these additional services, they will not be covered by your insurance or benefit provider and will be your responsibility to pay out of pocket. Additional services may include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

Insurance. I do not accept any insurance and can create an insurance statement, called a superbill, for you to submit to your insurance provider. **Based on your insurance, you may be eligible for out-of-network reimbursement for some of the costs of your therapy**. **It is your responsibility to contact your insurance provider to confirm these benefits**. You understand that you also need to specifically ask about coverage for couple, family, and telehealth sessions if applicable. If you would like to receive monthly superbills, you agree to request them from me at the outset of therapy. **You, the client, are financially responsible for paying all charges for your services at the fees listed, regardless of payments from health insurance or any other sources**.

24-Hour Cancellation Policy

In the event that you are unable to keep either an in-person or telehealth appointment, you must notify me **at least 24 hours prior to your appointment time**. If you "late cancel" (do not cancel in the allotted window) or "no-show" (do not show up for your session), you will be charged for that appointment at **full session price**. Exceptions may be made for emergencies, such as sudden illness or accident, at my discretion. These charges are not eligible for insurance reimbursement and you are solely responsible for them. You agree to pay, and authorize me to charge your credit card on file, for "late cancels" and "no-shows." Please know, this policy is not designed as a punishment. Appointment times are reserved solely for you; without adequate notice I am unable to fill your appointment time, resulting in a significant loss of income for myself and a missed opportunity for other clients who want to be seen. There will be no fee charged for appointments cancelled prior to 24 hours from the appointment time.

Professional Records

Professional records generally consist of dates of service, fees paid, electronic communication, and a summary of each meeting which may include general issues addressed, possible symptom presentation or change, level of functioning, mental status, diagnosis, and treatment plans. Pennsylvania law requires that I maintain appropriate treatment records for 7 years from the last date of service. If the client is a minor child, I must maintain treatment records for 3 years from the date the child turns 18. Treatment records are destroyed promptly after these deadlines to help ensure client confidentiality.

If, as a part of our therapy, you create and provide to me records, notes, artworks, or any other documents or materials, I will return the originals to you at your written request but will retain copies as part of your record.

As a client, you have the right to obtain a copy of your records, with the exception of "psychotherapy notes." The records of your treatment will contain confidential information about you. Pennsylvania law requires that all requests to review or obtain copies of your records must be made in writing. I require clients to sign an appropriate authorization before I will release any records.

Records of therapy can be misinterpreted and/or can be upsetting to lay readers. If you request a copy of your records, I will provide them to you within 30 days of receiving the request unless I believe that to do so would be harmful to you or endanger the life of another person. If I believe I must withhold the records due to a situation involving life endangerment, I will provide a written explanation of the reasons for withholding the records and your options.

I have determined that a reasonable, cost-based charge for providing you with a copy of your records will be $25. Generally, I am not required to provide copies of requested records until the fee is paid. If you request records be sent by some method that costs more than regular mail, overnight for example, then that additional cost will be passed onto you. The transmission of records cannot be done via email to protect your privacy. The best way to transmit records is via mail.

As a client, you have the right to request an amendment of your records. This request must be made in writing. An amendment does not delete parts of the record, it adds information as required. I will provide the amendment or refusal to do so, within 60 days of receiving the request in writing. If I refuse to amend the record, I will provide to you the reasons why in writing.

Termination of Treatment

Ideally we will mutually agree about when to end therapy, so we can schedule final sessions to review our progress and develop a plan to help protect you from future distress. However, you may wish to end therapy before reaching your goals. If you feel this is the case, it is in your best interest to discuss your concerns with me. If you choose to end therapy, I will be happy to provide referrals to other therapists. You may stop treatment with me at any time; you do not need my consent. The only thing you will still be responsible for is paying for the services you have already received. You understand that you may lose other services or may have to deal with other problems if you stop treatment (for example, if your treatment has been court-ordered, you will have to answer to the court).

If I believe that my approach and training are no longer appropriate for your specific concerns, and/or that you are not benefitting from treatment, I will inform you that I can no longer provide services and will provide referrals to other therapists who may be better suited to meet your needs. I understand that any termination may be difficult, but my decision on this matter will be final.

If you schedule a session and "no-show"/do not attend the session or contact me within 7 days of that appointment, I will understand that as a termination in our services. If you do not schedule your next session, and fail to do so for three consecutive weeks, I will understand that as a termination in our services. In either case, if you reach out to return to therapy, you understand I may not have availability in my schedule. In this event, I will provide you with referrals.

If referrals are made for any reason, and you request and authorize it in writing, I will confer with your new therapist to assist with the transition.

