Progressive Counseling & Hypnosis
REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth Date:	Age:	Sex: ☐ M ☐ F

Street address:	Cell Phone:	Home Phone no.:

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone no.:

Referred by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

E-Mail Address:

INSURANCE INFORMATION

(Please give your insurance card to Jennifer so a copy can be made)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]

☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ Welfare *(Please provide coupon)*	☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone no.:	Work Phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jennifer Molinari, LCPC, NCC to release any information required to process my claims.

Patient/Guardian Signature *Date*

Progressive Counseling & Hypnosis
Jennifer Molinari, LCPC, NCC 10715
7350 Grace Drive
Columbia, MD 21044
(410) 707-5786
jenmolslight@gmail.com
www.jennifermolinari.com

Practice Policy/Bill of Rights

Client Bill of Rights:

Each client has the right to:

1. Be treated with dignity and respect.
2. Receive treatment, care and services that are adequate, appropriate, and in compliance with local, state, and federal laws and regulations.
3. Not be physically or mentally abused.
4. Be free of discrimination.
5. Be free from restraints.
6. Have all confidentiality laws strictly adhered to (HIPAA).
7. Have all fees and services explained prior to receiving services.
8. Refuse participation in any experimental research unless the research complies with 45 CFR Part 46 (the code for the Federal Regulations Protection of Human Subjects.)

Confidentiality of Patient Records:

Federal Law and Regulations protect the confidentiality of patient records maintained by Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC,NCC. Progressive Counseling& Hypnosis/Jennifer Molinari, LCPC, NCC may not reveal identifying information to any outside third party unless:

1. The patient consents in writing
2. The disclosure is allowed by court order
3. The disclosure is made to medical personnel in an emergency or to qualified personnel for research, audit, or program evaluation.

Violation of Federal Law and Regulations by a therapist is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines. Federal law and Regulations do not protect information about crimes committed by a patient in the presence of a therapist of against a coworker in the same office, or about any threat to commit such a crime. Federal Law and Regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state and local authorities.

Electronic Communications:

Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC cannot ensure the confidentiality and privacy of communications through electronic media, including text messages. Electronic communications are one of the least secure ways to communicate. If you choose to communicate via email or text messaging for issues regarding scheduling or cancellations, Jennifer will do so. Jennifer will do the best on her end to maintain privacy and confidentiality through keeping her cell phone password protected and verifying user identities when texts and emails are exchanged (you will be asked to devise a code word for verification purposes when exchanging texts and e-mails to verify the identity of the sender/responder.)

Please be advised that any email sent via computer in a work-place environment is legally accessible by your employer. In addition, please remember that even when you think you have deleted a message that copies will still remain in "cyberspace" and could potentially be retrieved by law enforcement, ISP professionals and possibly hackers.

Jennifer will try to return messages in a timely manner; however, she cannot guarantee immediate responses. It can take 24 to 48 hours (or longer due to certain circumstances-illness, vacation etc.) for Jennifer to respond to messages (voice, text, and e-mail.) If you have an emergency, Jennifer requests that you call 911 or go to your nearest ER.

Jennifer requests that you do not use these methods of communication to discuss therapeutic content and/or requests for assistance with emergencies.

Jennifer is ethically and legally obligated to maintain records of all correspondences both in person and via electronic communication such as emailing or text messaging. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. The limits of confidentiality apply to all forms of communication including electronic and written communications. Please see Jennifer's separate intake form on the limits of confidentiality.

Internet Searches:

While Jennifer's present or potential clients might conduct online searches about her practice and/or her, Jennifer does not search her clients with Google, Facebook, or other search engines unless there is a clinical need to do so, as in the case of a crisis or to assure your physical well-being. If clients ask Jennifer to conduct such searches or review their websites or profiles and she deems that it might be helpful,

Jennifer will consider it on a case by case basis and only after discussing possible impacts to the professional relationship and your privacy.

Acknowledgement and Consent Regarding Notice of Privacy Practices:

Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC's Notice of Privacy Practice is provided to each client and is available upon request. The Notice of Privacy Practices of Progressive Counseling& Hypnosis/Jennifer Molinari, LCPC, NCC provides information about how Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC,NCC may use and disclose your protected health information (PHI.) The Notice of Privacy Practices states that Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC,NCC has the right to change her terms. If this should happen, client's will be provided with a written copy of the new Privacy Policy Notice.

You have the right to revoke this consent, in writing, except where Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC,NCC has already made disclosures in reliance to your prior consent. You have the right to request restrictions on how your PHI may be used or disclosed for treatment, payment, and health care operations. Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC is not required to agree to your restrictions, but if she does, it is bound by it's agreement with you.

By signing the form provided to you, you consent to the use and disclosure of your PHI for treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. You specifically consent to Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC,NCC communicating with you using the contact information you provide, as further described in the Notice of Privacy Practices.

