Kindred Counseling Center

Welcome to Kindred Counseling Center!

Please complete the following forms to the best of your ability. **Important**: If you are participating in relationship or family therapy, each person attending therapy will need to fill out their own packet. These forms represent my commitment to you to engage in ethical, legal, and collaborative practice.

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

Please review the "Notice of Privacy Practices" carefully. This required document explains your rights under HIPAA and how your protected health information (PHI) is managed.

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

This agreement outlines important practice policies, including confidentiality, payment, the 24-Hour Cancellation Policy, and your rights as a client. Please read it thoroughly, initial every page (including the last), and sign where indicated.

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

As required by the No Surprises Act (effective January 1, 2022), this form explains your rights related to "surprise billing." While I do not issue surprise bills, completing this form is required by federal law. All fees are clearly outlined in the "Client Agreement & Informed Consent" form. Please review, complete, and sign this form.

☐ **Form 4: "Client Demographic Information"**

This form helps me get to know you and ensures I can contact you or your emergency contact if needed. The information you provide supports the development of a personalized treatment plan. Please sign this form.

☐ **Form 5: "Medicare Private Pay (Opt-Out) Contract"**

This required contract for Medicare-eligible clients explains that I have opted out of Medicare. It confirms you agree to pay for services out-of-pocket and understand that Medicare will not reimburse you for these costs. Please review and sign this contract if you are Medicare-eligible.

If you have any questions, I'm happy to go over them with you. I look forward to working with you!

Warmly,
Meghan Jerry, LMFT, CST

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

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

This Notice of Privacy Practices ("Notice") is required by federal law and describes how I may use and disclose your protected health information (PHI), your rights, and my legal duties regarding your privacy. This Notice applies to services provided by Meghan B. Jerry, MFT, LLC, doing business as Kindred Counseling Center (the "Practice"). Services are provided by Meghan Jerry, LMFT, CST ("Therapist") through the Practice. Throughout this Notice, "I," "me," and "my" refer to the Therapist, who provides services on behalf of the Practice, and "you" and "your" refer to the client.

I am committed to maintaining the privacy of your PHI. PHI refers to information that may identify you and relates to your past, present, or future physical or mental health or health care services, whether in paper or electronic format.

I am required by law to keep your PHI confidential and to follow the privacy practices outlined in this Notice. "Use" refers to internal use within my practice; "disclosure" means sharing it with others outside my practice. Except in certain situations, I may only use or disclose the minimum necessary PHI to accomplish the intended purpose.

Please read this Notice carefully and feel free to bring any questions or concerns to my attention.

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 outlined in the "Client Agreement and Informed Consent" document. Below are categories of permitted uses and disclosures, with examples. Not every specific use of disclosure is listed, but all permitted uses fall within these categories.

For Treatment. I may use or disclose your PHI to provide and coordinate your mental health care. For example, if you are also working with a psychiatrist, I may share relevant information to coordinate treatment. Except in emergencies, I will obtain your written authorization before any such consultation.

For Payment. I may use and disclose your PHI to bill and collect payment for services provided. For example, if your account becomes delinquent, I may share relevant information with billing or collection agencies, but will make every effort to resolve the matter with you directly before doing so.

For Healthcare Operations. I may use your PHI to support practice operations, improve services, or contact you when needed. For example, I may use your information to monitor treatment outcomes or evaluate service quality.

Employees and Business Associates. If services are provided by employees or contract business associates (e.g., billing or IT support), I ensure they are bound by a contract requiring the same confidentiality protections I uphold.

Note: Federal and state law provide additional protections for certain types of health information, including mental health, substance use, and HIV/AIDS-related information. These laws may limit how and when your PHI is disclosed.

Special Circumstances. Federal and state laws allow or require me to use or disclose your PHI in the following situations, even without your signed consent:

- **Persons Involved in Your Care**. I may share information with individuals involved in your care or payment, such as a health care proxy, personal representative, or family member you identify. In a disaster situation, I may disclose your PHI to assist with family notifications.
- **Abuse, Neglect, or Domestic Violence**. I must report suspected abuse or neglect of a child, elder, or dependent adult, in accordance with Pennsylvania law.
- **Minors**. If you are a minor, I may disclose certain information to your parent(s) or guardian as allowed or required by law.
- **Worker's Compensation**. I may disclose your PHI to comply with worker's compensation laws.
- **Legal Proceedings**. I may disclose your PHI in response to a court or administrative order, subpoena, or other lawful process. Whenever possible, I will notify you and give you an opportunity to object or seek protective measures.
- **Public Health and Safety**. I may disclose information to prevent or control disease, report births or deaths, notify persons exposed to a disease, or comply with other public health mandates.
- **Food and Drug Administration (FDA) Oversight**. I may disclose information to the FDA regarding the safety of products you use.
- **Health Oversight Agencies**. Your PHI may be disclosed to government agencies for audits, investigations, licensing, or compliance reviews (e.g., HIPAA compliance).
- **Law Enforcement**. Disclosures may be made when required by law, court order, or under limited conditions such as locating a missing person or reporting a crime.
- **United States Department of Health and Human Services (HHS)**. I am required to disclose your PHI to HHS when requested for compliance audits under HIPAA.
- **Research**. In limited cases, your PHI may be used for approved research projects, with appropriate safeguards to protect your privacy.
- **Coroners, Medical Examiners, and Funeral Directors**. I may disclose PHI for identification, determining cause of death, or as required for their duties.
- **Organ or Tissue Donation**. Disclosures may be made to facilitate organ or tissue donation in compliance with applicable law.
- **Correctional Institutions**. If you are incarcerated, I may disclose your PHI for your health and safety or the safety of others.
- **To Prevent Serious Harm**. If I believe in good faith that you pose a serious threat to yourself or others, I may disclose your PHI to those who can help prevent harm.
- **Military and National Security**. I may disclose PHI to authorized military or national security officials if required by law.
- **As Required by Law**. Your PHI will be disclosed if mandated by federal, state, or local law.

Other Permitted Uses.

- **Treatment Alternatives**. I may use or disclose your PHI to inform you of alternative treatment options or services that may benefit you.

- **Health-Related Services**. I may contact you to inform you of benefits or services that may be of interest to you.
- **Appointments**. I may use or disclose your PHI to schedule or remind you of upcoming appointments (e.g., voicemail, email, text).

Other Uses and Disclosures of PHI

Your Authorization. I will obtain your written authorization before using or disclosing your PHI for any purpose not described in this Notice (or otherwise permitted or required by law). If you authorize use or disclosure, you may later revoke that authorization at any time by providing written notice. Your revocation will become effective when I receive your written request. Please note that revoking an authorization does not apply to any disclosures already made. I am also required to retain records of the care provided, and I will continue to comply with any legal obligations related to disclosures.

