

 **Jina Wilson, MS, LMFT, RPT**

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Professional Disclosure Statement

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Welcome To Inner Balance Counseling LLC! Please review the information below and feel free to ask questions or to request assistance if needed. Please sign last page indicating you understand and was provided a copy of this form.

1. **Qualifications**: I graduated from University of Wisconsin, Eau-Claire in 1995 with a Bachelor of Arts in Psychology, and from Saint Cloud State in 1997 with a Master of Science in Counseling Psychology. I obtained my post-masters Marriage and Family Therapy certificate in 1998. After 2,000 hours of post-masters clinical experience, I obtained my Marriage and Family Therapy license in 2004. I have specialized training in Play Therapy and obtained my Registered Play Therapist credential in 2016. Over the years, my primary focus and experience has been working with children, adolescents, and their caregivers. I am a member of the American Association for Marriage and Family Therapy, and National Association for Play Therapy.

2. **Public Records:** My credentials may be verified by visiting the Minnesota Board of Marriage and Family Therapy website (<http://mn.gov/boards/marriage-and-family>).

3. **Standards of Practice:** Upon request, I can furnish you with a copy of the American Association of Marriage & Family Therapy Code of Ethics for Marriage and Family Therapists, as well as the Standards of Practice for Play Therapists by the Association for Play Therapy.

4. **Complaints:** If you feel you have been treated unfairly or unethically, please free to speak with me about the issues. If this conversation does not bring satisfactory resolution to the problem, you have the right to file a complaint with the Minnesota Board of Marriage and Family Therapy (address: 2829 University Ave SE, Suite 400, Minneapolis, MN 55414; email: mft.board@state.mn.us; phone: 612-617-2220)

5. **Fees and Services:** Services are provided for the following fees:

* Initial evaluation (approx. 90 minutes): $300.00
* Individual therapy session: $140
* Parent/carer or family therapy session (with or without child present): $140
* Phone Consulations (over 15 minutes): pro-rated based on client’s regular fee for service
* Records Request: no charge

A 24-hour cancellation notice is required. Failure to provide adequate notice will result in a $70 charge (50% of session fee).

If utilizing in-network health insurance benefits, your insurance company will be billed directly. Deductible, co-pay, or co-insurance is due at time of service. If utilizing out-of-network benefits, payment is due at time of service and a superbill will be provided to you for submission to your insurance company for reimbursement. I accept cash, checks, and credit card.

6. **Privacy and Confidentiality:** All information provided by or obtained about a client is considered confidential and shall be protected. Client information includes the therapist’s personal knowledge of the client and client records (written, electronic, or verbal). Except as provided herein, client information may be disclosed or released only with the client’s (or parent/legal guardian’s) written informed consent. A marriage & family therapist may release client records without the client’s written consent under the following circumstances:

* Where a client’s authorized representative consents in writing to the release
* Where communications to the marriage and family therapist reveal abuse and/or neglect of children, elders, or dependent adults which impose an obligation on marriage and family therapists as mandatory reporters
* When the marriage and family therapist has a duty to warn in relation to communications of threats of physical violence to others or to self, including suicide threats
* Where the marriage and family therapist has been appointed to conduct an evaluation for child custody or visitation by the court
* Where circumstances giving rise to the list of exceptions to the healthcare provider-patient privilege
* Where mandated by the federal or state law requiring release of records or where the marriage and family therapist is served with a subpeona

Minor clients must be informed, at the beginning of the professional relationship, of any laws, which impose a limit on the right to privacy of a minor. Confidentiality of client information will continue to be maintained upon termination of the professional relationship, including upon the death of the client, except as provided under applicable law.

Please note that cell phone calls, texts, and emails can be intercepted by other parties. If you contact the therapist via cell phone, text or email, she will assume that this is an acceptable way to communicate with you. Please alert the therapist if you have limitations or preferences regarding communication methods.

7. **Limited access to client information:** Reasonable measures will be taken to restrict access by others to confidential client information, which includes password protected access for electronic records and locked file cabinets for paper records.

8. **Consultation:** It is sometimes beneficial to your case for the therapist to consult with other mental health professionals for the purpose of case analysis and discussion. Please be aware that identifying information will remain confidential.

 9. **Discrimination:** There will be no discrimination on the basis of age, gender, sexual orientation, race, color, national origin, religion, disability, political affiliation or social/economic status.