Communication Response Time

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I cannot be available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I will do my best to return communication from you (e.g. phone, text, email) within 24 hours. However, I do not return communication on weekends, vacations, or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

Emergencies and Crisis Situations

Psychotherapy is not an emergency service. I am not a crisis counselor and do not have the resources needed to quickly respond to a crisis or emergency. **In an emergency, including suicidal thoughts, you agree to call 911, or go immediately to the nearest emergency room.** You are welcome to call me once you are safe, but I may not be immediately available to answer the phone. I will return your call as soon as possible.

Additional Emergency Resources:

- The National Suicide Hotlines: 1-800-SUICIDE, 1-800-273-TALK (8255), 1-800-799-4889 (for deaf or hard of hearing)
- Crisis Text Line: Text HOME to 741741
- Bucks County Mobile Crisis Hotline: 1-800-499-7455, Central & Upper Bucks (215) 345-2273, Lower Bucks (215) 785-9765
- Crisis Hotline: (800) 273-8255
- Domestic Violence Help: (800) 220-8116
- Youth Shelter: (215) 442-9760
- Doylestown Hospital: (215) 345-2200

Litigation Policy and Fees for Court-Related Services

The therapeutic relationship is one that I consider sacred and it is built on confidentiality and trust. The private things that people share with me involve pain, heartbreak, trauma, and are shared with me because they feel it is a safe space to do so knowing there is confidentiality. I want to uphold that trust agreement given to me by keeping private the things that have been shared with me in confidence. Asking me to break that confidence in court goes against everything that the therapeutic relationship stands for. Therefore I expect that my clients will not use or request that I use the information discussed in therapy sessions for their own legal purposes or against any other persons in a court or judicial setting.

The nature of the therapeutic process often involves making a full disclosure with regard to many matters which may be extremely private, upsetting, and/or embarrassing. If you become involved in any legal proceeding during your therapy, including but not limited to divorce and custody disputes, or personal injury lawsuits, you agree that neither you, nor your attorneys, nor anyone acting on your behalf will subpoena records from my office, or subpoena me to testify in court, in a deposition or in any legal proceeding. By your initials and signature below, you acknowledge my position and agree to abide by this litigation policy.

If you involve me in your litigation, or if you or your attorneys subpoena me to provide my records, testify in court or give a deposition in violation of this agreement and against my stated wishes, I will comply with lawfully issued subpoenas. You agree to pay for all of my professional time, including but not limited to preparation, record review, transportation charges (door-to-door), waiting time, and time spent testifying in court or deposition regardless of who issues the subpoena or requires me to testify at the rate of **$400 per hour**.

You also agree by your initials and signature below to authorize me to charge your credit card on file to ensure payment for the time related to your litigation. Personal checks are not accepted for court-related fees.

If I am required to testify in court or give a deposition, I will charge an hourly fee of $400 per hour for a **minimum of 5 hours ($2,000)** and this includes preparation time, travel time, and attendance at any legal proceeding. If the testimony or deposition exceeds 5 hours, there will be an **additional charge of $400 per hour** for every hour spent in travel, preparation, court and/or deposition.

Court-related cancellations. When I must go to court or give a deposition for a case you are involved in, I must clear my schedule and not see other clients, so there is a 2-business-day cancellation policy for court and depositions. For example, if the court appearance or deposition is scheduled for 12pm on Monday, you must notify me of any cancellation no later than 12pm on the Thursday before. Any cancellations that occur within the 2-business-day time frame of the court appearance or deposition are **NON-REFUNDABLE** and you will be charged the **full minimum cost as described above**.

By initialing and signing below you agree to pay for the court/deposition fees described above if I am subpoenaed by a third party for legal matters involving you. For example, if your ex-spouse subpoenas me regarding your litigation you will be responsible for paying the fees. Clients should carefully consider whether or not they want to issue a subpoena for a therapist to testify in court. The process is always expensive to the client, and there is no guarantee that what I will say will be of benefit to your case. **In some cases, a therapist's testimony may be detrimental to the client's case**. Finally, if I am subpoenaed by one party to provide records or testimony in violation of this agreement and against my stated wishes, I reserve the right to terminate our professional, therapeutic relationship immediately and refer you to other therapists.

Children in Session and in the Waiting Room

If you are receiving individual or couple counseling, children are generally not allowed in session unless there is a clinical reason for them to be part of the therapy session and it has been discussed in advance with me. I request that you do not bring children with you if they are young and need babysitting or supervision, which I cannot provide. The waiting room and lobby area are not attended or monitored. You agree to take responsibility for your children or dependents left unattended in the public areas. Due to the importance of confidentiality, you will also take care to ensure your children are cared for and not within earshot during telehealth sessions.

