JENNIFER M. RITTER, MA, LCPC, CCTP
Licensed Clinical Professional Counselor
Idaho License #4730
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223 N. 6th Street, Suite 320, Boise, ID 83702 | (208) 602-5850 | by appointment only
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DISCLOSURE & CONSENT

I hold a Bachelor's degree in Psychology (BA) from California State University in Long Beach, a Master's in Counseling (MA) from Boise State University (BSU) and have worked in the counseling field since 2006. I have also completed coursework toward the Masters in Addictions Studies at BSU. I hold a Nationally Certified Counselor (NCC) certification and a Licensed Clinical Professional Counselor (LCPC) endorsement from the State of Idaho. In addition to working with clients in my private practice, I work as an Inpatient Counselor on the Behavioral Health Unit at St. Alphonsus Hospital in Boise, and am an adjunct faculty member in the Psychology Department at Boise State University.

My work has encompassed a diverse group of clientele from the young (as young as 5 years old) to the elders in our community (83+ years). In my private practice, a variety of issues are addressed: issues of divorce, grief and loss, depression, anxiety, anger management, rebuilding trust within relationships, communication, boundary work, etc. I enjoy working with individuals as well as running a variety of mental health groups, and view all therapeutic interactions with my clients as a dynamic learning and healing process.

A core belief integral to my work with clients is that of a preventative mental health model for long-lasting emotional and behavioral change. As is true with physical health, our mental health changes as we go through life, and benefits from therapeutic exercises designed to specifically address problem areas (e.g., irrational vs. rational thinking patterns). Therapy works best as a lively interaction between whomever is involved in the room and requires patience, trust, and a willingness to work—even when it's uncomfortable to do so. My goal is to help people discover a life that has purpose, deeply meaningful relationships, and spontaneous joy. I fully believe in the benefit of not being alone while navigating the complexities of life; virtually *any* issue confronting an individual can be addressed through counseling and turned into healing, empowerment, and continued inner strength.

CONFIDENTIALITY

The information shared in therapy is considered privileged and confidential. I cannot release information to another party without your written consent. Confidentiality laws do require that I make an exception in some very limited circumstances. If I believe that you are seriously dangerous to yourself or others, I have both a legal and ethical responsibility to report this and seek the necessary help for you. In addition, if I suspect a child or vulnerable adult is being abused, neglected or exploited, I have a similar ethical and legal obligation. In the event of an issue related to potential self-harm or suicidal thinking, you are encouraged to call the Idaho Suicide Prevention Hotline at 1-800-273-8255.

I seek consultation at times from other professionals—primarily therapists—in the area. Your case may be discussed for the purpose of maintaining the highest quality care. Please know that other professional consultants are also bound by the legal responsibility of protecting your confidentiality and client names are rarely (if ever) used. If you have any questions about this, please ask.

Confidentiality is at risk with the use of electronic media (e-mail, texting, Skype) which I use frequently to augment session time. I will use discretion to limit the use of information discussed; however, clients willingly engage in these forms of dialogue at their own risk and discretion.

There is no audio or visual recording of any kind during therapy without prior written consent from any and all parties. Should a recording occur a $750 fine may be imposed to the responsible party. If client is a minor, the custodial parent responsible for the child will be subjected to the fine.

CLIENT AGREEMENT FORM

Professional Fee Payment. The initial "Intake Session" fee is $150.00, will run 60 minutes in length, and covers a more detailed history on issues to be covered within the scope of counseling. All individual sessions thereafter (with the exception of reintegration work) are $125.00 and will run approximately 50 minutes in length; conjoint sessions are also $125.00. Payment is required at the beginning or end of each session.

Reintegration Family Therapy Rates. Intake and subsequent sessions billed at $165/hour (typically runs 60 minutes) and is commonly split between both parents; however, these arrangements vary. Reviewing paperwork, coordinating care via e-mails, and consultations with other persons involved (e.g., therapists, attorneys) are billed at $125 per hour, in 15-minute increments.