Fee Schedule:

Intake: $150
*Missed Appointment: $60
Written Report: $40 per report
Court Appearance: $200 per hour
(minimum of $1,600 per day)
Letters/Forms: $25
Outside Correspondence (over 5 min.) $45
*Hypnosis Initial Session: $175
*Hypnosis Reinforcement: $125

Individual Counseling (45-50 min.): $125
Disability/Worker's Comp: $300
Crisis Session: $150
Bounced Checks: $25
* Yoga Nidra (Individual): $50
*Yoga Nidra Group (5 or more $25pp)
*Online Video Session (HIPAA Compliant): $60 with insurance and $125 (for out-of-network)

*Payment is out-of-pocket (no insurance accepted)
Jennifer does offer a sliding pay scale if needed

Appointments/Scheduling:

1. Appointments can be made by phone or e-mail. Current clients can text.
2. Intakes are 50-60 minutes and regular sessions are 45-50 minutes long (unless other arrangements are made.)
3. If you arrive late to your session the time will not be made up.
4. If you arrive 15 minutes or later (and you do not contact Jennifer) then your appointment may be cancelled. You will then be charged a missed appointment fee.
5. If Jennifer is late to a session the time WILL be made up. Time will either be tacked on to the end of your session OR it will be tacked on to the end of future sessions.
6. If you need to cancel your appointment then you must provide 24 hour advance notice to avoid a $60 fee.
7. Jennifer will do her best to provide reminder calls. However, these calls are a courtesy and if one is not received it is not an indication that your appointment has been cancelled. Jennifer will contact you directly via phone, e-mail, or text if she needs to cancel your appointment. Not showing for your appointment because you did not receive a reminder call will result in a no show fee of $60.

Please note that the office may be locked when you arrive for your appointment. This DOES NOT mean your appointment has been cancelled. Please wait for Ms. Molinari to arrive. If Ms. Molinari is late, the time will be made up at the end of the session (or at the end of a future session.)

Fees/Payment:

1. Payment for sessions will be collected at the time of service.
2. Payment can be made by cash, check, or credit card.
   (Checks to be made payable to Jennifer Molinari)
3. There is a $25 fee for bounced checks.
4. Missed sessions and appointments cancelled less than 24 hours prior to your appointment will be billed at $60 for each missed and/or last minute cancelled session regardless of the reason.
5. Clients are strongly advised to provide credit card/debit card information to be kept on file to save time with session payments and to allow Jennifer the ability to collect funds in the event of a missed appointment. Signing the authorization will allow Jennifer to bill your card without further consent if you miss an appointment or do not cancel your appointment 24 hours in advance. If there is a dire emergency and your credit card gets billed there are no refunds. You will simply have a credit that will be applied towards your next session.
6. There are no payment refunds.

Failure to Pay:

You agree that failure to pay within 10 days of service, may, at the option of Jennifer, be construed as a discharge of service by the client. You agree that if any unpaid balance is not received within 60 days that your account will be forwarded to a collection agency. You further agree that in the event that legal

action is taken to collect the money, you will pay the amount owed plus 40% of the collection fees. You agree that information pertinent to the collection of any amount due will be released to a third- party collection agency or attorney. You further agree and consent to suit being held in Howard County, MD and waive any right to claim improper jurisdiction and/or venue.

Insurance:

At this time, Jennifer is paneled with Aetna, Magellan, Carefirst BCBS Insurance Companies, Value Options, and Tricare. Jennifer does utilize services from an external billing company (Stone Creek Medical Billing) to submit claims and handle insurance billing.

If you are paying for sessions out-of-pocket due to being out-of-network, then you will be provided with a completed claim form at the end of the month to provide to your insurance company for reimbursement. Jennifer does not guarantee reimbursement from your insurance company. You will need to contact your insurance company prior to starting services to verify if you have out-of-network mental health benefits. You will be responsible for the full payment regardless of what your insurance company covers.

It is your responsibility to call your insurance company prior to services to verify your mental health benefits (if you have mental health coverage, what your deductible is, co-insurance, and what your copay is.) If you don't have mental health coverage you will pay the full cost for services. If you have a deductible you will pay the "allowable amount" determined your insurance company (usually between $55-$65 dollars) for each session until your deductible is met (it is your responsibility to keep track of your deductible.) If you are covered and have no deductible (or your deductible has been met), then you will be responsible for your copay for each session. It is your responsibility to find out your copay amount prior to your sessions.

Any costs not covered by your insurance (regardless of the reason) are to be paid out-of-pocket in-full.

Court Appearances:

Jennifer charges $200 per hour, with a minimum of $1,600 per day for any court appearance (whether requested or summoned.) In the case of minors, parents/legal guardians are responsible for the fees. You will be charged per hour for travel time, consultation time, preparation time, and any time spent waiting. A deposit of $1,600 must be paid prior to the court appearance. If a court date is cancelled or rescheduled, then Jennifer must be given 10 days' notice. If 10 -day notice is not provide, then Jennifer may still charge $1,600 for each day if she is unable to reschedule appointment and for preparation time, administrative time, and for the reports that were already completed.

Understanding Separate Practices:

Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC practices at two separate office locations. Jennifer Molinari, LCPC,NCC has a private practice located at Grace Drive in Columbia, MD and she is affiliated with a larger group practice in Columbia (Congruent Counseling.) Each of these practices are completely separate entities and are in no way affiliated with each other.

In addition, Jennifer Molinari is in no way affiliated with any of the other practitioners at the Grace Drive office location.