Divorced or Separated Parents Seeking Treatment for Minors

If you are a legal guardian who is divorced, separated, or in the process of separating or getting a divorce you agree to supply all custody determinations to me immediately and accurately (**this must happen before I will see the child and I will need some time to review the documents**). If you have been ordered by a court to notify the other parent of medical and/or behavioral health services, you are attesting by your initials and signature below that you have done so.

Minors

Parents may be legally entitled to some information about therapy for a minor aged client. I will discuss this with the client and parent(s) regarding what information is appropriate for parents to receive and which issues are more appropriately kept confidential.

Electronic Communication and Technology

Electronic communication, defined here as email and texting, offers an easy and convenient way for clients and therapists to communicate. In many circumstances, it has advantages over telephone calls but also presents risks. I do not use electronic communication with clients regarding clinical matters. If you choose not to respect this policy regarding e-mail and text communications, I will take steps to block further electronic communications. I reserve the right to terminate therapy and refer you to other providers if you continue to violate this policy. Any e-mails you send to me may be printed and will become part of your clinical record.

Below are the rules for contacting me using electronic communication:

- Electronic communication is never, ever, appropriate for urgent or emergency problems. In an emergency, you agree to call 911 or go to the nearest hospital emergency room.
- Appropriate uses of electronic communication includes appointment scheduling requests and billing/insurance questions.
- Electronic communications will not be used to communicate sensitive medical/clinical information.
- **Electronic communication is not confidential**. It is like sending a postcard through the mail. If you are sending electronic communications from work, your employer has a legal right to read your electronic communication if they so choose. I take every precaution to make sure I use electronic communication methods that are HIPAA compliant; however, there is always a risk of data breach.
- Electronic communication will become a part of the medical/clinical record.
- Electronic communication is not a substitute for seeing me. If you think that you might need to be seen, you will book an appointment.

Finally, either the client or therapist can revoke permission to use electronic communication at any time. By using electronic communication to communicate with me you affirm you have evaluated the risks and elected to proceed.

Audio/Videotaping. **I do not allow audio/videotaping of sessions by clients** unless we have agreed otherwise in advance and I have signed a specific written authorization for the taping to occur. This is to protect your private health information. For this reason, you agree to turn your phone off when in session. I reserve the right to confirm that your telephone is off, or request that you leave your telephone in your car. If you refuse to confirm your phone is off, or if you refuse to leave your phone in your car when requested to do so, I will cancel the session. We can then discuss whether to reschedule the session or terminate our therapeutic relationship. If the decision is to terminate, I will provide referrals to other providers. By your initials and signature below, you acknowledge that you understand the policy on the audiotaping of sessions and agree to abide by it.

Social Media. I do not engage in communication or relationships via social media with clients. This is for the protection of your privacy as well as the therapy relationship. If you happen to encounter me by accident through social media or the internet, you can discuss it with me in session. I do not accept "friend" requests from current, or former clients, on personal/professional/psychotherapy related profiles on social networking sites since these can compromise clients' confidentiality and privacy. For the same reason, you agree to not try to communicate or engage with me via any interactive or social networking websites.

I will not post information about you on a public website. I ask you give me the same courtesy and refrain from posting any "reviews" or other information regarding myself or my practice on any website such as Health Grades, Angie's List, or other forum for posting public reviews of health care providers. By your initials and

signature below, you agree that you will not post any "review" or any other information on any website without my prior written permission. If I believe that you have violated this agreement, you understand I reserve the right to terminate our professional relationship immediately and refer you to other therapists.

Telehealth Services

A telehealth session is similar to a routine outpatient therapy office visit, except interactive video technology allows you to communicate with me at a distance. Just like with in-office visits, I will perform a safety assessment and make recommendations for a higher level of care or crisis services when needed. The telehealth platform allows access to mental health services that might not otherwise be available to you due to your physical health, geographic limitations or other factors. It is up to my discretion to determine whether you, or your child, would be eligible to participate in and would benefit from telehealth services. Together, we will regularly reassess the appropriateness of continuing to deliver services to you through the use of the technologies we have agreed upon, and modify our plan as needed. You have the right to withdraw your consent to telehealth services at any time.

Telehealth appointments are considered outpatient services and are not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies must be directed to the local county crisis line or by dialing 911. Despite that, at times people present in crisis when showing up for sessions. Because of this, the law requires that I have an up-to-date home address, an emergency contact person to call with their phone number, identified police department with contact number, and local hospital name and number should there be a need to call for help for you. It is your responsibility to keep me updated with any changes to your contact information/address and the contact information of your emergency contact.