- **Psychotherapy Notes**. I do keep "psychotherapy notes" as defined in 45 CFR § 164.501. These notes receive special protections under HIPAA, and their use or disclosure requires your written authorization except in the following limited circumstances:
    - For my own use in your treatment.
    - For training or supervising mental health professionals to improve their skills.
    - For my use in defending myself in legal proceedings initiated by you.
    - For use by the Secretary of Health and Human Services when investigating HIPAA compliance.
    - When otherwise required by law, and the disclosure is limited to the relevant legal requirements.
    - When required for certain health oversight activities related to the originator of the psychotherapy notes.
    - When required by a coroner or medical examiner performing duties authorized by law.
    - When necessary to prevent or reduce a serious and imminent threat to the health or safety of a person or the public.
- **Marketing of Health-Related Services**. I will not use or disclose your PHI for marketing 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**.**
- **Fundraising Communications**. I may contact you regarding limited fundraising efforts. You have the right to opt out of such communications, and I will honor that request.

Changes to This Notice

The terms of this Notice apply to all records containing your PHI that are created or retained by me. Please note that I reserve the right to revise or amend this Notice at any time. Any updates will apply to all PHI I have created or maintained in the past, as well as any PHI I create or maintain in the future. A copy of the most current Notice will be available in my office, in a clearly visible location, and on my website. You may also request a copy at any time. The effective date of the most recent revision will be listed at the end of this 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 may exercise these rights, ask questions about them, and file a complaint if you believe your rights are being denied or your health information is not adequately protected. Health care providers and insurers subject to 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 request limits on how I use or disclose your PHI. While I will consider your request, I am not required to agree to it. If I do agree, I will document the restriction and follow it, except in emergency situations or as otherwise permitted by law. If you pay for a service or health care item in full and out-of-pocket, you may request that I not share that information with your health insurer for purposes of payment or operations. I will honor that request unless required by law to disclose it or it is necessary to administer my business.

To Access PHI. You have the right to inspect or obtain a copy of your PHI in my records, with the exception of "psychotherapy notes." Requests must be made in writing. I will respond within 30 days. If I deny your request, I will provide a written explanation and inform you of your right to request a review of the denial. You may be charged a reasonable fee for labor, copies, supplies, and postage. With your consent, I may offer a summary or explanation of the PHI instead of the full record.

To Request Confidential Communication. You may request that I contact you in a specific way (e.g., by home phone or a specific mailing address). I will honor all reasonable requests.

To Choose Someone to Act for You. If you have designated someone to act as your legal representative (e.g., via medical power of attorney or legal guardianship), that person may exercise your rights and make decisions regarding your PHI. I will verify their legal authority before taking action.

To Obtain an Email or Paper Copy of the Notice. You may request a paper or electronic copy of this Notice now, or the current version at any time. The most current version of this Notice is also available on my website.

To Request an Amendment of PHI. If you believe information in your record is inaccurate or incomplete, you may request an amendment in writing. Your request must identify the information to be amended, the correction you seek, and your reason. I will respond within 60 days. If I deny your request, I will provide a written explanation and inform you of your right to submit a written statement of disagreement, which will be included in your record and with any future disclosures.

To Receive an Accounting of Disclosures. You may request a list of certain disclosures of your PHI made within the six years prior to your request, provided those records still exist. This list will not include disclosures made with your authorization or for treatment, payment, health care operations, or certain other limited exceptions. I will respond within 60 days. You are entitled to one free accounting in any 12-month period. Additional requests may incur a reasonable fee, which I will disclose in advance.

To Be Notified of a Breach. You have a right to be notified in the event of a breach involving your PHI. I will notify you as soon as possible, and no later than 60 calendar days after the breach is discovered, 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 me or with the U.S. Department of Health and Human Services Office for Civil Rights at 200 Independence Avenue, S.W., Washington, D.C. 20201, 1-877-696-6775, or www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be retaliated against for filing a complaint. However, depending on the nature of your complaint, professional ethics and licensing board requirements may require me to refer you to another provider.

Updates. The Practice may amend these privacy practices and this Notice at any time to comply with applicable law, professional standards, or Practice procedures. Updates may apply to past, current, and future services or records as required by law or professional obligations. Notification of updates will be provided by posting the date of the last revision at the bottom of this document. For your convenience, you may review

the most current Notice at any time on the website at www.kindredcounselingcenter.com/forms, in the waiting room, and by submitting a request in writing to the privacy office listed below.

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

Privacy Officer: Meghan Jerry, LMFT, CST, (267) 603-1624, meghan@kindredcounselingcenter.com

Last Revised: December 20, 2025

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

Welcome to Kindred Counseling Center! Thank you for trusting me to be your therapist. I look forward to working with you. This document is designed to help you understand what to expect from therapy, including information about confidentiality, emergencies, and other important aspects of our work together.

While providing this document fulfills an ethical obligation in my profession, more importantly, it reflects my commitment to keeping you fully informed and involved in your therapeutic experience. Our relationship is a collaborative one, and I welcome your questions, comments, or suggestions at any time throughout our work together.

Client Agreement & Informed Consent

Please review each page carefully and sign where indicated to confirm that you have read, acknowledged, understood, and agreed to the terms outlined herein.

The therapeutic relationship is unique in that it is both highly personal and a contractual agreement. Because of this, it's important to have a clear understanding of how we'll work together and what each of us can expect.

The policies outlined in this agreement ("Agreement") apply to both in-person and telehealth sessions. This Agreement is made between Meghan B. Jerry, MFT, LLC, doing business as Kindred Counseling Center (the "Practice"), and you (the "Client"). Services are provided by Meghan Jerry, LMFT, CST ("Therapist") through the Practice. Throughout this Agreement, "I," "me," and "my" refer to the Therapist, who provides services on behalf of the Practice, and "you" and "your" refer to the Client. Once signed, this document will serve as our mutual agreement. If you have any questions or concerns about these policies, please bring them up as I welcome the opportunity to discuss them with you.

Therapist & License Information

Therapist: Meghan Jerry, LMFT, CST (PA License #MF001145)

I am dedicated to helping people gain greater insight and create more joy in their lives. I provide therapy for individuals, families, and all types of relationships. While I have expertise in relationship and sexuality issues, I also work with a wide range of concerns, including anxiety, mood and adjustment disorders, infidelity, trauma, grief and loss, divorce, assertiveness, life transitions, and other challenges. My approach includes consultation with other highly trained, specialized, and licensed therapists in accordance with ethical best practices to ensure high-quality care. When appropriate, your information may be discussed in consultation, collaboration, or supervision; however, all such conversations are anonymized and held in strict confidence by all parties.

I am licensed to practice in Pennsylvania, and state law requires you to be physically located within Pennsylvania at the time of our sessions, including telehealth. By signing this agreement, you agree to meet with me only while in Pennsylvania. You are responsible for informing me of any changes to your contact information or address.

Understanding Therapy Services

Psychotherapy ("therapy") is not easily described in general terms. It involves working collaboratively to address mental, emotional, cognitive, or behavioral challenges. Therapy can support clients in developing

greater self-awareness and insight, improving coping strategies and problem-solving, easing emotional distress and symptoms, and helping resolve specific issues.

Successful therapy requires commitment from both the client and the therapist. Progress and outcomes depend on many factors, including but not limited to, your level of motivation, desire to change, follow-through with therapeutic tasks between sessions, consistency in attending appointments, and openness throughout the process. My approach will vary based on the concerns you've identified, your personality, the unique qualities you bring to therapy, and the training and professional experience I bring. You are always welcome to ask about the methods I use and may decline to answer any question I pose. Depending on your needs, we may consider individual, relationship, family, or group therapy. In some cases, I may recommend an evaluation for medication and refer you to a qualified prescribing professional.