Telephone/Internet Sessions:

If you need to talk to Jennifer before your next scheduled session then you can arrange a telephone or internet video session. Telephone and internet sessions can NOT be submitted to the insurance companies for reimbursement and are an out-of-pocket charge. Please note that privacy can't be guaranteed for telephone/internet sessions. In addition, the sessions will be documented (as all sessions are documented) and that the limits of confidentiality apply to telephone and internet sessions.

If you are a current client and are using your insurance you will be charged the full amount that your insurance would normally reimburse to Jennifer (usually around $60.) Sessions must be paid by credit card at the time of service. Your credit card will be billed $60 for missed sessions or sessions that are cancelled less than 24 hours prior to your appointment. There are no refunds.

Therapist and Client Contact Outside of Sessions:

In order for therapists to provide the best care, it is important for them to be healthy too. They need a balance between work and their private lives. If there is ever a life -threatening emergency, please call 911. If you have an issue that is NOT life threatening and need to talk to Jennifer before your next appointment, then please feel free to leave a confidential message for Jennifer at 410-707-5786. Jennifer will do her best to return your call within 24-48 hours. Jennifer will not return phone calls when no message is left. Jennifer asks that if you know that a conversation will take longer than 10 minutes to please schedule and appointment.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

Progressive Counseling & Hypnosis Communications Policy

These are the most effective ways to get in touch with Jennifer:

- By phone (for non-emergencies only) please call: 410.707.5786.
- You may leave messages on Jennifer's voicemail (which is confidential.) Jennifer will do her best to return calls within 24-48 hours Monday-Friday between 9am and 5pm.
- If you wish to communicate with Jennifer by email or text message, please read and complete the *Consent For Non-Secure Communications* form included with these office policies.
- If you have an emergency, please call 911 or go to your nearest emergency room.

Jennifer subscribes to the following service(s) that can allow for more private communication. None of the services will cost you money. However, each requires setup before they can be used. Please notify Jennifer if you would like to use any of these services:

- Encrypted email
- A secure "client portal," where we can exchange private messages via a secured website.

Please refrain from making contact with Jennifer using social media messaging systems such as Facebook Messenger or Twitter. These methods have very poor security, and she is not prepared to watch them closely for important messages from clients.

It is important to communicate and also keep the confidential space that is vital to therapy. Please speak with Jennifer about any concerns you have regarding her preferred communication methods.

Response Time

Jennifer may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response within 24-48 hours. Jennifer may occasionally reply more quickly than that or on weekends, but please be aware that this will not always be possible.

Be aware that there may be times when Jennifer is unable to receive or respond to messages, such as when she is out of cellular range or out of town.

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jenmolslight@gmail.com
www.jennifermolinari.com

Emergency Contact

If you are ever experiencing an emergency, including a mental health crisis, please call *911.*

Disclosure Regarding Third-Party Access to Communications

This is to inform you that if we use electronic communications methods (email, texting, online video etc.) that our communications are insecure. There are various technicians and administrators who maintain these services and who may have access to the content of our communications.

Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations with which you are affiliated.

Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

I understand the risk of using electronic forms of communications and still want to use these methods of communication:

Signature:_____ Date:_____

Code:_____

I understand the risk of using electronic forms of communication and wish only to communicate by phone:

Signature:_____ Date:_____

Best contact number: _____

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HIPPA PRIVACY POLICY
(Keep for Your Records)

This notice describes how psychological and medical information about you may be used and disclosed. It also describes how you can get access to your protected health information**.**

PLEASE REVIEW IT CAREFULLY

I am required to provide you with this Notice of Privacy Practices under the Federal Health Insurance Portability and Accountability Act (HIPPA). I am required by law to:

- Maintain privacy of your Protected Health Information (PHI)
- Provide this Notice of my legal duties and privacy practices for use and disclosure of your Protected Health Information.
- Follow the terms of this Notice.
- Communicate any changes of this Notice to you.

This Notice describes how I may use or disclose your Protected Health Information, with whom this information may be shared, and the safeguards I have in place to protect your information. This Notice describes your right to approve or refuse the release of specific information, except when the release is required or authorized by law.

I will provide you with an Acknowledgement and Consent Form by which you can acknowledge your receipt of this Notice and you can consent to my use and disclosure of your Protected Health Information (as described in this Notice.) My intention is to make you aware of the possible uses and disclosures of your Protected Health Information.

1. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use and or disclose your Protected Health Information (PHI), for treatment, payment, and health care operation purposes with your written authorization.

2. Definitions

The following are a list of definitions to help clarify terms used in this document: a.

"PHI" refers to information in your health record that could identify you.

b. *"Treatment"* is providing, coordinating, and managing your health care and other services related to your health care. An example of treatment would be consulting

with another health care provider such as your primary care physician, psychiatrist, or another therapist.

c. *"Payment"* refers to obtaining reimbursement for your health care. Examples of payment are when your PHI is disclosed to your insurance company to obtain reimbursement for your health care or to determine your eligibility for coverage.
d. *"Health Care Operations"* are activities that relate to the performance and operations of my practice. Examples of health care operations are quality assessments, improvement activities, business related matters (such as audits and administrative services, case management, and case coordination.)
e. *"Use"* refers to activities within the office such as sharing, utilizing, examining, and analyzing information that identifies you.
f. *"Disclosure"* refers to activities outside of the office such as releasing, transferring, or providing access to information about you to other parties.
g. "*Authorizations*" refers to your written permission for me to disclose confidential mental health information. All authorizations to disclose information must be on a legal form.

3. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when appropriate authorization is obtained. If I am requested to release information outside of treatment, payment, or health care operations, then I will obtain written authorization from you, the client, before releasing any information. This same process is in effect for releasing "Progress Notes." "Progress Notes" or "Psychotherapy Notes" are the notes that I write regarding the conversations we have during your private, group, joint, or family counseling sessions. Progress Notes have a higher degree of protection than PHI.

You make revoke all authorizations of PHI or Progress Notes at any time provided that your request is in writing. You may not revoke your authorization to the extent that:

a. I have relied on that authorization to perform services.
b. The authorization was obtained under a condition of obtaining insurance coverage.

4. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

a. ***Child Abuse***: If there is reason to believe that a child has been subjected to abuse or neglect (regardless of when it occurred or if the perpetrator is deceased), then I am required to report my belief to the appropriate authorities (CPS, Police, etc.)

b. ***Adult and Domestic Abuse***: I may disclose PHI if I believe that you are a victim of abuse, neglect, self-neglect, or exploitation to the appropriate authorities (APS, Police etc.)

c. ***Payment:*** Your PHI will be used (as needed) to obtain payment or for you to receive reimbursement.

d. ***Health Care Operations***: I may use or disclose PHI to support daily activities providing health care. These activities may include performing quality assessments, oversight and reviews, licensing, communicating a product or service, or conducting or arranging health care activities. I may call you by name in the waiting room when I am ready to see you for an appointment, I may contact you regarding your satisfaction with my services, to schedule or cancel appointments, or to provide you with behavioral health information.

e. ***Treatment***: I will use or disclose your PHI to provide, coordinate, and manage your behavioral health care and related services. This might involve talking to specialists or other providers. I may have to disclose PHI at an office visit or when I need to contact you. I will assume that the contact information you provide will be accurate and will be a safe and appropriate way for me to call you, send e-mails, send faxes, or mail without having to call you first for permission.

f. ***Required by Law or Government***: If I receive a subpoena from the Maryland Board of Professional Counselors because they are investigating my practice, then any PHI information may be disclosed to the Board. I will provide your PHI if law regulations require the use or disclosure. I may provide PHI to a government oversight agency for activities authorized by law. These oversight agencies might include government agencies or their subcontractors who oversee health care systems, government benefit and regulatory programs, and civil rights laws.

g. ***Public Health Research***: I may disclose your PHI to public health authorities permitted by law to collect or review information. Such disclosure may be necessary to control disease, injury, disability, report births, deaths, child abuse or neglect, report reactions to medications or problems with products, providing notice to a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition. I may also provide PHI to researchers when authorized by law.

h. ***Judicial and Administrative Proceedings***: If you are involved in a court proceeding and a request is made for information regarding your diagnosis and/or your treatment or if there is a request for your records, then I will not provide your PHI without your written permission or a court order (as this information is privileged under State Law.) This privilege does not apply when you are being evaluated by a third party r when the evaluation is court ordered. You will be notified in advance if this is the case.

i. ***Serious Threat to Health or Safety*:** If I believe there is a threat of harm against another individual or if I feel there is a clear and imminent risk of physical harm or mental injury being inflicted upon another individual then it is within my rights to disclose necessary information to protect that individual from harm. In addition, if you feel that there is a serious risk of physical or mental injury or the risk of death to you, then I will provide the necessary disclosures in order to protect you from harm.

j. ***Disclosures upon Death***: I may disclose your PHI to coroners and medical examiners for the performance of duties authorized by law; to funeral directors and for cadaver organ, eye, or tissue donations.

k. ***Other Individuals Involved in Your Healthcare***: With your permission, I may disclose information to a family member, relative, close friend, or other person you

identify to me if your PHI is directly related to that person's involvement in your care. I may also give your PHI to someone who helps pay for your care. I may use or disclose information to notify or assist family members or personal representatives of your location, general condition, or death if necessary. Finally, I may use or disclose your information to an authorized public or private entity to assist in disaster relief efforts and to coordinate use and disclosures to family or other individuals involved in your health care.

l. ***Parental Access***: Some state laws concerning minors permit or require disclosure of PHI to parents and/or guardians. I will act consistently with Maryland Law and will make disclosures in accordance with such law and applicable federal law. If there is a conflict between laws, HIPPA requires that the more stringent law apply.

5. Patient's Rights and Therapist's Duties

Patient's Rights:

a. ***Right to Request Restrictions***: You have the right to request restrictions on certain uses and disclosures or PHI. However, I am not required to agree and follow the restrictions you request.

b. ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations***: You have the right to request and receive confidential communications of PHI by alternative means and at an alternative location. For example, you may not want your spouse or family to know you are seeing a therapist. At your request, I can send bills/correspondences to another address. Or, you can request to have a session by phone or e-mail rather than in person.

c. ***Right to Inspect and Copy***: You have the right to inspect and/or obtain a copy of your PHI from your mental health record. I have the right to deny access if I feel it is necessary. You also have the right to inspect and/or obtain a copy of your Progress Notes. I may deny you access if I feel the disclosure of the records would be a disservice to you and your health (mental and/or physical.)

d. ***Right to Request an Amendment***: If you believe the information I have provided about you in incomplete or incorrect, you may request an amendment to your PHI as long as I maintain this information. I am not required to agree to an amendment.

e. ***Right to Obtain a Paper Copy***: You may obtain a paper copy of my Notice of Privacy Practices.

