

New Choices Counseling

Jennifer Curran, MC, LPC

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480-275-9277

LPC-14053

DISCLOSURE STATEMENT AND TREATMENT AGREEMENT

This document provides information regarding my professional background, treatment offered, fees, cancellation policies, and treatment agreement to ensure the best quality of service that I can provide you. Therapy is an important and useful part of your health and self-care. Please read this document thoroughly and then sign at the bottom.

My educational background includes a Bachelor of Arts in Psychology and a Master of Counseling from Arizona State University. I am a Licensed Professional Counselor in the state of Arizona (LPC-14053). I am also a Certified Hypnotherapist and received my training at the Southwest Institute of Healing Arts in Tempe, AZ. I have extensive knowledge in the treatment of children, adolescents, adults, and families. Along with using other therapeutic skills, I utilize a combination of cognitive-behavioral, attachment-focused, and family systems approaches to treatment. I also provide EMDR treatment, an approach which focuses on the reprocessing of traumatic memories. I believe in a holistic approach to therapy, which includes exploring the spiritual paradigm, for the most effective treatment possible. I may suggest alternative forms of therapy, such as energy work or dietary changes, during the course of treatment.

TREATMENT RECORDS

It is required that I keep appropriate treatment records regarding each session and contact. You are entitled to view and/or receive a copy of your records, unless I believe that obtaining them would be detrimental to you. In this case, I would be able to provide them to an appropriate mental health professional of your choice. I can also review your records with you using my standard fees.

My records retention policy is as follows: The complete record will be retained for at least six years. The retention time period begins from the date of the last visit, session, or service. At the end of the retention period, the record will be entirely destroyed, unless you request otherwise, or it seems necessary that records will be needed after that time (i.e., legal reasons).

SESSIONS AND FEES

Session fees are as follows: \$165 for a 60 minute session. There are times, especially during the course of a hypnotherapy session, where it may take longer than this to appropriately complete the session. In this case, where possible, I will talk to you beforehand about the approximate length of the session. If you are using insurance, you will be charged a pro-rated fee for any session that goes over 60 minutes.

Payment for services is your responsibility, not your insurance company's responsibility. It is also your responsibility to know and understand your insurance benefits. I accept United, Aetna, and Blue Cross Blue Shield insurance plans. If you do not provide me with the information I need to bill your insurance company, I will not bill your insurance company for you. You will owe the full fee for that session, and I will provide you with a receipt that you can use to submit a claim to your insurance company for reimbursement. I have a form available on my website at www.newchoicescounseling.org that you can fill out about how to obtain the necessary information for billing.

My preferred form of payment is Zelle, cash, or check, made payable to New Choices Counseling or Jennifer Curran. I also accept credit, debit, and HSA cards, but a processing fee of 3% will be added to all card payments (the fee is 3.5% if I have to run the card numbers manually.) Payment is due at the beginning of each session. I also require a credit card number on file that I will charge for any late cancellations or no-shows that occur. Refer to the last page of this disclosure for more information about this policy. Please know that your credit card information will be handled with the same care and attention to the confidentiality laws as the rest of your information, and will be kept securely locked up at all times. If at any time you are unable to make payments, please bring such concerns to my attention as soon as possible.

My cancellation policy is as follows: I require a notice of cancellation (by phone) by *at least 6 pm two days before* your scheduled appointment. Any cancellations made after this time, as well as any no-shows (no advance notice was given for missing the appointment), will be charged a fee of \$120.00. This fee will be billed to the credit card I have on file for you on the day of the missed appointment. Also, my late cancellation/no-show fee will be applied to any session in which you arrive 15 minutes late or more. Please be aware that my schedule is sometimes flexible and in order to use my time efficiently, and I may leave the office after 15 minutes if you are not there. I cannot bill insurance for a partial session (under 45 minutes) so if you are late, and I am still in the office and you would still like to keep the appointment, you will be responsible for my cash rate of \$120.00 for that session. Partial sessions will still end at the time originally scheduled. In the case of an emergency where advance notice is impossible, your fee may

be waived. Such emergencies include serious illness/injury, car accidents, and similar traumas involving you or your family.