You need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. In case of technology failure, I will contact you via phone to coordinate alternative methods of treatment.

Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth services; however, there are no guarantees. The laws that protect the confidentiality of your medical information also apply to the telehealth services. As such, the information disclosed by you during the course of your therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality outlined above in the "Confidentiality" section. The telehealth platform I use is HIPAA compliant to protect your privacy and confidentiality to the highest degree possible.

There are risks associated with telehealth including, but not limited to the possibility, despite reasonable efforts on my part, of breaches of confidentiality, theft of personal information, disruption of service due to technical difficulties, and disruption or distortion of the transmission of your medical information due to technical failures. It is your responsibility to maintain privacy on the client end of communication. Please make sure that you are attending a telehealth session in a private location free from distractions. In addition, telehealth services may not be as complete as face-to-face services. For example, I may not be able to observe important non-verbal factors in your appearance and mannerisms that might be clinically relevant. You may benefit from telehealth, but results cannot be guaranteed or assured. I cannot provide telehealth services to you if you are outside of Pennsylvania.

Telehealth services may be covered by your health insurance plan. It is your responsibility to determine coverage and you are solely responsible for all telehealth fees regardless of coverage. Fees associated with

telehealth appointments are payable by credit or debit card only and at the end of the session. If your card is declined, you agree to provide alternative card information to me immediately after your telehealth session.

The policies outlined in the rest of this agreement also apply to telehealth services. You agree you have been advised of all the potential risks and benefits of telehealth. You have discussed it with me and all of yours questions have been answered to your satisfaction. Your initials and signature below indicates that you have read and understand the information provided above and that you give your willful and informed consent to receive telehealth services.

Public Health and Safety

Weapons Policy. For the safety of all my clients, their accompanying family members and children, and other therapists and clients in the building, I maintain a zero tolerance weapons policy. No weapon of any kind is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, garrotes, or anything that could be harmful to yourself or others. I reserve the right to contact law enforcement officials and/or terminate treatment with any client who violates my weapons policy.

COVID-19. This section contains important information about the decision to attend in-person sessions in light of the COVID-19 public health crisis. This decision is based in part on recommendations by the Center for Disease Control (CDC), but other factors may be considered. Some of these include but are not limited to: whether we (client and therapist) and our families have been vaccinated, our health and/or the health of those we are in close contact with, and risk of exposure outside of this setting. There may be other concerns that we can talk about. Please bring any concerns you have to me.

If we have agreed to meet in person for sessions and there is a resurgence of the pandemic or if other health concerns arise, I have the sole discretion in deciding whether we will meet via telehealth or remain in-person. If you have concerns about meeting through telehealth, you agree to discuss them with me. If we cannot come up with a solution I will provide referrals for other therapists who can meet your needs.

If you decide at any time that you would feel safer with telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services is determined by the insurance companies and applicable law and it is your responsibility to confirm coverage with your insurance company.

You acknowledge that by coming to the office, you are assuming the risk of exposure to COVID-19 (or other public health risks).

To obtain services in person, you agree to take certain precautions which will help keep everyone (yourself, myself, other therapists, other clients, and our families) safer from exposure, sickness, and possible death. If you do not adhere to these safeguards, it may result in discontinuing in-person therapy and switching to telehealth or terminating our therapeutic relationship as necessary. You agree to the abide by the following:

- You will only keep your in-person appointment if you are symptom free and have no known exposure.
- You will take your temperature before coming to each appointment. If it is elevated (100°F or more), or if you have other symptoms of COVID-19, you agree to cancel the appointment or proceed using telehealth.
- You will wait in your car or outside until no earlier than 5 minutes before your appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions that are set up in the waiting room and therapy room.

- You will wear a mask in the office.
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with myself, other therapists, and other clients.
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- If you are bringing your children, you will make sure they follow all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID-19.
- If you (or a member of your household) have a job that exposes you to other people who are infected, you will notify me.
- If your commute or other responsibilities or activities put you in close contact with others (beyond members of your household), you will let me know.
- If you (or a member of your household) is knowingly exposed or tests positive for COVID-19, you will immediately let me know and we will then conduct treatment via telehealth.

You understand I may change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, we will talk about any necessary changes. I have taken steps to reduce the risk of spreading COVID-19 within the office. These steps are posted on the office bulletin board. Please let me know if you have questions about these efforts. I am committed to keeping you, myself, other therapists, other clients, and our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. I will arrange for us to follow up with services by telehealth as appropriate.