Therapist's Duties:

a. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practice policies with respect of PHI.

b. I reserve the right to change the privacy policies and practices described in this notice. If I change any of my privacy policies then I am required to inform you of these changes.

c. If I change any of my privacy policies and/or procedures then I will provide you with a revised copy of this document in person or by mail.

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6. Complaints

a. If you are concerned that I have violated your privacy rights, or if you disagree with a decision I have made in regards to you having access to your records then you may contact me to discuss your concern.
b. If you feel after our discussion that I have not adequately addressed your concerns, then you can send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. I can provide you with the address upon request. No retaliation will occur against you for filing a complaint.

7. Effective Date, Restrictions, and Changes to Privacy Policy

a. I reserve the right to change the terms of this notice and to make new provisions to this notice. You will be notified of any changes to this notice and will be provided with a new copy of this document in-person or by mail. You may contact me at (410) 707--5786 or at jenmolslight@gmail.com if you want further information or have questions about this notice.

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (You may refuse to sign this form)

I have received a copy of Progressive Counseling & Hypnosis /Jennifer Molinari, LCPC, NCC's Notice of Privacy Practices.

_____
(Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

_____

☐**Individual Refused to Sign**
☐**Communication barriers prohibited obtaining the acknowledgement**
☐**An emergency situation prevented Jennifer Molinari, LCPC, NCC from obtaining acknowledgement** ☐**Other:**

_____
_____

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Progressive Counseling & Hypnosis

Contract for Personal Services

I, _____, understand that Jennifer Molinari, LCPC, NCC is a Licensed Clinical Professional Counselor and a National Certified Counselor in the State of Maryland. In consideration of the promises and conditions herein, I seek and it is my intent to hire Ms. Molinari for counseling services.

I agree to provide current, complete, and accurate information about myself as required on Ms. Molinari's registration forms and during our sessions in order to receive the best quality care. I will notify Ms. Molinari of any changes to my personal information or in regards to my personal well-being.

No one representing Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC offers me false hopes, false promises, expectations, warranties, or assurances of the successes or outcomes of Ms. Molinari's work. I take responsibility for the outcomes of my therapy. I realize that therapy is a partnership and that the outcome of my sessions largely depends on the effort I put forth in and outside of my sessions. I realize that Ms. Molinari can't "fix me" or "make me change." I agree to partake in Ms. Molinari's services at my own risk.

I have read and understand Ms. Molinari's financial policies and agree and adhere to these policies. I agree to provide 24 hours' notice prior to the cancellation of my appointment. I agree to provide credit card information to be kept on file and possibly charged (in the amount of $110) in the event that I miss an appointment or do not provide adequate notice when cancelling an appointment. I agree to participate in a closing session before terminating services with Ms. Molinari.

_____ _____

Signature Date

_____ _____

Provider's Signature Date

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Credit Card Authorization Form

(To Be Completed By All Clients)

Credit Card Billing Information:	
Name:	
Person Authorizing:	
Credit Card Type:	Visa ( ) MasterCard ( ) American Express ( ) Discover ( )
Credit Card Number:	
CVC Code (3 digits on back of card):	
Expiration Date:	
Billing Address:	
City:	
State/Province:	
Zip Code:	
Phone Number:	
E-mail address:	

I understand that my credit card information is being kept on file. I also understand that my credit card will ***only*** be billed in the event that I miss or cancel an appointment (without providing 24-hour notice.) I understand if I am billed that it is not a punishment. I understand that Ms. Molinari is still required to pay rent and business related expenses even when I cannot attend my appointment. I understand that appointments canceled with less than 24-hour notice are hard to fill and that I have to be billed to offset costs. I understand that funds charged to my card cannot be refunded. If Jennifer decides charges were incurred in error, then there will be a credit applied to my next session.

I authorize Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, and NCC to charge my credit card in the amount of $60 if I miss an appointment (or fail to cancel an appointment within 24 hours prior to my appointment) without additional consent. I will receive an e-mail receipt if my credit card is billed. I understand that if Jennifer is unable to bill my credit card due to invalid credit card information and me have an outstanding balance that is 60 days past due that my account will be forwarded to the collections agency.

_____ _____

Signature Date

Progressive Counseling & Hypnosis
Release of Information Form

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

I, _____, authorize ***Jennifer Molinari, LCPC, NCC dba Progressive Counseling*** to release and discuss all pertinent mental health, healthcare, and billing information with:

Name
Address:

City: State: Zip Code:

The following information may be exchanged:
_____ Full client record
_____ Progress and attendance reports
_____ Admission and discharge diagnosis and recommendations
_____ Reason for termination of treatment and discharge summary
_____ Other _____

The above information will be exchanged for the following reason(s):
_____ To coordinate treatment
_____ As required by my employer or EAP
_____ To assist my attorney
_____ Other _____

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that the information has already been disclosed in reliance with this consent.

