Journey of Hope Counseling

11224 86th Ave N
Maple Grove, MN 55369
Phone: (763) 400-7076 Fax: (763) 400-7078

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

Professionals Include:
Jessica Zingelman, MSW, LICSW

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service. Contact through social media sites will not be responded to or accepted.

AVAILABLE SERVICES: Journey of Hope Counseling offers a wide array of counseling services, including individual, family, and couples. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: We provide short-term counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if both agree that Journey of Hope Counseling can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The goal of Journey of Hope Counseling is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist.

CANCELLATION/NO SHOW POLICY: If you must cancel or reschedule your appointment, we require that you call our office at (763) 400-7076 or cell at (612) 382-9274 **at least 24 hours in advance**, in order to serve all our clients. **Late cancel or no show appointments will be charged $75 each session missed.** Please note that insurance companies do not pay for missed appointments.

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$240.00
	Regular Office Visits (60 minutes)	$210.00
	Regular Office Visits (45-50 minutes)	$190.00
	Regular Office Visits (30 minutes)	$115.00
	Couples/Family (60 minutes)	$230.00
	Family Sessions (90 minutes)	$290.00
	Outside Office Work (inpatient visits, court, collaborative law services)	$300.00/hour
	Written Reports (insurance companies, supervisors, etc. pro-rated at	$120.00/hour
	Returned check fee per check or declined credit card	$30.00

A reasonable fee will be charged for copies of any records requested by the Client.

PAYMENT/INSURANCE FILING If you are using insurance benefits, Journey of Hope Counseling will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Copayments are required at the start of every session. If you choose to not use insurance, the rates will be reduced and determined prior to starting therapy.

CREDIT CARD ON FILE AUTHORIZATION

At Journey of Hope Counseling, we are committed to provide you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible. To streamline our billing and payment system and to provide a seamless, convenient way for you to pay your bill, as of August 1, 2022, Journey of Hope Counseling will require all clients to keep an active debit or credit card on file. If you prefer to pay your bill with cash or check, you may make arrangements with your therapist to do that; however, we will still require a credit card on file for circumstances that require it. Circumstances when your credit card would be charged include but are not limited to: missed or late canceled appointments, missed co-payments and/or co-insurance, and any non-covered services and/or denial of services.

Name on Credit/Debit Card:

Credit Card Type: Visa: _____ MasterCard: _____ Discover: _____

Card #: _____

Exp Date: _____ 3 Digit # on Back of Card: _____ Zip Code: _____

I acknowledge I have been informed and agree to the above billing policy. I understand that payments are due on the date of service. I agree that Journey of Hope Counseling may bill the credit card on file for any payments which are my responsibility, that have not been paid on the date of service. I hereby consent for Journey of Hope Counseling to utilize my credit card information for any outstanding balance.

_____ Signature

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If you experience an emergency after hours or on a weekend, your Therapist's cell number will be given. Please utilize this cell phone number at 612-382-9274 in the event of a serious crisis, and your Therapist will call you back as soon as possible. If you are experiencing a life threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your Therapist is out of town, you will be advised in advance.

CONFIDENTIALITY: Journey of Hope Counseling follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These

records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name _____ Telephone Number _____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Journey of Hope Counseling will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature – Spouse/Partner/Parent Date

_____ _____

Therapist Date