

PROFESSIONAL DISCLOSURE STATEMENT

Jennifer Johnson, MS, MS, MFA, CRC, LPC
217 N. 5th Ave. Suite 103
Wilmington, NC 28401
910-208-0518

Credentials:

M.S. Community Counseling, Georgia State University, 1991
M.S. Rehabilitation Counseling, Georgia State University, 1996
M.F.A. Interdisciplinary Arts, Goddard College, 2007
Licensed Professional Counselor, North Carolina #6478
Licensed Professional Counselor, Georgia #2891
National Certified Counselor #26687
Certified Rehabilitation Counselor #34472
Distance Credentialed Counselor #827

I have been practicing as a counselor since 1991.

Services:

Services offered include individual and group psychotherapy, Mindfulness Based Psychotherapy, Yoga Therapy for Emotional Balance, Therapeutic Writing, PhotoTherapy, rehabilitation counseling, career assessment and counseling, and vocational evaluation. My theoretical orientation is eclectic and holistic, considering the person as a whole being, emotionally, physically, and spiritually. I utilize techniques from Mindfulness Based Therapy, Yoga, Cognitive Behavioral Therapy, writing therapy, poetry therapy, PhotoTherapy, Depth Psychotherapy, Career Counseling, and Rehabilitation Counseling. Client populations served include adults and teens dealing with stress, depression, anxiety, grief/loss, life transitions, ADHD, career transitions, adjustment to injury or illness, food/weight issues, PTSD related to medical events, loss, accidents, and war, personal and spiritual growth, and artists dealing with creative blocks, depression, and anxiety.

Fees:

Psychotherapy, Rehabilitation Counseling, and Career Assessment and Counseling sessions are as follows: \$125 per 45-minute session, \$210 per 75-minute session and \$250 per 90-minute session. Group sessions vary in length from 50 minutes to 90 minutes, and the fee for group sessions is \$60 per 45-minute session and \$125 per 90 minute session. The fee for vocational evaluation is \$1200 per evaluation for standard evaluation and \$1800 for evaluation of persons with blindness or visual impairment. Payment is accepted in cash or check only. Insurance reimbursement is currently not accepted.

Diagnosis:

Diagnosis is often utilized as a tool to guide the development of a treatment plan and the course of treatment. The diagnosis becomes a part of the client's record.

Confidentiality Policy:

Records remain confidential and cannot be released to a third party without the client's written consent with the following exceptions: If there is an indication that the client is at risk of harm to self or others, if there is an indication of child or elder abuse, or if there is a court order to release the records. Under these circumstances, the client's record will be released to the appropriate authorities without the client's consent.

Procedure for registering complaints:

If you are dissatisfied with my services in any way, I request that you discuss the matter with me so that we can attempt to address your concerns. If after discussing the matter with me you remain dissatisfied, and you wish to do so, you may file a complaint with the North Carolina Board of Professional Counselors. To file a complaint with the North Carolina Board of Professional Counselors, you may send a complaint to:

North Carolina Board of Licensed Professional Counselors

P.O. Box 77819

Greensboro, NC 27417

Phone: 844-622-3572 or 336-217-6007

Fax: 336-217-9450

E-mail: Complaints@ncblpc.org

I have read and understand the above disclosure statement, and I consent to participating in psychotherapy treatment with Jennifer Johnson.

Client Signature

Date

Parent Signature

Date

Counselor Signature

Date

INFORMED CONSENT

AGREEMENT FOR COUNSELING SERVICES WITH JENNIFER JOHNSON, MS, MS, MFA, LPC

THE THERAPY PROCESS

Participation in counseling or coaching may result in a number of benefits to you, including improvement of symptoms and/or resolution of the specific concerns that led you to counseling or coaching. Participation in counseling and coaching requires your active involvement, openness, and honesty in order to change your thoughts, feelings, and behavior. On the other hand, participation in counseling and coaching may result in experiencing considerable emotional discomfort and/or strong feelings of anger, sadness, anxiety, fear, depression, insomnia, etc. Participation in counseling and coaching may result in changes that were not originally intended, such as changes in relationship status, housing, employment, education, substance use, and other behaviors and circumstances. Family and friends may react positively or negatively to your decisions and changes, and they may make unanticipated decisions or behavior changes in response to yours. There is no guarantee that participation in counseling or coaching services will result in positive or intended results. I will attempt to work with you to address the issues through approaches that include but are not limited to Mindfulness-Based counseling, Rehabilitation Counseling, Narrative Therapy, Therapeutic Writing, PhotoTherapy, Life Coaching, and Wellness Coaching.

DISCUSSION OF TREATMENT PLAN

During the initial sessions, as I become familiar with your story and concerns, we will begin to discuss a treatment plan to address your concerns. If you are dealing with issues that are not within the realm of my areas of expertise, you may be referred to another practitioner who can better assist you. Progress toward your treatment goals will be reviewed on an ongoing basis during the counseling process. If you have questions regarding the treatment plan, any techniques utilized to address your concerns, or my training, experience, and expertise, I encourage you to ask.