Therapy has both potential benefits and risks. Risks may include experiencing uncomfortable feelings such as sadness, guilt, anxiety, or anger during and after some sessions as past experiences are explored and problems are brought to the surface. You may be asked to revisit difficult personal or family history to help loosen the grip those past events have on your life now. Sometimes, changes made as a result of therapy may not be welcomed by other people in your life and can lead to some strain in your relationships. In some cases, symptoms may temporarily worsen before improving. Most of these risks are to be expected when people are making important changes in their lives. On the beneficial side, therapy often improves emotional well-being, communication, coping skills, and relationship satisfaction.

There are no guarantees about what you may experience during therapy or how you may respond. You acknowledge that no promises have been made regarding specific outcomes from therapy or any methods used. You accept responsibility for your participation in exercises or activities I suggest, and you agree not to hold me legally responsible for their effects during or after sessions.

Scope of Practice. I do not practice outside the boundaries of my licenses and training. I do not perform custody evaluations or provide legal recommendations regarding visitation, custody, or parenting time. I do not provide medical or legal advice, nor do I prescribe or manage medication.

Role of Diagnosis. I do not assign a diagnosis unless it is clinically indicated or required for coordination of care, such as for out-of-network insurance reimbursement. If a diagnosis is needed, I use the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association, to determine the most appropriate code. This coding supports treatment planning and required documentation. If a diagnosis is added to your record, I will inform you, and you are welcome to ask questions or discuss them at any time. My approach prioritizes understanding your experience in context rather than labeling or pathologizing it.

Confidentiality & Privacy Notice (See also "Notice of Privacy Practices")

Information shared in therapy is kept strictly confidential in accordance with state and federal laws, including the regulations of the Pennsylvania State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors. However, there are specific exceptions to confidentiality where disclosure is required or permitted by law or ethical standards.

By signing below, you acknowledge that you have received, read, and understood the "Notice of Privacy Practices", which explains the limits of confidentially in greater detail.

The limits to confidentiality in therapy include, but are not limited to, the following:

- **Release of Information**. If you sign a Release of Information form, I will comply with your authorization. In relationship or family therapy, I will not disclose confidential information unless all participants provide their written authorization.
- **Risk of Harm to Self or Others**. If I believe you are at serious risk of harming yourself or someone else, I may notify medical or law enforcement personnel, and/or a friend or family member, if appropriate.
- **Abuse or Neglect**. I am legally required to report suspected abuse or neglect of a minor, elder, or dependent adult.
- **Legal Proceedings**. If your therapy records are subpoenaed or ordered by a court, I am required to respond and may be required to comply. If subpoenaed, I will notify you so that you (or your attorney) can attempt to contest it. If you take no action, I must comply. You agree to notify me promptly of any action taken to contest a subpoena and to share the outcome.
- **Complaints or Legal Action Against Me**. If you file a complaint or initiate legal action against me related to your therapy, I may disclose your information as needed for my legal defense. In such cases, the therapeutic relationship will be terminated, and I will offer referrals for continued care.
- **Use of Insurance**. If you seek out-of-network reimbursement, your insurance company may request information such as type of services, diagnosis, treatment plans, dates of service, progress notes, or summaries. I have no control over how your information is used once in their possession. By electing to pursue reimbursement, you acknowledge and accept this risk.
- **Collections**. If payment for services is overdue and collection efforts are necessary, I may share your name, contact information, dates of service, and outstanding balance with a billing or collection agency.
- **Electronic communication**. Communication by email, text, phone or telehealth is not fully secure and may compromise your privacy. If you choose to use these methods, you accept the associated risks.
- **Reporting Past Provider Misconduct**. If you report a previous therapist's sexual misconduct, I am legally obligated to report it to the licensing board and district attorney.
- **Consultation**. I participate in confidential consultation with other licensed professionals to enhance quality of care. Identifying details are omitted, and all consultants uphold the strictest standards of confidentiality.
- **Professional Writing or Speaking**. I may refer to anonymized clinical experiences in writing or presentations. Any shared material will be composite in nature and carefully de-identified to protect your privacy.
- **No-Secrets Policy in Relationship or Family Therapy**. In relationship or family therapy, I may use information shared in individual sessions when working with the group. I will not disclose a secret directly, but will support you in making the disclosure. If you choose not to share the information, I will discontinue my role in your case and provide referrals.
- **Electronic Record Storage**. Your records are stored in a secured, web-based system with backup protections. While precautions are taken, no system is completely risk-free.

Emergency Contact. By signing below, you authorize me to contact your emergency contact in the event of a crisis or if I have serious concerns for your safety and you have not responded to my attempts to reach you. You also consent to my sharing any information necessary to help prevent a life-threatening situation. It is your responsibility to notify me of any changes to your emergency contact information.

Acknowledgement. By signing below, you acknowledge that you understand the limits of confidentiality and the potential risks involved in therapy, and you have chosen to proceed with treatment.

Professional Relationship

Our relationship must be different from most other relationships. It may differ in how long it lasts, the topics discussed, or the goals involved—and it must remain strictly limited to the roles of client and therapist. If we were to interact in any other capacity, it would create a "dual relationship," which is considered unethical in the mental health profession and can be harmful to you. Dual relationships can create conflicts between your needs and my professional judgment. To provide you with the best care, my focus must remain fully on your well-being, which is why our relationship must remain professional in nature.

Because of the importance of confidentiality and avoiding dual relationships, I do not accept friend or contact requests from current or former clients on social networking platforms (e.g., Facebook, Instagram, LinkedIn). For the same reasons, I will also not attend personal events to which you might invite me, such as family gatherings, parties, or weddings.

If we encounter each other outside the therapy office, I will not address you unless you address me first. I am happy to return a brief, friendly greeting, but I will not initiate interaction in public—leaving that choice up to you—and I will not engage in clinical discussion outside of session. This protects your privacy and autonomy. If you prefer not to acknowledge me, that is completely acceptable. If I attend an event and discover that you are also present, I will use my best clinical judgment to determine whether staying could create discomfort or blur boundaries. If so, I may choose to leave to prioritize your comfort and privacy.

Initial Assessment

Therapy requires a significant commitment of time, energy, and financial resources, so it's important to be thoughtful about choosing the right therapist for you. Our first few sessions will focus on assessing your needs and goals and determining whether my clinical skills and therapeutic approach are a good fit. These early sessions are an opportunity for both of us to evaluate whether working together may be beneficial.

If we decide to continue, I will share some initial impressions about the focus of our work and what therapy may involve. I encourage you to consider this feedback, along with your own sense of comfort and connection, in deciding whether to proceed. If you have any questions about my approach at any time, please raise them with me.

If, during or after the assessment, you feel another therapist might better suit your needs, I will gladly provide referrals. Likewise, if I determine that your concerns would be better addressed by a different provider, I will clearly communicate that and offer appropriate referrals.

