***Jennifer Bonness, LMHC, LLC***

***All About You Counseling Center***

*1881 NE 26th Street, Suite 102, Wilton Manors, FL 33305*

*Phone: 954-601-4402 Email:* *JenniferBonnessLMHC@gmail.com*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT FOR PSYCHOTHERAPY AND OFFICE POLICIES**

**This form provides you, the Client, with information that is additional to that detailed in the Notice of Privacy Practices. Please take the time to read this document carefully. Any questions about this document, contact Jennifer Bonness, LMHC.**

**SESSIONS:** Weekly 50- minute sessions are recommended. Sessions will be scheduled in advance and are made by appointment only. Making the effort to come to sessions on a consistent and timely manner will provide you with the most benefits of working toward you treatment goals. Additional or less frequent sessions may be arranged.

**FEES:** The standard rate for a 50- minute session is $ \_\_\_\_\_. Payment is due at the time of service, at the beginning of session, unless other arrangements have been made. You can make payment by cash, check, or credit card. The Client assumes any and all responsibility for paying Jennifer Bonness, LMHC/All About You Counseling Center, LLC, the fee of $35 per returned or bounced check. The agreed-upon fee per session will be indicated on page 2 of this agreement. Other than phone calls to schedule and confirm appointments, any phone consultations longer than 10 minutes will be charged in 15-minute increments at on-quarter of your agreed-upon rate for a 50- minute therapy session. If I will be unavailable for an extended time, I will provide you with the name of a colleague for you to contact if necessary. This colleague is bound by the same legal, ethical, and privacy policies as I am. *Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments.*

**CANCELLATION:** Since the scheduling of an appointment involves the reservation of time specifically for your, a minimum of 24 hours (1 day) notice is required for re-scheduling or cancelling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notifications and due at the time of the next session. Most insurance companies do not reimburse for missed sessions. If you must cancel, please leave me a phone message with as much advance notice as possible.

**HEALTH INSURANCE & INSURANCE REIMBURSEMENT:** At this time, I do not accept direct payment from insurance. However, some insurance plans have “out of network” benefits. If you have “out of network” benefits, you may be able to seek reimbursement for your treatment. If you choose to utilize “out of network” benefits please be aware that you are responsible for payment at the time of service. Upon your request, I will provide you with a statement of services for you to submit to your insurance company for reimbursement. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality.If you have “out of network” benefits, and plan to seek reimbursement, please remember that professional services are rendered and charged to the client and not to the insurance companies. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

**TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact me between sessions, please leave a message at 954-601-4402 and your call will be returned as soon as possible. I check messages several times during the day. Unless there is an urgent need, I generally do not return calls on the weekends or after 9:00 pm on business days.

**Please be aware, I do not provide emergency/crisis services. In an emergency situation, please call 911, go to the nearest emergency room, or call the Broward 211 24-hour Behavioral Health INFO Line.**

**CONFIDENTIALITY:** All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required or permitted by law.

**WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW:** Some of the circumstances where disclosure is required or may be required by law are: (1) where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; (2) where a client presents as a danger to self, to others, to property, or is gravely disabled; (3) when a client’s family member communicates that the client presents as a danger to others; and (4) as required by a third-party to obtain reimbursement. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain psychotherapy records and/or testimony. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. I do not release records to any outside party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy, or other treatment that involved more than one adult client.

**This form does not cover every possible exception. Please refer to the HIPAA Notice of Privacy Practices, which I provided to you.**

**EMERGENCY:** If there is an emergency during therapy, or in the future after termination, where I become concerned about your personal safety and wellbeing; the possibility of you injuring someone else; or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others; and to ensure that you receive the proper medical care.

**CONSULTATION:** I consult regularly with other professionals regarding my clients; however, each client’s identity remains completely anonymous and confidentially is fully maintained.

**RECORDS AND YOUR RIGHT TO REVIEW THEM:** State law requires that I keep treatment records for seven years from the date of last contact. Unless otherwise agreed to be necessary, I will retain clinical records only as long as mandated by Florida law. I keep confidential records and personal information of our sessions. If you have concerns regarding the treatment records, please discuss them with me. As a client, you have the right to review or receive a summary of you records at any time, except in limited legal or emergency circumstances or when I assesses that releasing such information might be harmful in any way. In such a case, I will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon you request, I will release information to any agency/person you specify unless I assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment. Please also note, if you are using insurance or the employee assistance program for payment, they have a legal right to your information, including records.

**ADDITIONAL CHARGES:** Additional charges may be assessed for services other than therapy in session. Additional charges may be discussed with **Jennifer Bonness, LMHC**, in advance for such things as: request for specific letters, copies of records, disability paperwork, litigation, or others not listed here. You may request a letter, or you may become involved in litigation, which may require my participation.