If you have tested positive for COVID-19, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for data collection and will not go into any details about the reason(s) for our visits. By initialing and signing below, you agree I may do so without an additional signed release. If I test positive for COVID-19, I will notify you so that you can take appropriate precautions.

By initialing and signing below you indicate your agreement to follow the above guidelines.

Statement of Principles and Complaint Procedures

In my practice as a therapist, I do not discriminate against clients because of any of these factors: age, sex, gender, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment, as well as being required by federal, state, and local laws and regulations. I will always take steps to advance and support values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this to my attention immediately.

Problems can arise in our relationship, just as in any other relationship. If you are not satisfied in any area of our work, please raise your concerns with me at once. Together we can assess the situation and determine if we can find a way to proceed or if another therapist may be better equipped to help you. You have a right to have your complaints heard and resolved in a timely manner.

I am committed to providing competent and ethical treatment, and follow the code of ethics for my profession. If you believe I have violated this commitment, and we cannot resolve it, you can file a complaint with my

licensing board. The practice of licensed persons in the field of psychotherapy is regulated by the Pennsylvania State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors. Questions and complaints may be directed to this Board, which can be reached at One Penn Center, 2601 N. 3rd Street, Harrisburg, PA 17110, (717) 783-1389. If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the U. S. Department of Health and Human Services, Office for Civil Rights, at OCRMail@hhs.gov. If you have a dispute regarding charges that exceed the cost estimates for services detailed above by $400 or more, and we cannot resolve it, you have the right to issue a complaint by contacting the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. To learn more and get a form to start the process, go to www.cms.gov/nosurprises.

Plan for Practice in Case of Death or Disability

In the event of my death, incapacity, or disability, I have made arrangements for another psychotherapist to assume control of my records, meet with clients, and make appropriate referrals to other providers, if necessary. By your initials and signature below, you authorize the designee to contact you directly, and use and disclose your confidential mental health information and records for the stated purposes. Designee: Jessica Floresta, LCSW, CST, (856) 812-414.

Consent to Treatment

By initialing and signing below you indicate your informed and willful consent for me (the Therapist) to provide treatment for yourself and/or your dependents.

Client Agreement to All Terms, Policies, and Information and Acknowledgment of Informed Consent

I, the Client (or Parent/Guardian), understand I have the right not to sign this form. I understand that I do not have to proceed with treatment with the Therapist. I understand any of the points above may be open to change at the discretion of the therapist. No specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the practices used by this therapist, or the number of sessions necessary for therapy to be effective. By signing this document, I indicate that I have carefully reviewed, understand, and agree to comply with the policies in this Agreement, as well as the ***Notice of Privacy Practices*** provided separately, and that I do hereby seek and consent to take part in the treatment by the Therapist. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I understand that this Agreement is a contract between myself and the Therapist, and may be legally enforced as a written contract. I understand this Agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated AFTER the date of this Agreement and must be provided to the Therapist. I agree that a copy of this Agreement has the same force and effect as the original.

Printed Name (Client or Parent/Guardian)	Signature of Client	Date
Printed Name, Age (Minor)	Signature of Minor	Date

Kindred Counseling Center
kindredcounselingcenter.com | 215.622.9628
contact@kindredcounselingcenter.com

Doylestown
350 S. Main St.
Suite 306
Doylestown, PA 18901

Philadelphia
401 S. 2nd St.
Suite 401
Philadelphia, PA 19147

THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

SURPRISE BILLING PROTECTION FORM

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

Kindred Counseling Center
kindredcounselingcenter.com | 215.622.9628
contact@kindredcounselingcenter.com

Doylestown
350 S. Main St.
Suite 306
Doylestown, PA 18901

Philadelphia
401 S. 2nd St.
Suite 401
Philadelphia, PA 19147

Meghan B. Jerry, MFT, LLC
FEDERAL TAX ID: 81-2964599
NPI#: 1245783018

Estimate of what you could pay

Patient name: _____ **Date of Birth**: _____

Diagnosis: **Z65.9** *Problem related to unspecified psychosocial circumstances*.
This tentative diagnosis is only to meet the requirements of the Good Faith Estimate and is subject to change. If the diagnosis changes, the fees for service will not change.

Out-of-network provider(s) or facility name: Meghan Jerry, LMFT

Total cost estimate of what you may be asked to pay: It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment. Please see the breakdown of possible fees on page four.

- **Review your detailed estimate.** See page three for a cost estimate for each item or service.
- **Call your health plan.** Your plan may have better information about how much of these services are reimbursable.
- **Questions about this notice and estimate?** Contact Meghan Jerry, LMFT
- **Questions about your rights?** Contact: Patients who receive a surprise medical bill for services provided on or after January 1, 2022, may contact the Insurance Department at www.insurance.pa.gov/NoSurprises, 877-881-6388, or TTY/TDD: 717-783-3898 with any questions or to file a complaint. Patients may also seek assistance from their health plan.