Client Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date:_____ Witness Signature:_____ Date:_____

This release is valid for one year starting the date this form is signed.

Progressive Counseling & Hypnosis
7350 Grace Drive
Columbia, MD 21044
410.707.5786
jenmolslight@gmail.com
www.jennifermolinari.com

Jennifer Molinari, LCPC, NCC
Progressive Counseling & Hypnosis
7350 Grace Drive Columbia, MD 21044
(410) 707-5786 (P)
(410) 992-7073 (F)
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Progressive Counseling & Hypnosis Primary Care Physician (PCP) Notification

It is often helpful to notify your doctor of your mental health treatment so that your doctor can provide Jennifer with information regarding possible medical issues that may affect your mental health treatment. In some cases, medications or medical issues can cause or worsen mental health issues. Most insurance companies also request that therapists notify primary care physicians about a client's mental health treatment.

Please check the appropriate box below. Checking the "Yes" box and signing this form will allow Jennifer Molinari, LCPC, NCC to notify your primary care physician that you are receiving treatment.

☐Yes, I would like Jennifer to notify my PCP.

☐No, I would **NOT** like Jennifer to notify my PCP.

If you check yes, please fill out the rest of this form to the best of your ability.

I give permission to Jennifer Molinari, LCPC, NCC to notify my PCP that I, _____, am being seen by Jennifer Molinari, LCPC,NCC. I understand that a copy of this letter may be placed in my chart and I encourage my doctor to discuss my treatment with Jennifer and myself.

Jennifer Molinari, LCPC, NCC
Progressive Counseling & Hypnosis
7350 Grace Drive Columbia, MD 21044
(410) 707-5786 (P)
(410) 992-7073 (F)
Jenmolslight@gmail.com
www.jennifermolinari.com

Dr. _____

Address: _____

Phone Number: _____

Fax Number: _____

Client Signature:_____ Date:_____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Jennifer Molinari, LCPC, NCC
Progressive Counseling & Hypnosis
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Jenmolslight@gmail.com
www.jennifermolinari.com

Date:_____

Dear Dr. _____:

I have received written authorization from a mutual patient asking me to notify you that I am currently providing _____ with counseling services for _____.

This mutual patient felt that it was important for me to contact you in the event that you ever need/want to collaborate on treatment or in the event that you feel a medical issue could affect this client's mental health treatment.

If you have any questions, comments, or concerns please contact Jennifer by phone at 410-707-5786. You may also reach Jennifer by e-mail at jenmolslight@gmail.com.

Sincerely,

_____ _____
Client's Signature Date

_____

Jennifer Molinari, LCPC, NCC

PROGRESSIVE COUNSELING & HYPNOSIS

LIFE HISTORY QUESTIONNAIRE

NAME OF CLIENT: _____ DATE: _____

The information you provide will help in the planning of your counseling, and assist you and your therapist in clarifying your therapy goals. Please be as open and honest as possible. This questionnaire will be kept in your private confidential file.

Current Status:

Are you married? □ Yes □ No

If not have you been married/partnered before? □ Yes □ No
If yes, when and for how long? _____

Approximately how many significant intimate relationships (e.g. lasting 6 months or more) have you been involved in? _____ Are you in one now? □ Yes □ No □ I think so

What is your sexual orientation? _____

Please list the names of your children or dependents.

Names of Children	Date of Birth	Age	Lives With You?
_____	_____	_____	□ Yes □ No
_____	_____	_____	□ Yes □ No
_____	_____	_____	□ Yes □ No
_____	_____	_____	□ Yes □ No
_____	_____	_____	□ Yes □ No

List others who may live with you including their ages and occupations (e.g. brother 16, student, mother-in-law 55, etc.)

_____

_____

_____

Please check any past, present, or impending special problems in your family:

□ Deaths □ Divorce □ Frequent relocations
□ Serious illness □ Debilitating injuries/disabilities □ Alcohol/drug abuse
□ Psychiatric disorder □ Physical/sexual abuse □ Legal problems
□ Financial crisis/unemployment □ Attempted/completed suicide □ Eating disorders
□ Other _____

Please specify family member(s), with special problems, and approximate year of occurrence (e.g. mother, serious illness, 1998.) _____

_____

_____

What is your ethnic background?

□ African/African American □ Asian American/ Chinese/ Filipino/ Japanese/ Korean/ Vietnamese
□ East Indian/Pakistani □ Latino/ Hispanic/ Mexican-American/ Puerto Rican
□ Middle Eastern □ Native American/ Alaskan Native
□ Polynesian/Micronesian
□ White/Caucasian □ Other (specify) _____

How much do you identify with your ethnic heritage? (Check one):

□ Not at all □ A little □ Somewhat □ Moderately □ Strongly

Were you and both your biological parents born in the United States? □ Yes □ No □ Unsure

If no, who was foreign-born, where and what was the approximate age of immigration to the USA? (e.g. myself, Korea, 12; father Korea, 40; etc.) _____

Does your family speak a language other than English at home? (Check one):

□ Not at all □ Very little □ Sometimes □ Frequently □ Always

Family History:

In general, how happy or adjusted were you growing up? (Check one):

□ Not at all □ A little □ About average □ Substantial □ Completely

How much is your family a source of emotional support for you now? (Check one):

□ None □ A little □ Somewhat □ Substantial □ Very strong

How much conflict in values do you currently experience with your parents? (Check one):

□ Very little or none □ Some □ Moderate □ Strong □ Extreme

Who in your family do you currently feel closest to? _____

_____

distant from?_____In most conflict with? _____

Do you have any siblings? If so, please list:

How was conflict handled in your family? Please, describe:

How did your parents get along?