Therapy Sessions and Attendance

Typically, sessions are 50 minutes and scheduled weekly, ideally on the same day and time. Depending on the nature and severity of your concerns, longer or more frequent sessions may be recommended. The duration of therapy varies and is influenced by your goals, symptom severity, level of engagement, and available support systems. We will work together to identify therapy goals, such as reducing symptoms, building coping skills, or improving communication and relationships. These goals may evolve over time and we will revisit them as needed. The approaches I use will vary depending on your needs, and you agree to discuss any questions or concerns with me directly.

Attendance. Consistent attendance plays an important role in the success of therapy. Frequent cancellations or rescheduling can interfere with your progress and reduce availability for others seeking care. If you cancel or reschedule more than three times within a two-month period, I may offer you a different time slot (if available) or refer you to another provider.

If you schedule a session and do not attend ("no-show") or fail to contact me within seven days after that appointment, I will understand that as a termination of services. Likewise, if you do not schedule your next session and more than three weeks pass without prior arrangements for a break, I will assume you are discontinuing services. If you wish to return to therapy, please know I may not have availability at that time and will provide referrals if needed.

Relationship or Family Therapy. If you are participating in relationship or family therapy and one member is unable to attend, individual therapy will not be substituted unless previously agreed upon by all participants. In such cases, the session will be considered a late cancellation, and the full session fee will be charged to your credit card on file. I may occasionally recommend individual "breakout sessions" as part of our work together, but these must be discussed and agreed upon in advance.

Late Arrival. If you are more than 15 minutes late, the session will be considered a late cancellation and rescheduled. The full session fee will be charged to your credit card on file. If you arrive within that 15-minute window, we will still end at the scheduled time out of respect for clients following your session. Please note that insurance companies do not reimburse for missed or late-cancel sessions.

Substance Use. Substance use interferes with your ability to fully participate in therapy. For this reason, I request that no alcohol or recreational drugs be used for at least eight hours prior to your session. If I believe you are under the influence, I will end the session and charge the full session fee, in accordance with the cancellation policy. Sessions ended early for this reason are not reimbursable by insurance. If you attend an in-person session under the influence and attempt to drive, I may contact law enforcement to protect your safety and that of others.

Court-Ordered Therapy. If therapy is being used to satisfy a court order, you must provide share the relevant documentation at the start of treatment. This allows us to clarify the purpose and structure of therapy and how communication or documentation will be handled.

Children in Session and in the Waiting Room. Children are generally not permitted in sessions unless there is a clinical reason for their presence and we have discussed it in advance. If your child requires supervision, please do not bring them with you to your appointment, as I am unable to provide childcare. The waiting room is not attended or monitored, and you agree to take full responsibility for your child(ren) or dependent(s) left unattended in the office.

Fees & Insurance

The standard fee is $280 per 50-minute session. Payment is due at the time of service unless other arrangements have been made in advance. I use the HIPAA-compliant platform Ivy Pay to process payments. Ivy Pay stores your credit card information, but I do not have access to it. By signing below, you authorize the storage of your credit card information on this platform. You may also pay by personal check or cash (except for telehealth and court-related fees). If paying with cash, please note I cannot provide change; any overpayment will be applied as a credit to your account.

Failed Payments and Collections. If your card is declined, you agree to promptly provide alternative card information. Returned checks are subject to a $25 processing fee plus any bank fees incurred. These charges will be applied to your credit card on file. You agree that any insufficient funds or overdraft fees from your bank or card issuer are your sole responsibility.

If payment is not made, I may pause scheduling future sessions, initiate termination of services, or use a collection agency to recover payment. You understand that if a collection agency is used, I must disclose part

of your record (e.g. your name, contact information, dates of service, outstanding balance). Therapy services and fees are non-refundable.

Disputes and Chargebacks. You agree not to dispute valid charges for services rendered, including late cancel and no-show fees, or any other fees outlined in this agreement. Initiating a payment dispute (e.g., a credit card chargeback) may result in termination of services. If you believe a charge was made in error, please notify me immediately; if confirmed, a refund will be issued promptly.

Fee Changes. Fees are reviewed annually and may be increased. You will receive 30 days' written and verbal notice of any changes. If you are unable to continue due to the new fee, I will provide referrals or discuss a need-based reduced fee, if available.

Reduced Fee Agreements. I reserve a limited number of reduced-fee slots for clients experiencing financial hardship. If we agree on a reduced rate, you will be asked to sign a form documenting the arrangement. This rate is based on current need and will be revisited periodically. If your situation changes, I request that you notify me promptly so the reduced-fee slot can be made available to another client in need.

Additional Services & Fees. If we agree to extend a session beyond 50 minutes, you will be billed at the pro-rated session rate. Insurance typically does not reimburse extended time, and you are responsible for any additional cost.

You may also be billed for professional services beyond therapy sessions. These are billed at the standard session rate, pro-rated for work under one hour. Examples include report writing, phone calls lasting longer than 15 minutes, preparing summaries, coordination with other professionals, any other non-session services you request. These services are not billable to insurance and are your financial responsibility. For court-related fees, please refer to the "Litigation Policy and Fees for Court-Related Services" section.

Insurance. I do not accept insurance. However, you may be eligible for out-of-network reimbursement depending on your plan. It is your responsibility to contact your insurer and confirm coverage—especially for out-of-network care, relationship/family therapy, and telehealth services. I can provide a monthly superbill for you to submit to your insurance. If you would like to receive superbills, you agree to request them at the start of therapy. You are financially responsible for all services, regardless of whether your insurance reimburses you. In rare cases, insurance companies may request a "clawback"—a refund of previously paid services. You understand you are responsible for the full amount of services received, even if your insurer later reverses payment.

24-Hour Cancellation Policy

If you are unable to keep a scheduled appointment, whether in-person or via telehealth, you must notify me at least 24 hours in advance. If you cancel with less than 24 hours' notice ("late cancel") or do not attend your appointment ("no-show"), you will be charged the full session fee. These charges are not eligible for insurance reimbursement and are your sole responsibility. You agree to pay all late cancel and no-show fees. If you have a credit card on file, you authorize me to charge your credit card for these fees. Exceptions may be made for emergencies, such as sudden illness or accidents, at my sole discretion.

Please know that this policy is not intended as a punishment. Your appointment time is reserved specifically for you. Without sufficient notice, I cannot offer the time to another client. This results in a missed opportunity for others and a significant loss of income for myself. There is no fee for cancellations made with at least 24 hours' notice.

If we are scheduled for an in-person session and you would prefer to switch to telehealth, you agree to notify me as soon as possible, and no later than 8am the day of your session, so that I can plan accordingly.

Termination of Therapy

Ideally, we will mutually agree when it is time to end therapy, allowing us to schedule final sessions to review your progress and create a plan to help you maintain your gains and navigate future challenges. Therapy with me is voluntary and may be ended by you at any time. If you choose to end therapy before reaching your goals, I encourage you to bring your concerns into session so we can discuss them. Should you decide to discontinue therapy, I am happy to provide referrals to other therapists. You are responsible only for payment of services already received. Please note that ending therapy may affect other areas of your life or obligations. For example, if your therapy has been court-ordered, you will need to address that decision with the court.

There may also be circumstances in which I determine that I am no longer the best fit for your needs. If I believe that my training or approach is no longer appropriate for your concerns, or that therapy is no longer benefitting you, I will inform you and offer referrals to other professionals who may be better suited to support you. While I understand this may be difficult to hear, the decision to end services will be made with your care in mind and with clear communication.