Prior authorization or other care management limitations
Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

More information about your rights and protections
Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for more information about your rights under federal law.

If you have a dispute regarding charges that exceed the cost estimates for services detailed below by $400 or more, and you cannot resolve it with your therapist, you have the right to issue a complaint by contacting the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original bill. There is a $25 fee to use the dispute process. To learn more and get a form to start the process, go to www.cms.gov/nosurprises.

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

GOOD FAITH ESTIMATE: TABLE OF SERVICES AND FEES

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service* (Number of Sessions Will Be Determined as We Progress)
	90791	Initial Diagnostic Evaluation, 50 minutes	$200
	90834	Psychotherapy, 38-52 minutes	$200
	90846	Family Psychotherapy without Patient Present, 50 minutes	$200
	90847	Family Psychotherapy with Patient Present, 50 minutes	$200
	98966-98968	Telephone Assessment & Management	Prorated based on the amount of time spent at session rate
	98970-98972	Online Digital Evaluation & Mgmt. (Responding to Email & Text Messages)	Prorated based on the amount of time spent at session rate
	Cancellation Fee	Your Therapist Requires a 24-Hour Cancellation Notice	You are Responsible for the Full Fee of the Appointment Missed
	Production of Records		$25
	Returned Check Fee		$25
	Legal Fees	Minimum of 5 hours for court appearances and/or depositions.	$400/hr.
	Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.	

Please note that Place of Service (in office vs. telehealth) is not delineated above since the charges are identical.

*** This estimate does not take account for sliding scale fees as those fees are based on patient's income and fall under "Other Financial Arrangements." This estimate is based on fees quoted at time of initial contact and confirmed in initial telephone consultation with the patient.**

The effective date of this Good Faith Estimate is January 1, 2022. If fees or patient treatment needs change, a new estimate will be provided in writing.

By signing, I give up my federal consumer protections and agree I might pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ Meghan Jerry, LMFT

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under Federal law.
- I may get a bill for the full charges for these items and services or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on _____ explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you.

_____	or	_____
Patient's Signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

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Client Demographic Information

Please complete this form to the best of your ability with the information you have available to you at this time. Take your time and do your best to answer each item as fully as you can. Although it may seem like a lot, the information you provide here enables me to provide you with a tailored treatment plan.

Today's Date: _____ Therapist: Meghan Jerry, LMFT

General Client Information			
Name (First M.I. Last):			
DOB:	Age:	Preferred Name/Nickname:	
Gender:	Pronouns (e.g. he, she, they):		
Address 1:			
Address 2:			
City:	State:	Zip:	
Nearest Emergency Room:		Phone:	
Nearest Police Station:		Phone:	
Cell Phone:	May I leave a voice message? ☐ Yes ☐ No	May I send text messages to your cell phone? ☐ Yes ☐ No May I send you email? ☐ Yes ☐ No	
Work Phone:	May I leave a voice message? ☐ Yes ☐ No		
Home Phone:	May I leave a voice message? ☐ Yes ☐ No		
Email Address:			
Sexual Orientation:	Ethnic/Cultural Background:		
Religion:	Highest Education Level:		
Occupation:	Annual Income:	Employer:	

Emergency Contact Information		
Name (First M.I. Last):	Relation to Client:	
Address 1:		
Address 2:		
City:	State:	Zip:
Cell Phone:	Work Phone:	

About You
Please provide a brief description of why you are seeking counseling/therapy services at this time:
My strengths are:
My sources of stress are:
My leisure activities are:

My current life goals are:
What are effective coping strategies that you've learned?
On a scale of 1-10, how would you rate the quality of your current relationships in general?
In the last year, have you experienced any significant life changes or stressors? ☐ Yes ☐ No If yes, please describe them briefly:

Adult Concerns Checklist

(For minors, please complete this section and the separate "Child Checklist of Characteristics" provided by your therapist.)