What else do you feel I should know about your family?

Educational Background:

Where did you attend high school? _____

Did you attend college/professional school and/or graduate school? When, where, degree earned?

Any plans to further your education? □ Yes □ No

If so, when and what?

Religion/Spirituality:

Religious/Spiritual preference: _____

_____

Do you consider yourself a religious person? □ Yes □ No or spiritual person? □ Yes □ No

Comment: _____

Faith: Group/Denomination in which you were raised: _____

Current Congregation: _____

How active are you? □ Inactive □ Slightly □ Moderate □ Very

Symptoms Checklist:

Reason for seeking treatment:

What is the nature of the problem you are experiencing?

_____

_____

Briefly describe how the problem noted above causes you difficult.

_____

_____

Directions:

Please check all the items below that you currently experience or have difficulty with, and feel free to add any others at the bottom under "Other Concerns or Issues." You may add details as needed to clarify at the end of this questionnaire.

□ Abortion	□ Grieving, Mourning	□ Physical Problems
□ Abuse - Emotional	□ Guilt	□ PMS
□ Abuse - Neglect	□ Headaches, Pains	□ Poor Self-care
□ Abuse - sexual	□ Health, Illness	□ Pornography Use
□ Adoption	□ Hearing Voices	□ Procrastination
□ Aggression	□ Hostility	□ Relationship Problems
□ Alcohol Use	□ Hyperactivity	□ Relaxation
□ Ambition	□ Impulsive Spending	□ Re-marriage
□ Anger	□ Impulsiveness	□ Risk-taking
□ Anxiety	□ Incest	□ Sadness
□ Arguing	□ Indecision	□ School Problems
□ Attention Problems	□ Inferiority Feelings	□ Self Abuse - burning
□ Career Concerns	□ Infertility	□ Self Abuse - cutting

□ Childhood Issues	□ Inhibitions	□ Self Abuse - other
□ Children – care of	□ Interpersonal	□ Self Abuse - scratching
□ Children - custody	□ Irresponsibility	□ Self Abuse – pulling hair
□ Children - management	□ Irritability	□ Self-centeredness
□ Choices I've Made	□ Judgment Problems	□ Self-control
□ Chronic Pain	□ Laziness	□ Self-esteem
□ Codependence	□ Legal Matters,	□ Self-neglect, Poor Self-
□ Communication	□ Loneliness	□ Separation
□ Compulsive Spending	□ Loss of Control	□ Sexual Addiction
□ Confusion	□ Losses	□ Sexual Conflicts
□ Constant Conflicts	□ Loss of Interest In	□ Sexual Desire
□ Crying	□ Loss of Interest	□ Shyness
□ Deaths	□ Low Energy	□ Smoking
□ Debt	□ Low Frustration	□ Spirituality
□ Decision Making	□ Low Income	□ Step-parenting
□ Dependence	□ Low Mood	□ Stress
□ Depression	□ Marital Conflict	□ Stress-management
□ Distractibility	□ Marital Distance	□ Suspiciousness
□ Divorce/Separation	□ Marital	□ Temper Problems
□ Domestic Violence	□ Medical Concerns	□ Tension/Stress
□ Drug Abuse – over the counter	□ Memory Problems	□ Thought
□ Drug Abuse - prescription	□ Menopause	□ Threats of Violence
□ Drug Abuse – street drugs	□ Menstrual Problems	□ Tiredness
□ Drug Abuse - Alcohol	□ Mixed feelings	□ Tobacco Use
□ Education	□ Mood swings	□ Unhappiness
□ Employment – lack of	□ Motivation	□ Violence
□ Employment - overdoing	□ Mourning	□ Violence – Victim of
□ Employment Problems	□ Nail-biting	□ Weight and Diet issues
□ Employment - Termination	□ Nervousness	□ Withdrawal - isolating
□ Emptiness	□ Nightmares	□ Work Problems
□ Exhaustion	□ Obsessions,	□ Worry All the Time
□ Failure	□ Outbursts	□ Other concerns or issues:
□ Fatigue, Low Energy	□ Oversensitive to	
□ Fears, Phobia	□ Oversensitive to	
□ Feelings of	□ Overweight	
□ Financial Troubles	□ Panic or Anxiety	
□ Friendship Problems	□ Parenting	
□ Gambling	□ Perfectionism	
□ Gender Identity	□ Pessimism	
□ Goals Not Being Met	□ Phobias	

Health History:

How is your physical health at present? □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, diabetes, headaches, etc.) _____

Are you presently taking any prescribed or non-prescribed medication? □ Yes □ No

Please indicate _____

_____

Are you having any problems with your sleep habits? □ Yes □ No

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

How many times per week do you exercise? _____ About how long each time? _____

Are you having any difficulty with appetite or eating habits? □ Yes □ No

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Poor appetite

□ Making myself vomit □ Significant weight change (last two months)