If referrals are made for any reason, and you provide written authorization, I am happy to consult with your new provider to support a smooth transition and ensure continuity of care.

Communication Response Time

My practice is considered an outpatient facility and is designed to support individuals who are reasonably safe and able to manage outside of session. I cannot be available at all times. If you ever feel this level of support is not sufficient, please let me know so we can discuss additional resources or consider a referral to a therapist or clinic that offers 24-hour care.

I will do my best to return communication (e.g., phone calls, texts, emails) within 24 business hours. I do not generally respond to communication on weekends, holidays, or during vacations.

If you are experiencing a mental health emergency and need immediate assistance, please follow the emergency instructions provided below.

Emergencies and Crisis Situations

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

Additional Emergency Resources

- **The National Suicide Hotlines**: 988, 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
- **Domestic Violence Help**: (800) 220-8116
- **Doylestown Hospital**: (215) 345-2200

- **Youth Shelter**: (215) 442-9760
- Additional crisis resources are available on my website at www.kindredcounselingcenter.com/crisis.

Electronic Communication and Technology

Electronic communication, including email, text messages (message and data rates may apply), and secure messaging through Spruce, offers convenience for both clients and therapists. While useful in many circumstances, it also presents risks.

You agree to the following when contacting me electronically:

- Electronic communication is not appropriate for urgent or emergency situations. In an emergency, you agree to call 911 or go to the nearest hospital emergency room.
- I will make every effort to respond to electronic messages within 24 business hours, but that is not guaranteed.
- Electronic communication may be used for scheduling, billing, or administrative questions.
- It should not be used to share sensitive clinical or medical information.
- You understand that unencrypted email and text messages are not HIPAA-compliant, and you accept the risks involved. These risks include but are not limited to: a) messages sent to unintended recipients; b) accidental forwarding or circulation; c) back-up copies that may exist after deletion; d) employers or third-party monitoring; e) interception, alteration, detection, or unauthorized use; f) use in legal proceedings, g) data breaches or hacking.
- Electronic communication may become a part of your clinical record.
- It is not a substitute for therapy sessions. If you need to discuss something in depth, you agree to schedule an appointment.

If this policy is not followed, I may block further electronic communication. Repeated violations may result in termination of services and a referral to another provider. Either of us may revoke permission to use electronic communication (opt out) at any time by notifying the other in writing. By contacting me electronically, you affirm that you have evaluated these risks and consent to proceed.

Recording. Recording (e.g. audio, video, AI transcription/recording) or transmitting sessions is not permitted unless we have agreed in advance and I have given you a written authorization. This policy is in place to protect your privacy and preserve the integrity of the therapeutic space. You agree to turn off your phone during sessions. I may ask you to confirm your phone is off or to leave it in your car. If you decline either request, I may cancel the session and charge the full session fee. We will then discuss whether to reschedule or terminate therapy. If therapy is terminated, I will provide appropriate referrals. By signing below, you acknowledge that you understand and agree to this policy.

Social Media. To protect your confidentiality and the boundaries of the therapeutic relationships, I do not connect with current or former clients on social media (e.g., Facebook, Instagram, LinkedIn). If we encounter each other online unintentionally, feel free to bring it up in session. Please do not attempt to engage with me on a social platform. If I see you on a social platform, I may block you to protect your privacy. This is not a personal rejection, but a professional boundary intended to support your care.

Reviews. I will not solicit reviews from you about myself or my practice on any website or platform that allows public reviews of healthcare providers. If you have concerns, I encourage you to bring them to me directly rather than posting online. If you choose to post a negative review while we are still working together, I may determine that the therapeutic relationship has been compromised and is no longer clinically appropriate to continue. In that case, I will discuss this with you and, if necessary, provide referrals for alternative care.

Telehealth Services

A telehealth session is similar to an in-person outpatient therapy office visit, except interactive video technology allows us to meet remotely. Telehealth increases access to mental health services that might not otherwise be available due to physical health, geography, transportation, or other limitations.

Just like in-person sessions, I will assess for safety and may recommend a higher level of care or crisis services when needed. Participation in telehealth is at my clinical discretion, and we will regularly assess whether it remain appropriate and beneficial for you (or your child). You have the right to withdraw your consent for telehealth services at any time.

Emergencies and Safety. Telehealth appointments are considered outpatient services and are not a substitute for crisis or emergency care. In an emergency, you agree to call 911 or go to the nearest emergency room. Because some clients present in crisis during sessions, the law requires that I have the following information on file and up to date: your current home address, the address from which you are attending the session, an emergency contact name and phone number, your local police department and phone number, and your local hospital name and phone number. It is your responsibility to notify me of any changes to this information. If you are in crisis during a telehealth session, leave abruptly, and cannot be reached, I may contact your emergency contact or local emergency services.

Technology Requirements. You must have a reliable internet connection or a smartphone with a stable cellular signal. If we experience a technology failure during session, I will contact you by phone to coordinate alternative options.

Confidentiality and Privacy. The same privacy laws and ethical standards that apply to in-person therapy also apply to telehealth. I use a HIPAA-compliant telehealth platform to protect your confidentiality. While every reasonable effort is made to reduce risk, no system is entirely risk-free.

Potential risks include but are not limited to breaches of confidentiality or theft of personal information, disruptions due to technical difficulties, and loss of nuance due to limited observation of non-verbal cues. While telehealth can be effective, results cannot be guaranteed. If I believe in-person care may be more appropriate, I will discuss that with you.

Client Responsibilities. It is your responsibility to ensure that sessions take place in a private, quiet space free from distractions. To maintain confidentiality and boundaries, you agree to ensure that children are supervised and not within hearing range during telehealth sessions.

I am licensed to provide therapy only to clients physically located in Pennsylvania. You agree to attend telehealth sessions only while in Pennsylvania.

Billing and Payment. Telehealth services may or may not be covered by your insurance. It is your responsibility to confirm coverage. Regardless of reimbursement, you are responsible for payment. Fees are payable only by credit or debit card at the end of the session. If your card is declined, you agree to provide alternative card information promptly.

Consent to Telehealth Services. The policies outlined in this agreement apply to both in-person and telehealth services. By signing below, you confirm that you have read, understood, and agree to the terms of telehealth services and voluntarily consent to receive care through this format.

Records

I strive to maintain records in a manner consistent with professional, legal, and ethical standards. Professional records generally include dates of service, fees paid, electronic communications, and a summary of each session. Summaries may include general issues addressed, symptom presentation or changes, level of functioning, mental status, diagnosis, treatment plans, and other personal health information. If, as a part of your therapy, you provide written material or artwork, I will return the originals at your written request; however, copies may be retained as part of your client record.

Records are retained for at least six years from the date of the last entry, in accordance with HIPAA and Pennsylvania law. Records may be retained longer when clinically or legally appropriate. Once the retention period has passed, records may be destroyed at my discretion. Deleted records cannot be recovered.

You have the right to request a copy of your records, excluding "psychotherapy notes," which are given special protection under HIPAA. All requests must be made in writing and must include a signed authorization. I will generally fulfill your request within 30 days. Because therapy records contain sensitive clinical information, they may be misinterpreted or distressing when read outside the therapeutic context. If I believe releasing your record would be harmful to you or could endanger your life or the life of another person, I may withhold the record and will provide a written explanation and available options.