TERMINATION

The initial sessions of our work together will include an ongoing assessment of your current circumstances. During the first session, if I determine that your current circumstances are out of the realm of my areas of expertise, you may be referred to other practitioners who can better assist you. If during the course of treatment I determine that I can no longer be of assistance to you, we will discuss this, and if you need further treatment, I will provide you with referrals to other practitioner who may be able to assist you. If you continue treatment with me, we will work toward mutually agreed upon goals, and we will discuss when termination is appropriate based upon when you have met your desired goals and no longer need services. You have the right to terminate counseling at any time.

PRIVACY & 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 by law. Disclosures required by law may include 1) When there is a reason to suspect that a child, dependent, disabled person, older adult or otherwise vulnerable person is being abused or neglected, 2) If I determine that you are a potential danger to yourself, others, or property, 3) Should I be involved in a Health Oversight investigation, or 4) If you are involved in a court proceeding and/or I receive a court order or administrative tribunal to release your records, I will be required to release your personal health information to the appropriate authorities. I may also use your records to defend myself should you initiate any legal proceedings toward me.

If you choose to email me from your personal email account, please limit the contents to housekeeping issues such as a cancellation or change in contact information, as email communications are not secure, and confidentiality regarding email communications cannot be guaranteed. I will not respond to personal and clinical concerns via email. If you call me, please be aware that unless we are both on landline phones, the conversation is not secure and could be intercepted, and therefore, confidentiality cannot be guaranteed. Likewise, text messages are not confidential, and my business line will not receive text messages.

I make every effort to keep all information confidential. Likewise, if we are working together via Skype on computers, I ask that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors, and friends. I encourage you to only communicate through a computer that you know is safe, i.e., wherein confidentiality can be ensured. Be sure to fully exit all online counseling sessions and emails. If we are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible, please email me to schedule a new session time.

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc. involving you and another party), neither you nor your attorney, nor anyone else acting on your behalf will request me to testify in court or at any other proceeding, unless I have specifically been hired for court testimony, nor will you request disclosure of your psychotherapy records for such purposes.

Consultation: I consult regularly with other professionals regarding my clients; however, the clients' name or other identifying information is never disclosed. The client's identity remains completely anonymous, and confidentiality is fully maintained.

Considering all of the above exclusions, if it is still appropriate, upon your request, I will release information to an agency or person that you specify unless I conclude that releasing such information may be harmful in any manner.

TELEPHONE & EMERGENCY PROCEDURES

If you need to speak with me between sessions, please call 910-208-0518 and leave a message. If you have urgent or emergent need for assistance, please call 911 immediately or call the National Suicide Hotline at 800-784-2433 or go to your local emergency room for assistance. Your call will be returned as soon as possible. Messages are checked daily (but never during the night time).

FEES & PAYMENT

Current rates for therapeutic services are \$125 per 45-minute session for individual therapy and \$150 for couples therapy.

MEDIATION & ARBITRATION

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a precondition of the mediation process. The mediator shall be a neutral third party chosen by agreement of Jennifer Johnson MS, LPC, CRC and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful,

any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in accordance with the rules of the American Arbitration Association that are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney's fees. IN the case of arbitration the arbitrator will determine that sum.

CANCELLATION

Since scheduling an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. If you cancel an appointment with less than 24 hours notice, the full fee will be charged for sessions missed.

PHONE SESSIONS

If you are requesting telephone counseling, you as the client understand that phone sessions have limitations compared to in person sessions, among those being the lack of face-to-face interactions, the lack of visual and audio cues in the therapy process, and the fact that most insurance companies will not cover phone based therapy. You understand that telephone counseling with me is not a substitute for medication under the care of a psychiatrist or doctor. You understand that phone counseling is not appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts. As stated previously, if a life-threatening crisis should occur, you agree to contact a crisis hotline, call 911, or go to a hospital emergency room. You also understand that I follow the laws and professional regulations of the State of North Carolina (USA) and the psychotherapy treatment will be considered to take place in the state of North Carolina (USA).

FRAGRANCE FREE ENVIRONMENT

Please do not wear perfume, cologne or scented lotion products to your sessions out of consideration for those who come into my office who are chemically sensitive. Thank you for your cooperation.

Your signature below indicates that you have reviewed the information available on my website and have read and understand this Informed Consent and the HIPPA Notice of Privacy Practices.

Client Signature	Date
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Parent Signature	Date
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We will discuss this Informed Consent during our first session. If our sessions are scheduled by phone, please mail this form with your signature to me at P.O. Box 1963 | Wilmington, NC 28402

HIPPA NOTICE OF PRIVACY PRACTICES

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

YOUR RIGHTS

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory **We do not have a hospital directory. Contact you for fundraising efforts **We do not do fundraising and you will not be contacted regarding fundraising.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again. ** We do not do fundraising and you will not be contacted regarding fundraising.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Most sharing of psychotherapy notes.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease. Helping with product recalls. Reporting adverse reactions to medications. Reporting suspected abuse, neglect, or domestic violence.

Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research. ** We do not do share your information for health research in this practice.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you: For workers' compensation claims. For law enforcement purposes or with a law enforcement official. With health oversight agencies for activities authorized by law. For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations: Jennifer Johnson
Updated September, 2013.

Jennifer Johnson, MS, MS, MFA, LPC, CRC
217 N. 5th Ave, Suite 103
Wilmington, NC 28401
910-208-0518
jen@jenjohnson.com

**ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY
PRACTICES**

I have received and have read the HIPPA Notice of Privacy Practices provided by this office.

Printed Name

Date

Signature

Jennifer Johnson, MS, MS, MFA, CRC, LPC, CHWC

217 N. 5th Ave, Suite 103
Wilmington, NC 28401
910-208-0518

Name:

Date:

Parent Names if minor child:

Address:

Age: Date of Birth:

Name of Parents if Minor Child:

Email address:

Home phone:

Cell Phone:

Parents' Cell Phone:

Marital Status:

Do you have children or pets?

How many, and what ages?

Occupation:

Employer:

Educational History:

Are you a military veteran? If so, what branch, and when did you serve?

Emergency Contact Name, Relationship, and Phone:

Have you had previous counseling?

When?

Reason for previous counseling:

Was it helpful?

Why or why not?

Are you currently experiencing any of the following?

- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Difficulty remembering details
- ☐ Difficulty making decisions
- ☐ Fatigue or decreased energy
- ☐ Feelings of guilt, shame, worthlessness, and/or helplessness
- ☐ Feelings of hopelessness or pessimism
- ☐ Foggy thinking
- ☐ Difficulty falling asleep, waking early, difficulty waking, or excessive sleeping
- ☐ Irritability
- ☐ Restlessness
- ☐ Loss of interest in activities or hobbies, including sex
- ☐ Aches and pains
- ☐ Numbness or tingling sensations
- ☐ Digestive problems
- ☐ Persistent feelings of sadness, loneliness, or emptiness
- ☐ Suicidal thoughts
- ☐ Thoughts about harming yourself
- ☐ Thoughts about harming or killing someone else
- ☐ Anger outbursts/rage
- ☐ Violent behavior
- ☐ Anxiety
- ☐ Nervousness
- ☐ Ruminating thoughts
- ☐ Obsessions or compulsions
- ☐ Phobias
- ☐ Decreased appetite
- ☐ Increased appetite
- ☐ Eating disorder

Do you have a history of addiction to alcohol or drugs? Please provide detailed history of use and treatment:

Do you use alcohol?

What type?

How frequently?

Amount:

Do you use recreational drugs?

What type?

How frequently?

Amount:

Do you smoke cigarettes or use tobacco products?

Amount and frequency:

Do you exercise regularly?

Please describe:

How would you describe your general health and wellbeing?

___ Excellent ___ Good ___ Fair ___ Poor

Please describe in detail:

Do you have any history of any of the following?

- ___ Heart disease
- ___ Allergies
- ___ Chemical Sensitivities
- ___ Heart attack
- ___ High blood pressure
- ___ Cancer
- ___ Diabetes
- ___ Autoimmune Disorder
- ___ Visual difficulties
- ___ Hearing difficulties
- ___ Arthritis
- ___ Migraines
- ___ Surgeries
- ___ Significant Illness
- ___ Gastrointestinal symptoms
- ___ Anemia
- ___ Celiac Disease
- ___ Gluten Sensitivity
- ___ Multiple Sclerosis
- ___ Brain Injury/Head Injury
- ___ Concussion
- ___ Stroke
- ___ Brain Tumor
- ___ Thyroid Condition

- ☐ Hormonal Imbalance
- ☐ Auto Accidents
- ☐ Depression
- ☐ Anxiety
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Other

Have you been hospitalized previously for psychiatric issues?

Dates and reasons for treatment:

Have you been hospitalized previously for medical reasons?

Dates and reasons for treatment:

Do you currently have thoughts of hurting yourself or killing yourself or others?

Do you have a plan to hurt or kill yourself or others?

Please describe your plan:

Do you have a history of childhood abuse? If so, please provide brief details:

Do you have a history of any major accidents? If so, please provide brief details:

Do you have a history of other trauma related to war, violent crime, natural disaster, rape, assault, domestic violence, etc? If so, please describe:

Please describe any significant details with family, spouse, partner, or friends:

Please list any current medications or nutritional supplements:

Do you adhere to any particular dietary plan (GF, vegan, vegetarian, paleo, etc)?

What is missing from your life?

Is your life filled with love? Please describe:

What do you do for fun?

Do you enjoy a sense of financial stability?

Do you regularly engage in creative expression? Please describe:

Do you regularly enjoy sexual pleasure?

Do you practice safe sex?

Do you spend time in nature? Please describe:

Do you have a sense of spiritual connection in your life? Please describe:

What do you think may lie at the root of your struggles?

What do you believe your body, heart and mind need in order to heal?

Is there anything that I have not asked that you feel would be important for me to know about you?

What are your reasons for seeking counseling at this time?

What are your goals for your counseling sessions?