You may be charged for phone time with you or on your behalf, e-mail correspondence therapeutic in content, and letters or reports including preparation time. If I am required to appear in court (or in deposition) you will be charged $275.00 per hour to cover the additional requirements of additional preparation, travel, and being out of my office. There will be a $25.00 service charge for any returned checks.

Cancellations. I will make every effort to accommodate your scheduling needs. In return, I ask that you help out by keeping your scheduled appointment, and by notifying me in advance if you are unable to do so. With advance notice, I am often able to accommodate other clients that are waiting to get an appointment. You may cancel or reschedule your appointments by calling or texting (208) 602-5850, and leaving a message if you get my voice mail. That line is available 24 hours a day and records the time of your call.

All appointments cancelled with less than 24 hours advance notice are subject to a missed appointment fee. If you fail to arrive for your appointment without 24 hours advance notification, you will be charged the full hourly rate of $125.00. This fee is due and payable at your next appointment.

Insurance. Insurance companies vary with their agreements to cover mental health services. It is your responsibility to determine the benefits of your individual health plan. I will provide you with a billing invoice at the end of each month which details the procedure and, if applicable, a diagnosis code for insurance billing purposes; however, I do not work or subscribe with any insurance carrier. You will be responsible for making your payment at the time of each appointment and for negotiating reimbursement rates with your particular insurance provider.

CONSENT TO TREATMENT

Most people who participate in behavioral or mental health treatment benefit from an overall healthier lifestyle. Like most kinds of healthcare, this kind of treatment requires a very active effort on the individual's part. In addition, there may be certain kinds of risks involved. For example, the counseling process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find the benefits far outweigh any such risks.

I cannot guarantee a specific outcome for the people I work with; however, together we can set goals and work for the best result. While this is a unique relationship, it is a professional one and it is my policy to maintain only a professional relationship with you. This means that I cannot accept gifts or invitations, or engage in a business or personal relationship with you. Sexual intimacy is never appropriate and should be reported to the licensing board. These guidelines are meant to ensure the quality of your care.

It is important that the individual receiving mental health counseling participates in this treatment willingly. You have the right to participate in treatment decisions, to seek a second opinion and to file a complaint without retaliation to the licensing board and to refuse treatment. The address and telephone number of the licensing board is: State of Idaho, Idaho Bureau of Occupational Licenses, 700 West State Street, Boise, Idaho 83702.

If you have any questions or concerns about this document, about the services being provided, or about the treatment options, please feel free to ask questions.

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Informed Consent for Treatment

This form is to document that I, _____, give my permission and consent to Jennifer M. Ritter, MA, LCPC to provide therapeutic treatment to me and/or _____ _____ who is/are my (spouse, child, children).

While I expect benefits from this treatment, I fully understand that because of factors beyond our control or other factors, outcomes cannot be guaranteed. I understand this treatment may involve discussing relationships, psychological, and/or emotional issues that may at times be distressing; however, I understand that this process is intended to help me personally and with relationships. I am aware of alternative treatments available to me.

Confidentiality is at risk with the use of electronic media (e-mail, texting, Skype) which I understand is used to augment session time. I understand that, should this arise in the course of our work together, I willingly engage in these forms of dialogue at my own risk and discretion.

Ms. Ritter has answered all of my questions about treatment satisfactorily. If I have additional questions, I understand that she will either answer them or attempt to find answers for me. I understand that I may leave therapy at any time, although I have been informed that this is best accomplished in consultation with Ms. Ritter to effectively close the therapeutic relationship and provide referrals, where indicated.

Receipt of Notice of Privacy Practices. I hereby acknowledge that I have had access to a copy of the Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available upon request at any time, and that I will be offered a copy of any amended Notice of Privacy Practice at each appointment.

By signing this agreement, I acknowledge that I have read this agreement, understood its terms, agree to be subject to its provisions, and voluntarily agree to the participation in the treatment. I agree to pay for all services rendered and any legal expenses necessary for collection.

Guardian Signature (if client under the age of 13 years)	Date
Client Signature (if over the age of 13 years)	Date
Clinician Signature	Date