Fees for Record Requests. Fees are charged in accordance with the HIPAA Privacy Rule. By signing below, you acknowledge and agree to the following:

- **Electronic copies**: Labor for copying and delivering your record is billed at $30 per hour, rounded to the nearest 15 minutes.
- **Paper copies**: Same as above, *plus* the cost of supplies and postage.
- **Portable media**: If you request that your record be provided on portable media (e.g., USB drive), the cost of the media will be added to the applicable fees above.

By signing below, you agree that charges will be billed to your credit card on file unless other arrangements are made.

Treatment Summaries. If you request a treatment summary, either in place of or in addition to your record, the fee will reflect the time required to review your record, prepare the summary, and manage delivery. This work will be billed at your regular session rate, rounded to the nearest 15 minutes. If you request a paper copy, additional fees for supplies and postage will apply.

Amending Records. You may request an amendment to your record if you believe any information is inaccurate or incomplete. Requests must be made in writing. Amendments do not delete or alter existing record content but are added to clarify or correct information. I will respond to your request within 60 days. If I deny the request, I will provide a written explanation and inform you of your right to submit a statement of disagreement, which will be included in your record.

Litigation Policy and Fees for Court-Related Services

The therapeutic relationship is built on confidentiality and trust. Clients often share deeply personal information—including pain, trauma, and vulnerability—that may be extremely private, upsetting, or embarrassing. This information is shared with the understanding that what is disclosed in therapy will remain confidential. I take that responsibility seriously. Asking me to break that confidence in court goes against the very foundation of the therapeutic relationship. For this reason, I ask that you do not attempt to use therapy, or anything shared in therapy, for legal purposes or against another person in a legal proceeding.

Therapy is not a legal process, and the clinical setting is not intended to support litigation. If you currently are or become involved in legal proceedings during or after our work together, including but not limited to divorce, custody disputes, or personal injury claims, you agree that neither you nor your attorneys or representatives will subpoena my records or request that I testify in any legal capacity.

Subpoenas and Court Involvement. If you or your legal team subpoena me in violation of this agreement, or if I am subpoenaed by another party, such as an opposing attorney, I am required to respond and may be compelled to comply. If this happens, you agree to pay for all time I must spend related to the legal matter, regardless of who issues the subpoena. This includes, but is not limited to, time spent reviewing records, preparing for court, consulting with attorneys, traveling, waiting, and attending depositions or hearings.

Fees. The hourly rate is $560 per hour. There is a minimum charge of five hours ($2,800). Additional time will be billed in full-hour increments $560 per hour (not pro-rated). Fees will be charged to your credit card on file. Personal checks are not accepted for court-related services. There are no refunds for court-related fees. You agree not to dispute these charges with your credit card company.

Court-Related Cancellations. If I must appear in court or provide a deposition for a case involving you, I must clear my schedule, typically for the entire business day. Therefore, cancellations must be made at least two full business days in advance. For example, if the proceeding is scheduled for 12pm on Monday, you must cancel no later than 12pm on the preceding Thursday. If cancellation occurs after this deadline, the full minimum fee will be charged and is non-refundable.

Responsibility for Payment. By signing below, you agree to pay for all court-related fees, even if I am subpoenaed by a third party, such as your ex-spouse, as long as the legal matter involves you.

Important Considerations. Subpoenaing a therapist is expensive and may not benefit your case. There is no guarantee that my testimony will be helpful. In some situations, my testimony could be harmful to your case. If I am subpoenaed in violation of this agreement, I may determine that the therapeutic relationship has been compromised and is no longer clinically appropriate to continue. In that case, I will provide referrals for alternative care.

By signing below, you acknowledge and agree to this litigation policy.

Public Health and Safety

No Weapons Policy. To ensure the safety of everyone in the building, I maintain a zero-tolerance weapons policy. No weapons of any kind are permitted on the premises. This includes, but is not limited to, firearms, ammunition, knives, explosives, pepper spray, or any object that could be used to harm yourself or others. I reserve the right to contact law enforcement and/or terminate therapy with any client who violates this policy.

Public Health Considerations. To protect the well-being of clients, families, and colleagues, I reserve the right to implement or adjust health and safety precautions during periods of increased public health risk. This includes, but is not limited to, outbreaks of COVID-19, influenza, RSV, or other contagious illnesses. Decisions about in-person sessions will be informed by guidance from the Centers for Disease Control and Prevention (CDC), local authorities, and individual health considerations such as vaccination status, medical vulnerability, and exposure risk. Additional concerns can be discussed at any time.

In-person appointments may be shifted to telehealth at my discretion based on clinical appropriateness or evolving health guidance. If you have concerns about this change, I encourage you to raise them so we can

find a solution, or if needed, I can provide referrals. You may also request to return to telehealth at any time, provided it remains clinically appropriate. You are responsible for verifying whether your insurance covers telehealth services.

By choosing to attend in-person sessions, you accept the potential risk of exposure to contagious illness and agree to the following safety measures:

- You will only attend in-person if you are symptom-free and have had no recent known exposure to a contagious illness.
- If you have a fever (100°F or higher) or signs of illness, you agree to cancel or switch to telehealth.
- You will wash or sanitize your hands upon entering the building.
- You will avoid physical contact with others and make reasonable efforts to maintain physical distance.
- If a child or dependent accompanies you, you agree to ensure they follow the same precautions.
- If you or a household member tests positive or is knowingly exposed to a contagious illness, you agree to notify me promptly so we can switch to telehealth or reschedule.

If I become ill or exposed, I will notify you so you can take appropriate precautions.

These protocols may be updated in response to changes in local, state, or federal guidelines. I will communicate any changes and work with you to make adjustments as needed.

I have taken reasonable measures to reduce the risk of transmission in the office. If you arrive while symptomatic, I may ask you to leave and continue telehealth if clinically appropriate.

If these safeguards are not followed, I may end in-person therapy and transition care to telehealth or refer you to another provider.

In the event of a public health crisis, I may be legally required to notify public health authorities that you were present in the office if you test positive for a communicable illness. If that occurs, and only when required by law, I will share only the minimum necessary information and will not disclose the nature of your visits. By signing below, you agree that I may make this disclosure without additional written authorization.

By signing below you acknowledge and agree to follow these policies.

Statement of Principles

I do not discriminate against clients on the basis of race/ethnicity, color, religion, national origin, location, citizenship status, sex (including pregnancy, childbirth, and related medical conditions), sexual orientation, sexual or gender expression, gender identity, disability (physical or mental), age, genetic information, marital or family status, veteran or military status, place of residence, criminal record unrelated to present dangerousness, or any other characteristic protected by applicable law. This commitment reflects both my values and compliance with federal, state, and local laws. I actively support values of equity, inclusion, human dignity, liberation, and cultural, racial, and ethnic diversity. If you ever believe you have experienced discrimination in my practice, I encourage you to bring it to my attention immediately.

