Consent to Use and Disclose Your Health Information
Consent for Treatment

The Counseling/Psychotherapy Process: I believe that therapy is only effective in an atmosphere of safety, understanding, validation, empathy, and trust. My role is to help you to use your own strengths to find growth and healing. Your responsibility is to stay present and active in the process, listening to yourself, developing new understandings, setting goals and working at making the changes you desire in your life.

I use a variety of therapeutic techniques in my work, mainly cognitive behavioral therapy and psychodynamic therapy. The approach used depends upon the individual client's needs and goals. No matter what the therapeutic technique, though, the relationship between therapist and client is the primary agent of change. Therefore, I hope and expect that you will share any concerns you have about our therapeutic relationship with me.

The Benefits and Risks of Therapy: As with any powerful treatment, there are some risks as well as many benefits with therapy. You should think about both the benefits and risks when making any treatment decisions. For example, in therapy, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other feelings. Clients may recall unpleasant memories. These feelings or memories may bother a client at work or in school. Also, clients in therapy may have problems with people important to them. Family secrets may be told. Therapy may disrupt a marital relationship and sometimes may even lead to a divorce. Sometimes, too, a client's problems may temporarily worsen after the beginning of treatment. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy may not work out well for you.

While you consider these risks, you should know also that the benefits of therapy have been shown by scientists in hundreds of well-designed research studies. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved or their problems are solved. Clients' relationships and coping skills may improve greatly. They may get more satisfaction out of social and family relationships. Their personal goals and values may become clearer. They may grow in many directions—as people, in their close relationships, in their work or schooling, and in their ability to enjoy their lives.

I do not take on clients I do not think I can help. Therefore, I will enter our relationship with optimism about our progress.

This information is required by the Board of Professional Counselors and Therapists which regulates all certified and licensed counselors and therapists. The address of the Board of Professional Counselors and Therapists is 4201 Patterson Avenue, Baltimore, MD 21215; the phone number is 410-764-4732.

Jennifer Beall, LCPC
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645 Baltimore-Annapolis Blvd., Suite 107, Severna Park, MD 21146
Telephone 443-458-4221 • Toll-free 877-426-9272 • Fax 443-458-0422
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Code of Ethics: I hold a Master of Science degree in Pastoral Counseling from Loyola College in Maryland. As a Licensed Clinical Professional Counselor in the state of Maryland and as a pastoral counselor, I adhere to the Codes of Ethics adopted by the Maryland State Board of Professional Counselors and Therapists and the American Association of Pastoral Counselors.

Your confidentiality will be carefully protected. To assure quality care for my clients, I regularly consult with a group of colleagues about my work with clients. I protect my clients' identities in these consultations.

There are several instances in which confidential information, by law, can be released without your authorization. In this event, I would make every effort to gain your authorization. Any such release would be within the context of my concern for your and others' safety and welfare. Examples of this are: 1) when there is a serious threat to your health and safety or to the health and safety of another individual or the public, 2) in some lawsuits and legal or court proceedings, and 3) if a law enforcement official requires me to do so.

Fees and Payment: I charge $120 for a 50-minute therapy session. I request that you pay me at the end of each session. I accept cash, checks, and credit cards (Visa, Mastercard, and Discover). Checks should be made payable to Jennifer Beall. Upon request I will provide you with a statement at the beginning of each month that will reflect all sessions and payments made during the preceding month.

I realize that my fees involve a substantial amount of money, although they are consistent with similar professionals' charges. For you to get the best value for your money, we must work hard.

I will assume that our agreed-upon fee-paying relationship will continue as long as I provide services to you. I will assume this until you tell me in person, by telephone, or by certified mail that you wish to end it. You have a responsibility to pay for any services you receive before you end the relationship.

If you think you may have trouble paying your bills on time, please discuss this with me. I will also raise the matter with you so we can arrive at a solution. If your unpaid balance reaches $375, I will notify you by mail. If it then remains unpaid, I must stop therapy with you.

If there is any problem with my charges or any other money-related point, please bring it to my attention. I will do the same with you. Such problems can interfere greatly with our work. They must be worked out openly and quickly.

Insurance: If I am a provider for your insurance company or Employee Assistance Program, I will bill the insurance company on your behalf and collect only your copay at the time of the

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service. If I am not an in-network provider for your insurance plan, I ask that you pay me in full at the time of the session; upon request, I will provide you with a statement at the end of each month that you can use to request reimbursement from your insurance company. As each health insurance plan is different, I encourage you to check with your carrier in advance to find out what your benefits are. Please note that mental health (often called behavioral health) benefits often differ from other medical benefits. *Insurance companies do not generally reimburse for couples' counseling.*

Please sign the following if using your insurance plan or Employee Assistance Program:

"I authorize the release of any information (including treatment summaries and diagnosis) necessary to process insurance or Employee Assistance claims, or to request additional sessions.

I authorize payment of benefits to be made to Jennifer Beall, LCPC for services provided."

(Sign here)____

Name of primary insured, if not client ____

Primary insured's date of birth_________ Client's relationship to primary insured ___________

Cancellations: Please notify me as soon as possible if you need to cancel a session. If you cancel with less than 24 hours notice, you will be charged the full fee for that session except in cases of sudden illness or family emergency. *Note: Insurance plans will not pay for missed or late-cancelled sessions.*

Phone Calls: You are welcome to call me at any time. However, I cannot promise that I will be available at all times. In most cases, I will return your call within 48 hours.

Emergencies: I do not provide emergency services for my clients. Should an emergency arise, I encourage you to call the emergency services in your community and/or your local hospital or police. Please do not hesitate to use these community services when necessary in order to keep yourself safe.

Disclaimers: It is understood that any agreements made are only between you and me. The other therapists in the suite operate independent practices, and are not responsible for your care. I also cannot be responsible for the care provided by professionals or groups to whom I refer you.

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If I Need to Contact Someone about You: *If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you—perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned about your harming someone else.*

Please write down the name and information of your chosen contact person in the blanks provided:

Name: ____

Street____________________________City____________________State______Zip___________

Phone: _________________________ Relationship to you: _________________________________

Privacy Practices and HIPAA: You have a right to privacy that is in compliance with federal laws as stipulated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All information you share in therapy will be held in strict confidence except, when appropriate and necessary, your clinical record that contains demographic, diagnostic, emergency and treatment summary information. This protected health information (PHI) may be shared with others who provide treatment to you or who need it to arrange payment for your therapy, or for other business or government functions.

By signing this consent form, you are agreeing to let me record your information and, when appropriate and necessary, send it to others in order to professionally treat you and conduct business. If in the future I have to change how I use and share information, I will notify you. If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment, or administrative purposes. Please put that request in writing. I will try to comply with your wishes, although, by law, I am not required to do so. Also, after you have signed this consent, you have the right to revoke it in writing. (However, if I have already used or shared some of your information, I cannot change that.)

I have read the above information carefully. My signature below is my consent for treatment and my consent to use and disclose my health information.

Signature of Client ____Date _________________

Printed Name of Client____

Signature of Therapist____Date __________________

Printed Name of Therapist____

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