Do you regularly use alcohol? □ Yes □ No

In a typical month, how often do you have four or more drinks in a 24-hour period? _____

Do you consider your alcohol consumption a problem? □ Yes □ No □ Unsure

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

Do you consider this drug use a problem? □ Yes □ No □ Unsure

Do you have any problems or worries about sexual functioning? □ Yes □ No

If yes, check where applicable:

□ Lack of desire □ Performance problem □ Difficulty maintaining arousal

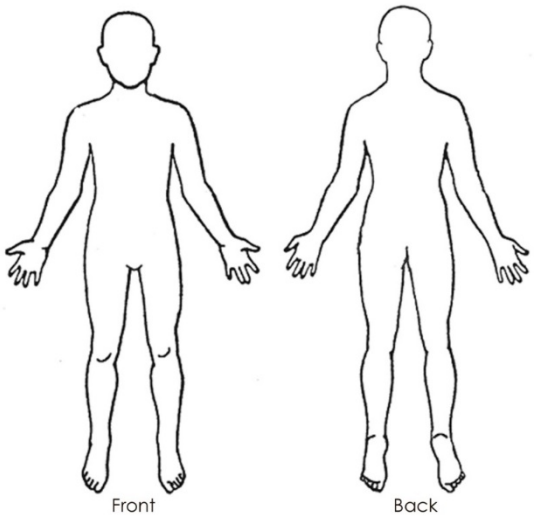
□ Worried about sexually transmitted disease □ Sexual impulsiveness

□ Other _____

Are you currently experiencing any physical symptoms? If so, please mark any physical symptoms that you are experiencing now with an "N", and any symptoms that you have experienced in the past with a "P".

	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
Head	☐	☐	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐	☐	☐
Upper Back	☐	☐	☐	☐	☐	☐	☐
Mid-Back	☐	☐	☐	☐	☐	☐	☐
Lower Back	☐	☐	☐	☐	☐	☐	☐
Shoulder	☐	☐	☐	☐	☐	☐	☐
Arm	☐	☐	☐	☐	☐	☐	☐
Forearm	☐	☐	☐	☐	☐	☐	☐
Wrist	☐	☐	☐	☐	☐	☐	☐
Hand	☐	☐	☐	☐	☐	☐	☐
Ribs	☐	☐	☐	☐	☐	☐	☐
Buttock	☐	☐	☐	☐	☐	☐	☐
Hip/Thigh	☐	☐	☐	☐	☐	☐	☐
Leg	☐	☐	☐	☐	☐	☐	☐
Knee	☐	☐	☐	☐	☐	☐	☐
Ankle	☐	☐	☐	☐	☐	☐	☐
Foot	☐	☐	☐	☐	☐	☐	☐

On the diagram, please circle or mark any area(s) where you are experiencing pain or other discomfort.



Psychological History:

Have you seen another therapist before? □ Yes □ No

If yes, who did you see? _____

Why did you discontinue counseling with your previous therapist?

_____
_____
_____
_____

What was helpful about your previous counseling experience?

_____
_____
_____
_____
_____

What was not helpful about your previous counseling experience?

_____
_____
_____
_____
_____
_____

Have you ever been hospitalized for psychological/emotional difficulties? □ Yes □ No

If yes, please note dates of hospitalization

_____

Are you (or have you been) on any medication for your psychological problems? □ Yes □ No

If yes, please note the type of medication, the dosage, and the dates you used this medication

_____

_____

Briefly describe again the problem that brought you here.

_____

_____

_____

Problem Intensity: How would you rate the intensity of the problem or concern that brought you in? (Circle the appropriate number):

1 2 3 4 5 6 7 8 9 10
Not intense Moderately intense Extremely intense

Problem Duration: Approximately how long have you had the current problem (in months or years)?

_____

Coping Strategies: In what ways have you attempted to cope with this problem_____

_____

_____

Have you had suicidal thoughts in the last few months?

□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?

□ Frequently □ Sometimes □ Rarely □ Never

Have you ever intentionally inflicted any harm upon yourself? □ Yes □ No □ Unsure

Expectations:

What do you hope to accomplish by coming to therapy? Be as specific as possible.

_____

_____

_____

_____

How motivated are you to make changes in your life in order to accomplish your goals?

1 2 3 4 5 6 7 8 9 10
Not Motivated Moderately Motivated Extremely Motivated

If you are a 5 or below in terms of being motivated, what needs to happen in order to make your motivation level a 10?

_____
_____
_____

Who do you have to support you with making positive changes in your life? Please list them:

_____
_____
_____

Would you like anyone else involved in the counseling with you? (family members, friends, etc.)

_____

****Please read about Jennifer's limits with confidentiality before answering these questions:****

Abuse History:

Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?

□ Frequently □ A few times □ Once □ Never □ Unsure

Is there a concern about violence in your life today ?

Please explain: _____

Have you experienced abuse?

□ None □ Unsure □ Emotional □ Physical □ Sexual

Have your experienced a traumatic event that you feel is currently contributing to your presenting issue? If so, please explain:

_____
_____
_____
_____

Please list any other information that you believe will be helpful for your therapist to know.