Please check all that apply:

- ☐ Abuse – physical, sexual, emotional, verbal, neglect (of children or elderly persons), cruelty to animals
- ☐ Aggression, threats, violence
- ☐ Anger, frustration, hostility, arguing, irritability
- ☐ Anxiety, tension, worry, nervousness, panic, anxiety attacks
- ☐ Attention, concentration, disorganization, distractibility
- ☐ Career concerns – goals, choices, work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
- ☐ Childhood issues (your own childhood)
- ☐ Codependence
- ☐ Compulsions, excessive behaviors (e.g. spending, gambling, drinking, sex)
- ☐ Decision making, indecision, mixed feelings, putting off decisions, procrastination
- ☐ Delusions, hallucinations (i.e. thinking/believing or seeing/hearing unusual things)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Destruction of property
- ☐ Divorce, separation, custody
- ☐ Eating problems – overeating, undereating, appetite, vomiting
- ☐ Emptiness
- ☐ Failure
- ☐ Family problems
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Feeling "hyper"
- ☐ Feeling "not real"
- ☐ Feeling detached from yourself
- ☐ Feeling guilty, shameful
- ☐ Feeling hopeless
- ☐ Feeling ignored, abandoned
- ☐ Feeling worthless, inferior
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Grieving, mourning, deaths, losses
- ☐ Health, illness, medical concerns, physical problems
- ☐ Housework, chores – quality, schedules, sharing duties
- ☐ Impact of your problems, behavior on others
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Isolating from others, social withdrawal
- ☐ Judgement problems, risk taking
- ☐ Lack of interest, enjoyment in life
- ☐ Legal problems, charges, lawsuits
- ☐ Loneliness
- ☐ Losing track of time, unexplained losses of time
- ☐ Lying
- ☐ Marital/couple/poly relationship problems – conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nausea
- ☐ Oversensitivity to rejection, criticism
- ☐ Pain – chest pain/tightness, headaches
- ☐ Parenting, child management, single parenthood, co-parenting
- ☐ Perfectionism
- ☐ Performing unusual rituals or habits
- ☐ Pessimism
- ☐ Poor body image
- ☐ Racing thoughts
- ☐ Rapid speech

☐ Relationships – interpersonal conflict, making/keeping friends, social skills, social support

☐ School problems
☐ Self-centeredness
☐ Self-criticism
☐ Self-esteem
☐ Self-injurious behaviors, thoughts of self-harm
☐ Self-neglect, poor self-care
☐ Sexual issues, dysfunctions, conflicts, desire differences
☐ Sleep problems – too much, too little, insomnia, nightmares
☐ Spiritual, religious, moral, ethical issues
☐ Stealing
☐ Strange, weird, or peculiar behavior
☐ Stress, relaxation, stress management, stress disorders, tension
☐ Stressors related to military deployment
☐ Substance use/abuse (e.g. alcohol, drugs, tobacco)
☐ Suicide – attempt(s), thoughts
☐ Suspiciousness, mistrustfulness
☐ Thought disorganization and confusion
☐ Thoughts of hurting others
☐ Tingling, numbness
☐ Trauma – experience, witness
☐ Unpleasant thoughts that won't go away, recurring thoughts
☐ Weight, diet issues
☐ Other (please describe):

_____
_____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:
_____

History of Counseling/Therapy			
Are you **currently** or have you **previously** been treated by a counselor, psychologist, psychiatrist, and/or other physician for the problems noted above (Please include any treatment for substance abuse)? ☐ Yes ☐ No If yes, please provide the following information:			
Dates (From – To)	Name of Professional	Phone	Treatment Type (e.g. counseling, therapy, medication, etc.)

Have you ever been hospitalized for treatment of an emotional or mental disorder? ☐ Yes ☐ No If yes, please provide the following information:				
Dates (From – To)	Name of Hospital or Facility	Phone	Reason for Hospitalization	Treating Physician

Have you ever attempted suicide? ☐ Yes ☐ No If yes, when?
Have you been thinking about suicide? ☐ Yes ☐ No
Have you been thinking about harming or killing someone else? ☐ Yes ☐ No
Has there ever been a time when you felt unsafe in your current relationship? ☐ Yes ☐ No

Medical History
How would you describe your physical health at present (e.g. poor, satisfactory, good)?
Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, allergies):
How many times per week do you exercise? For how long each time?
Do you restrict your eating in any way? ☐ Yes ☐ No If yes, How? Why?

Do you now, or have you ever, experienced difficulty with sexual activity? ☐ Yes ☐ No If yes, please explain:

At what age did you start to menstruate (get your period)?

Have you experienced any difficulty with menstruation? ☐ Yes ☐ No If yes, please explain:

Have you ever been pregnant? ☐ Yes ☐ No

Total Pregnancies: _____ Abortions: _____ Live Births: _____ Miscarriages: _____ Other: _____

Any complications related to pregnancy? ☐ Yes ☐ No If yes, please explain:

If your menopause has started, at what age did it occur?

What signs/symptoms have you had?