If you choose to terminate therapy for any reason, please let me know. If needed, adequate and appropriate referrals will be made available to you. I also reserve the right to terminate treatment for the following reasons: repeated no-shows/cancellations, failure to progress (I have an ethical obligation to terminate therapy if it is not helpful to you), conflicts of interest, failure to pay, or threats made to myself, my family, or property. If you no-show or cancel an appointment, you have 14 days to contact me to reschedule. If you do not contact me within this time frame, I reserve the right to close your file.

PROFESSIONAL TRAINING

There may be times where I will utilize clinical consultations in order to obtain treatment options for various clients. During these times, I would continue to uphold all confidential information and refrain from using any names. The consultations are used in order to provide the best possible treatment for my clients and the therapist/client relationship.

TECHNOLOGY

The use of technology has been increasing in the counseling field. It is important to understand that not all technological applications are secure and I cannot guarantee your confidentiality if you choose to use them (this includes things like email, Zelle, or Skype.) The use of this technology is your choice and therefore you agree to exempt New Choices Counseling from any harm or damage if a loss of privacy has occurred due to the use of this technology or actions by a third party (ie-hacking). You agree that you take sole responsibility for any possible outcomes in regards to your information if you use technology during the course of treatment. You also agree not to use technology to record any session without the express permission of all parties present, including any telehealth sessions conducted over Skype.

ETHICS AND PROFESSIONAL STANDARDS

I strictly follow the professional code of ethics as required by the Arizona Board of Behavioral Health Examiners, and presented by the American Counselors Association. I value the client/therapist relationship and will always make decisions and recommendations that are in the best interest of my clients. Under no circumstances will I violate my professional code of ethics and the laws by which I abide.

EMERGENCY CONTACT

If you are in crisis or need immediate assistance, you can call 911, the 24-Hour Crisis Hotline at 602-222-9444, or go to the nearest hospital emergency room. You may also leave a message on my voicemail at 480-275-9277. I am available to return calls or texts during my business hours. If we do speak by phone, you may be billed a pro-rated fee for the time if the conversation exceeds 10 minutes.

OTHER PAPERWORK

Please note that I do *not* fill out paperwork for other organizations. This includes FLMA, disability paperwork, or any other paperwork required by the courts.

TREATMENT AGREEMENT

I have read and understand the information provided in this document. I agree to these terms during my professional relationship with Jennifer Curran, MC, LPC, CCHt and I received a copy of this agreement.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CREDIT CARD AGREEMENT

Regular attendance at your scheduled appointments is important for a successful outcome in therapy. Furthermore, appointments cancelled at the last minute, and especially no-shows, are very detrimental to my practice and an inconvenience to my schedule.

Therefore, you will be billed \$120.00 for all late cancellations and no-shows, unless you encountered an emergency and I have agreed to waive the fee for you. Please be mindful of your scheduled sessions and take consideration of those that can benefit from time not used. Repeated late cancellations or no-shows may result in termination of therapy. It is my policy to obtain and maintain on record a valid credit card and authorizing signature. This will remain in your confidential file as a guarantee of payment and it allows me to avoid having to take collections action against any client. Late cancellation/no-show fees will be billed on the day of the missed appointment. It is important to understand that having insurance benefits is not a guarantee of payment. Therefore, if the insurance company declines to pay a claim, you are responsible for that amount. I will notify you of the debt in order for you to have the opportunity to call your insurance company to clear your account. By signing this form you are authorizing New Choices Counseling to collect any outstanding amount on the card listed below. A receipt will be sent to the email address you provide on the Client Information Form. If you do not want to fill out this form, you may seek services elsewhere and I will provide you with an appropriate referral. This signed Credit Card Agreement is for use only for services rendered at the office of New Choices Counseling.

Client's Name: _____

Name on Card: _____

Card Number: _____

Expiration Date: _____ CIV: _____

Zip Code associated with card: _____

Card Member Signature: _____