10. **Court-related issues:** Expert witness or testimonial services will not be provided. Should you, your attorney, or your spouse/ex-spouse’s attorney subpoena the therapist, a $1000 retainer fee will be required upfront. Additionally you will be billed $300 per hour, including, but not limited to, court time, travel time, review of materials and report preparation. The parent initiating the action will be responsible for payment.

11. **Access to records:** As allowed by law, a client has access to their own records or to the records of their minor child(ren).

12. **Emergency situations:** You may call me at 651-261-6330, however, please be aware that I do not provide 24 hour crisis services. If you or your child needs immediate attention, please call 911 or go to the nearest emergency room.

This is to acknowledge that I have read, understood, and agreed with the above information.

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Signature of client/parent/guardian Date

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Signature of clinician Date

Inner Balance Counseling, LLC 4886 Hwy 61, Suite L3

Jina Wilson, MS, LMFT, RPT White Bear Lake, MN 55110

Child, Adolescent, & Family Psychotherapy [www.InnerBalanceCounselingMn.com](http://www.InnerBalanceCounselingMn.com)



 **INFORMED CONSENT FOR TREATMENT**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I authorize INNER BALANCE COUNSELING LLC to provide mental health services to me/my child. Services will be provided by, or under the direction of a mental health professional. I understand that services can include a diagnostic assessment, individual therapy, family therapy, and group therapy. I understand that regular family involvement is expected.

2. I understand that the goals of service will address the mental health issues confronting me/my child. My child and I will work with INNER BALANCE COUNSELING LLC staff to identify those issues. I understand that the services I/my child will be receiving from INNER BALANCE COUNSELING LLC will be directed toward addressing specific goals aimed at improving me/my child's sense of wellness and health.

3. The nature and purpose of services, possible alternative methods of services, the risks involved, and the possibility of complications have been explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained.

4. I consent to services as described in the treatment plan. I understand that any major changes will be explained to me/my child at the time and that I may decline further treatment or negotiate for alternative procedures at any time.

5. I understand that private information will be used only in accordance with the Minnesota Data Privacy Act and that private health information will be used only in accordance with State and Federal law including HIPAA and will not be permitted to be distributed among unauthorized persons. I acknowledge that information concerning my/my child’s participation in treatment or support services may be used for the purposes of supervision and consultation.

6. Me/my child’s HIPPA Privacy Statement/Standards for Privacy of Individually Identifiable Health Information has been provided to me. Additional copies may be found in the forms section of InnerBalanceCounselingMN.com website or provided upon request.

7. I understand that me/my child’s insurance company may have access to INNER BALANCE COUNSELING LLC records for purposes of approving payment or auditing to verify compliance with medical necessity criteria.

8. I understand that my child’s treatment plan will be reviewed at regular intervals.

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Client name date

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Client/parent/guardian signature date

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 TERMS OF BILLING/CONSENT FORM

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Clients are responsible for knowing their insurance benefits and plan requirements. Therefore, if your insurance company does not pay, you are responsible for all charges incurred.
* The fee for an initial assessment is $300.00, Individual sessions and Family sessions (with or without child present) is $140 per session.
* There is a $70 charge for no-shows and/or cancellations made less than 24 hours in advance (unless you and your therapist agree that you were unable to attend due to circumstances beyond your control). These charges cannot be submitted to your insurance company.
* I will pay my co-payment each visit and/or total amount due.
* I will notify you immediately of any change in insurance company. Without such notification, any refusal on the part of my insurance carrier to pay for services because of needed preauthorization will by my responsibility.
* I consent to the release of protected health information to my insurance company or EAP group for the processing of claims. Such information may include diagnosis, dates of service, who was in the session, and other items as they relate to billing. I understand that Inner Balance Counseling LLC will give only the minimum necessary information for billing and authorization purposes.
* If I am covered or believe I am covered by Medical Assistance (MA), I authorize this office to contact the county or counties as it relates to my MA number and coverage. I also authorize release of protected health information to MA for billing and prior authorization purposes.
* If my account becomes past due (60 days) and I have not arranged for or made regular payments, I understand Inner Balance Counseling LLC may turn my account over to a collection agency to obtain payment. My failure to make payments or arrange payments to settle my account is tacit authorization for Inner Balance Counseling LLC to release the minimum protected health information necessary to the collection agency.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Inner Balance Counseling LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

In signing this, I am consenting to all the above.

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Client name Date

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Parent/guardian name Date

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