Complaint Procedures

As with any relationship, misunderstandings or concerns may arise in the course of our work together. If you are dissatisfied with any aspect of your therapy, I encourage you to raise those concerns so we can address them together. We will explore whether the issue can be resolved together or if a referral to another therapist

might better meet your needs. You have the right to have your concerns heard and resolved in a timely manner.

I am committed to practicing competently, ethically, and in accordance with the code of ethics for my profession. If you believe I have not upheld this commitment and we are unable to resolve the issue together, you have the right to file a complaint with the appropriate oversight agency.

The practice of licensed mental health professionals in Pennsylvania is regulated by the Pennsylvania State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors. You may contact the Board at One Penn Center, 2601 N. 3rd Street, Harrisburg, PA 17110, (717) 783-1389.

If you believe your privacy rights under HIPAA have been violated and we cannot resolve the issue directly, you may file a complaint with the U. S. Department of Health and Human Services, Office for Civil Rights, at OCRMail@hhs.gov.

If a bill exceeds your Good Faith Estimate by $400 or more and we cannot resolve the issue, you may initiate a formal dispute through the U.S. Department of Health and Human Services (HHS). You must begin the dispute process within 120 calendar days of the date on the original bill. There is a $25 fee to use this process. To learn more and start the process, visit: www.cms.gov/nosurprises.

Plan for Practice in Case of Disability or Death

In the event of my incapacity, disability or death, I have arranged for a trusted licensed psychotherapist to assume responsibility for managing my client records. This includes notifying clients, securing confidential information, and providing referrals to other providers as needed.

By signing below, you authorize this designated professional to contact you directly and to use or disclose your confidential mental health information solely for the purposes described above.

Designated Professional: Josephine Cooper, LCSW, (215) 330-6828, josephine@thecarecounselingcenter.com.

Updates

The Practice may amend these policies and this Agreement at any time to comply with applicable law, professional standards, or Practice procedures. Updates may apply to past, current, and future services or records as required by law or professional obligations. Notification of updates will be provided by posting the date of the last revision at the bottom of this document. The most current Agreement will be available on the website at www.kindredcounselingcenter.com/forms or by request for your convenience.

Consent to Therapy

By signing below, you confirm that you are giving your informed and voluntary consent for me to provide therapy services to you, your dependent(s), or both, as applicable.

_____

Acknowledgment of Informed Consent & Agreement

I understand that I am not required to sign this Agreement and that I am under no obligation to proceed with therapy. I understand that I may choose to end therapy at any time.

I acknowledge that no guarantees have been made regarding the outcomes of therapy, the effectiveness of any particular therapeutic methods, or the number of sessions that may be necessary. I further acknowledge that I have been informed of the limits to confidentiality and privacy.

I understand that the Practice may update its policies from time to time and I will be notified of any material changes. I understand that I may request the current version of this Agreement at any time.

By signing below, I confirm that I have carefully read, understood, and agree to all terms and policies contained in this Agreement, including all pages, as well as the separately provided "Notice of Privacy Practices." I have had the opportunity to ask questions, discuss any parts I did not understand, and receive answers to my satisfaction.

My signature below confirms my voluntary consent to participate in therapy with the Practice. I understand that this Agreement constitutes an agreement between me and the Practice and may be legally enforced as such. I understand that this Agreement applies to all therapy services provided by the Practice. Ending therapy does not affect services already provided or the Practice's legal obligations. I agree that a copy of this Agreement, including an electronic or scanned copy, has the same force and effect as the original.

Printed Name of Client	Signature of Client	Date

Last Revised: December 21, 2025

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

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 toyou.

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.

Out-of-network provider(s) or facility name:

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

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 hange.

Total cost estimate of what you may be asked to pay: It is your 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 three.

- **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, CST at meghan@kindredcounselingcenter.com
- **Questions about your rights?** 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 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 anything, 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	$280
	90834	Psychotherapy, 38-52 minutes	$280
	90846	Family Psychotherapy without Patient Present, 50 minutes	$280
	90847	Family Psychotherapy with Patient Present, 50 minutes	$280
	98966–98968	Telephone Assessment & Management	Pro-rated based on the amount of time spent at session rate.
	98970–98972	Online Digital Evaluation & Mgmt. (Responding to Email & Text Messages)	Pro-rated based on the amount of time spent at session rate.
	Late Cancel/No-show Fee	Your Therapist Requires a 24-Hour Cancellation Notice	You are responsible for the full fee of the appointment late canceled/missed.
	Production of Records	Labor for copying, delivering, supplies, postage, portable media	$30/hr., rounded to nearest 15mins, plus materials & postage
	Returned Check Fee		$25 *plus* any bank charges
	Legal Fees	Minimum of 5 hours for court appearances and/or depositions.	$560/hr. in full-hr. increments
	Total Estimate:	This Good Faith Estimate explains your therapist's rate for each service commonly 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 the Place of Service (in office vs. telehealth) is not delineated above since the charges are identical. The effective date of this Good Faith Estimate is December 20, 2025. If fees or patient treatment needs change, a new estimate will be provided in writing. You can request a copy or update of this estimate at any time.

*** This estimate does not take account for reduced-fee agreements 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.**

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, CST

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 _____ **(the date you received the appointment confirmation email)** 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 receiving services.

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

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

Client Demographic Information

Please complete this form to the best of your ability, using the information available to you at this time. Take your time and answer each item as fully as you can. While it may seem like a lot, the information you provide will help me develop a treatment plan that is tailored to your specific needs.

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

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 briefly describe your reason for seeking counseling/therapy:
My strengths are:
My sources of stress are:
My leisure activities are:
My current life goals are:

What are effective coping strategies 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

Please check all that apply:

Mood and Emotions
- ☐ Depression, low mood, crying spells
- ☐ Mood swings or emotional ups and downs
- ☐ Fatigue, low energy, lack of motivation
- ☐ Feelings of worthlessness, guilt, hopelessness
- ☐ Feelings of emptiness
- ☐ Loss of interest or pleasure in activities
- ☐ Grieving or mourning a recent or past loss

Anxiety and Stress
- ☐ Excessive worry, nervousness, tension
- ☐ Panic attacks or sudden surges of fear
- ☐ Specific fears or phobias (e.g. crowds, flying, needles)
- ☐ Feeling overwhelmed, stressed, "on edge"
- ☐ Difficulty relaxing, managing stress

Anger and Aggression
- ☐ Frequent anger, irritability, frustration
- ☐ Aggressive behavior, threats, physical altercations
- ☐ Impulsive outbursts, difficulty controlling temper

Trauma and Abuse History
- ☐ Past or current experiences of abuse (emotional, physical, sexual, verbal)
- ☐ Childhood trauma, neglect
- ☐ Exposure to violence, traumatic events (including military service)

Thought and Perception Concerns
- ☐ Confused, disorganized thinking
- ☐ Racing thoughts, rapid speech, feeling hyper
- ☐ Hallucinations, hearing/seeing things others don't
- ☐ Feelings detached from reality or yourself
- ☐ Unwanted or intrusive thoughts that won't go away
- ☐ Engaging in behaviors others find unusual or hard to understand
- ☐ Suspiciousness or mistrust of others

Self-Harm and Safety
- ☐ Thoughts of self-harm, suicide
- ☐ Past suicide attempt(s)
- ☐ Thoughts of harming others
- ☐ Self-harm behaviors
- ☐ Risk-taking, reckless behaviors