Please complete the information below regarding **past and current** medical conditions (e.g. diseases, illnesses, important accidents and injuries, surgeries, hospitalization) and treatment:

Dates (From – To)	Physician Name	Phone	Condition	Treatment

Please list **any current or previous** prescriptions and over-the-counter medication use:

Beginning Date	Medication	Dose (How much?)	Freq. of Use	Condition Treated

Please list any **current or previous** use of street drugs, tobacco products, and/or alcohol:

Dates (From – To)	Type Used	Freq. of Use	Amt. Typically Used	When Ended (if applicable)

Have you ever felt the need to cut down on your drinking? ☐ Yes ☐ No

Have you ever felt annoyed by criticism of your drinking? ☐ Yes ☐ No

Have you ever felt guilty about your drinking? ☐ Yes ☐ No

Family History

Has anyone in your family (either immediate family member or relatives) experienced difficulties with the following? Please indicate their relationship to you in the space provided.

Alcohol/Substance Abuse ☐ Yes ☐ No	Learning Differences ☐ Yes ☐ No
Anxiety Disorders ☐ Yes ☐ No	Panic Attacks ☐ Yes ☐ No
Bipolar Disorder ☐ Yes ☐ No	Schizophrenia ☐ Yes ☐ No
Depression ☐ Yes ☐ No	Suicide Attempts ☐ Yes ☐ No
Eating Disorders ☐ Yes ☐ No	Trauma History ☐ Yes ☐ No

Other (please specify):

Please tell me about your current partner(s):

Partner's Name	Partner's Age	Duration of Relationship	How do you define your relationship (e.g. dating, married)?

Please tell me about your children (Indicate those from a previous marriage or relationship with "P." Indicate stepchildren with "S." Please put "R" in the column marked "Residing" for the children currently living with you.)							
Name	Current Age	Gender	School	Grade	Adjustment Problems?	P? S?	Residing

Legal History
Are you required by a court, the police, or a probation/parole office to have this appointment? ☐ Yes ☐ No If yes, please explain:

Is there anything else you think it would be important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

How Did You Hear About Me?	
☐ Psychology Today ☐ Doctor's Office ☐ Direct Referral (please list below)	☐ **Kindred Counseling Center** website ☐ Internet Search ☐ Other: _____
Referred by:	May I thank them for directing you to my practice? ☐ Yes ☐ No
Phone:	Address:
How did this person explain how I might be of help to you?	

PLEASE CAREFULLY READ THE STATEMENT BELOW

I acknowledge I have read the ***Client Agreement and Informed Consent*** form and the ***Notice of Privacy Practices***. I understand that I am responsible for all fees for services provided to me. I agree to comply with the **24-Hour Cancellation Policy**. By signing this document, I indicate that I have reviewed, understand, and agree to comply with all of the policies outlined in these documents, and that I willfully consent to treatment for myself and/or my child. Furthermore, all of the information that I have provided is accurate and complete according to my current knowledge.

Additionally, **in case of emergency** I give my permission and consent for my therapist to contact the person listed above as my emergency contact. I give my consent for my therapist to provide this person with as much information as needed in an attempt to avoid a dangerous or potentially life-threatening emergency.

Printed Name (Client or Parent/Guardian)	Signature of Client	Date
Printed Name, Age (Minor)	Signature of Minor	Date

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Audio/Visual Consent to Record and Use Case Materials Form

By signing this form, you freely give your consent to allow the sessions with me, your therapist, at **Kindred Counseling Center**, to be electronically recorded. You further consent that I may share this recording with other therapists in my consultation group. You understand that any other therapist who watches this recording for training purposes is under the same confidentiality requirements as myself. Further, you understand that if by chance any therapist knows you socially or personally, she/he/they will immediately leave the session and will not observe, seek, or be given any information about your situation.

Furthermore, you freely give your consent to allow me to use information about your case in order to promote the development of the mental health field. You understand that I will, at all times, conceal your identity by withholding any and all identifying details about your case.

You understand that you may request the electronic recording to be discontinued at any time—either temporarily or permanently.

You understand that I may retain, but am in no way required to retain any electronic recordings produced in this process. You authorize me at my sole option, to erase or otherwise destroy any and all recordings after they have been used for the intended purpose, or at any other time, whether they have been used or not. You understand that these recordings are not part of your treatment record.

I fully reviewed and understand the information above. I understand that my decision about whether or not to permit electronic recording will have no impact on the treatment I will receive. I understand that I may withdraw this consent at any time by writing to my therapist.

☐ I hereby **Opt-In**. I fully and willfully consent to the conditions above.

☐ I hereby **Opt-Out. I do not consent.**

Printed Name (Client or Parent/Guardian)	Signature of Client	Date
Printed Name, Age (Minor)	Signature of Minor	Date