**BENEFITS AND RISKS OF THERAPY:** Participation in therapy can result in a number of benefits to you, including improvement of interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behaviors. I will ask for your feedback and views on your therapy, the therapy process and progress, as well as other aspects of the therapy and will expect you to respond openly and honestly. During evaluation, or while engaged in therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, or experiencing anxiety, depression, or insomnia. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member can be viewed as negative by another family member. Change will sometimes be easy and swift, but may be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

**BEGINNING TREATMENT:** During the first few sessions, I will be gathering information about your reasons for seeking treatment, your current and past difficulties, family history, and previous medical and/or psychiatric treatment. Within a reasonable period of time after the initiation of treatment, I will discuss with you my clinical impressions and work collaboratively with you to create a treatment plan. If you have any unanswered questions about any of the interventions used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you shall receive any and all pertinent information. You also have the right to ask about other treatments to your condition, and their risks and benefits.

**ENDING TREATMENT:** The decision to end therapy, in a perfect scenario, is a collaborative decision between therapist and client when agreed that sufficient progress has been made. Throughout therapy we will discuss and evaluate your progress on meeting your objectives and goals. If you wish to stop therapy at any time, I ask that you agree to meet for at least one more session to review our work together. If at any point during psychotherapy I either assess that I am not effective in helping you reach your therapeutic goals or you are not willing to participate, I may discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, appropriate and/or necessary, I will provide you with referrals that may be of help to you. I will talk to the psychotherapist of your choice in order to help with the transition. You have the right to terminate therapy and communication at any time.

**DUAL RELATIONSHIPS:** Therapy never involves any type of dual relationship that may impair **Jennifer Bonness, LMHC** objectivity, and clinical judgment. Dual relationships can be exploitative in nature.

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**INFORMED CONSENT FOR PSYCHOTHERAPY AND OFFICE POLICIES: FEES**

* Missed visits, or those cancelled with less than 24-hours notice, will be billed the full hourly rate.
* Phone consultations over 10 minutes in length will be billed in 15-minute increments, with each 15 minutes being billed at one-quarter of your agreed-upon hourly session rate.
* Letters or reports written at your request will be billed at your agreed-upon hourly session rate x the length of time required to complete this documentation.
* Court appearances will be billed at your agreed-upon hourly session rate x the number of hours required, plus travel expenses.
* Copies of records will be billed at $1.00 per page, plus any postage costs if mailed by Jennifer Bonness, LMHC

***I understand that payment is due at the time of service, at the beginning of session, unless other arrangements have been made. I assume any and all responsibility for paying Jennifer Bonness, LMHC, LLC/All About You Counseling Center the fee of $35 per returned or bounced check. I understand that I may have to pay additional fees for services provided other than scheduled therapy sessions, as listed above. I will notify Jennifer Bonness, LMHC, if I experience any problems arise during the course of therapy regarding my ability to make timely payments.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Client (or Legal Guardian if client under 18)**

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**Printed Name of Client (or Legal Guardian if client is under 18 and indicate relationship to client)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Therapist (Jennifer Bonness, LMHC)**

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**Printed of Therapist (Jennifer Bonness, LMHC)**

***Jennifer Bonness, LMHC***

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**INFORMED CONSENT FOR PSYCHOTHERAPY AND OFFICE POLICIES**

I give my consent to receive therapeutic services provided by Jennifer Bonness. LMHC. The undersigned understands that Jennifer Bonness, LMHC, is a Licensed Mental Health Counselor in the State of Florida. The undersigned has asked Jennifer Bonness, LMHC, any pertinent questions prior to initiating treatment and is voluntarily seeking her services.

I understand that therapy with Jennifer Bonness, LMHC can be cancelled at any time. I understand that, should I stop attending counselling sessions with Jennifer Bonness, LMHC, for thirty (30) days without prior notification, my case will be considered closed. I am aware that I may resume therapy with Jennifer Bonness, LMHC, at a later date by contacting her at (954) 601-4402.

I understand that Jennifer Bonness, LMHC, is not a medical physician, psychiatrist, attorney, or psychologist. Thus, she will not provide advice on medical, psychiatric, or legal matters, other than by means of referral. I understand that Jennifer Bonness, LMHC, is not responsible in any way for the actions of any professionals to whom referrals might be made.

**I have read the Informed Consent for Psychotherapy and Office Policies carefully; I understand and agree to comply with them.**

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**Signature of Client (or Legal Guardian if client under 18)**

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**Printed Name of Client (or Legal Guardian if client is under 18 and indicate relationship to client)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Other Participant**

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**Printed Name of Other Participant (and relation to Client)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Therapist (Jennifer Bonness, LMHC)**

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**Printed of Therapist (Jennifer Bonness, LMHC)**