Substance Use and Addictive Behaviors
- ☐ Use of alcohol, drugs, tobacco causing problems
- ☐ Difficulty controlling use of substances, behaviors
- ☐ Gambling, excessive spending, compulsive sexual behavior

Relationships and Family
- ☐ Ongoing relationship or marital conflicts
- ☐ Family problems, unresolved family issues
- ☐ Difficulty making or maintaining friendships
- ☐ Feelings of rejection, abandonment, loneliness
- ☐ Codependency, people-pleasing
- ☐ Divorce, separation, custody, co-parenting, blended families
- ☐ Infidelity/affairs
- ☐ Housework/chores (e.g. quality, sharing duties)
- ☐ Social withdrawal, difficulty connecting with others

Sexual and Intimacy Concerns
- ☐ Problems with sexual desire, function, satisfaction
- ☐ Mismatched sexual expectations in relationship(s)
- ☐ Sexual identity, orientation, gender-related concerns
- ☐ Sexual trauma or discomfort related to intimacy

Work, School, and Daily Functioning
- ☐ Problems at work, with career direction
- ☐ Difficulty with school, motivation, performance
- ☐ Trouble managing time, responsibilities, daily routines
- ☐ Workaholism, overworking

Financial and Legal Stressors
- ☐ Financial problems, debt, low income, impulsive spending
- ☐ Legal issues, criminal charges, court involvement
- ☐ Employment instability, inability to maintain a job

Self-Esteem and Identity
- ☐ Low self-esteem, poor self-image
- ☐ Perfectionism, fear of failure
- ☐ Oversensitivity to criticism or rejection
- ☐ Feeling "not good enough," comparing self negatively to others
- ☐ Guilt or shame about identity, choices, past actions
- ☐ Self-criticism

☐ Difficulty maintaining self-care, meeting basic needs

Behavior and Impulse Control

☐ Difficulty controlling impulses or behavior

☐ Engaging in risky or irresponsible actions

☐ Dishonesty, manipulating situations or others

☐ Performing rituals or repetitive behaviors (e.g. checking, counting)

☐ Destruction of property, stealing

Eating and Body Image

☐ Overeating, undereating, appetite concerns

☐ Concerns about weight, dieting, body image

☐ Vomiting, binging, purging behaviors

Physical and Somatic Symptoms

☐ Physical symptoms not explained by a known medical condition (pain, nausea, tingling)

☐ Sleep problems (too much, too little, nightmares)

☐ Menstrual or hormonal concerns

☐ Health worries or chronic illness concerns

Cognitive Difficulties

☐ Trouble focusing, concentrating, staying organized

☐ Memory problems, losing track of time

☐ Difficulty making decisions, procrastination

Spiritual or Moral Concerns

☐ Questions about spirituality, religion, personal values

☐ Moral or ethical conflicts causing distress

Other Concerns

☐ Other issue(s) not listed above (please list):

_____

Please review the concerns you have checked and indicate the one you would most like help with. It is:

_____

History of Counseling/Therapy				
Are you **currently**, or have you **previously** been, treated by a counselor, psychologist, psychiatrist, or other medical professional for the concerns noted above (including any treatment for substance abuse or addiction)? ☐ 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):
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?

Have you ever experienced challenges or distress related to sexual activity, intimacy, or sexual functioning (now or in the past)? ☐ Yes ☐ No If yes, please explain:

If applicable, at what age did you start to menstruate (i.e., get your first 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 applicable and 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	Ending Date (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 an immediate family member or relative) experienced difficulties with any of 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 children from a previous marriage or relationship with "P," and stepchildren with "S." In the column marked "Residing," use "R" to indicate children who currently live with you.

Name	Current Age	Gender	School	Grade	Adjustment Problems?	P? S?	Residing

Legal History & Information
Are you required by a court, the police, or a probation/parole office to attend this appointment? ☐ Yes ☐ No If yes, please explain:
Are you currently, or expecting to be, involved in any legal proceedings? ☐ Yes ☐ No If yes, please explain:

Other Relevant Information
Is there anything else you think would be important for me to know that you haven't already included on these forms? If so, please write it here or attach a separate sheet:

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?	

<u>Acknowledgement and Consent</u>
I have received the "Client Agreement and Informed Consent" form and the "Notice of Privacy Practices." I understand that I am responsible for all fees associated with the services provided to me, and I agree to comply with the 24-Hour Cancellation Policy. I voluntarily consent to treatment for myself, my child, or both, as applicable. I confirm that the information I have provided is accurate and complete to the best of my knowledge. In the event of an emergency, I authorize my therapist to contact the person I have designated as my emergency contact and to share any information necessary to help prevent a dangerous or life-threatening situation. By signing this document, I confirm that I have read, understood, acknowledged, and agreed to the policies outlined in these documents.

Printed Name of Client _____ Signature of Client _____ Date _____

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

Medicare Private Pay (Opt Out) Contract

Section 4507 of the 1997 Balanced Budget Act allows a physician or practitioner to enter a private pay contract with a Medicare beneficiary.

Why a special contract? I have not been excluded from providing medical services under Social Security Act Medicare (including sections 1128, 1156, 1892, CFR § 405, subpart D).

I, Meghan Jerry, LMFT, CST, providing services for Meghan B. Jerry, MFT, LLC, doing business as Kindred Counseling Center, have chosen to separate myself ("opt out") from Medicare. Because I opted out, Medicare requires I have you sign a private pay medical services contract before I treat you.

Who pays for services? You pay the bill and will have to use your own money to pay the ENTIRE cost of my services.

Are there charge limits? No, Medicare charge limits DO NOT apply to products or services you receive from me through this private pay medical services contract. I can charge you whatever amount you and I agree to.

Will Medicare help pay? No, Medicare will NOT help pay your bill. Because I separated from Medicare, it is against the rules for you to send a bill to Medicare for my services or ask to send the bill to Medicare for you. By signing below, you agree not to do so.

Isn't this a Medicare-covered service? Yes and no. Yes, Medicare would pay for the same service from a provider who is connected to Medicare. No, Medicare won't pay because I have separated myself from Medicare.

What options do I have? You have the right to get your service from a provider connected to Medicare or from me, a provider separated from Medicare. Even if you get your service from me, you can always get services from providers connected to Medicare. These providers are not required to have you sign private pay medical services contracts.

What if I am having a medical emergency? This contract does NOT cover emergency or urgent care services. If you have an emergency or urgent medical need, ask me for help. It is against Medicare rules for me to have you sign a private pay medical services contract for emergency or urgent medical services.

Will my medigap or other supplemental plan help pay? No, Medigap plans WILL NOT help pay for products or services you get from me. If you have some other medical insurance plan, it MIGHT NOT help pay your bill either.

What else do I need to do? It is important you retain a copy of this contract in case you have any questions about the contract in the future.

Will CMS get a copy of the contract? I, the provider, will supply a copy of this contract in the event CMS requests a copy.

By signing, you agree to receive private pay services from Meghan B. Jerry, MFT, LLC, and understand that it is against Medicare rules to send a bill to Medicare for my services or ask to send the bill to Medicare for you.

Printed Name of Client	Signature of Client	Date