

**Jennifer M. Gronholt, Psy.D.**  
2110 Iron Street, Bellingham, WA 98225  
(360) 734-2664 ext.14  
Licensed Clinical Psychologist # PY60118572

## **TERMS OF SERVICE / DISCLOSURE STATEMENT**

*I am pleased that you have selected me as your psychologist. This document is designed to ensure that you understand our professional relationship.*

---

### **CONFIDENTIALITY AND PRIVACY:**

Your privacy is important to me and I will keep everything you say and all information about you confidential including the fact that you are my client except in specific circumstances as required by law. These limitations are outline in the “Notice of Practices Regarding Protected Health Information” form you have received.

### **PEER REVIEW:**

Freedman & Associates is a consultative group of experienced therapists. Good clinical practice requires occasional peer review and consultation within this group. Please be aware that your case may be clinically reviewed in this setting.

### **OUR RELATIONSHIP:**

Although you may at times feel very close to me, it is important for you to realize we have a professional relationship rather than a personal one. Professional ethics require that our contact be limited to the paid sessions you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns.

### **FEES AND PAYMENT:**

Unless otherwise arranged with me, my fees are as follows:

Initial Interview	\$190
Individual Therapy	\$135/hr
Couple/Family Therapy	\$160/hr
Psychological Testing	\$150/hr

While this fee is usually collected in full at the beginning of each session, Freedman & Associates has agreements with Regence, Premera, Group Health Cooperative, and some other insurance companies to collect co-payments and co-insurance, if any, at the time of service and submit billings for the insurance company portion directly to them. They will pay Freedman & Associates directly for covered services. This billing procedure is a service to you provided through our arrangements with your insurer.

With other insurance carriers, we will decide together whether you will pay me the co-pay or co-insurance only or the full fee at the time of service. You are responsible for determining the specifics of your insurance coverage, as well as procuring relevant paperwork (such as primary care physician referrals) as your insurer may require. I will assist you by providing any necessary information.

**Please note that as the recipient of services, you are responsible for all charges not paid for by your insurance company. Payments will be due at the time the insurance company notifies us any unpaid portion.**

All insurance companies require that I diagnose your mental condition before they agree to pay for services. If you ask, I will inform you of the diagnosis I plan to render before I submit it to your insurance carrier. Also, some insurers require that I coordinate care with your primary care physician and/or a behavioral health care manager. If you have any questions about the details of your plan, please refer to your benefits booklet or contact your insurer.

**APPOINTMENTS/CANCELLATIONS:**

**Appointments:**

Appointments are 50 minutes and reserved for you alone. I try very hard to begin and end on schedule, out of respect to both our schedules. **In the event that you are unable to keep an appointment, you must notify me at least 24 hours in advance. If I do not receive such advanced notice, you will be responsible for paying for the full fee for the session you missed. We cannot bill your insurance for missed sessions, and insurance will not pay for missed sessions.**

If you need to cancel or reschedule, you can leave a message on my voice mail at **(360) 734-2664, ext 14**. Also, please remember to leave your home and work phone numbers with every message as I am not always in the office when retrieving messages and may not be able to get back to you otherwise.

Please initial the box provided to acknowledge that you have read and understand the Appointment and Cancellation/No Show Fee Policy.

**Attendance:**

Attending scheduled appointments is critical to the success of counseling. If missed appointments become a concern, I will initiate a conversation about how to remain engaged in services. I may request that an attendance contract be discussed and signed.

Please initial the box provided to acknowledge that you have read and understand the Attendance Policy.

**EMERGENCIES:**

If there is an emergency I can be reached by phone at **(360) 734-2664, ext 14**. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting psychotherapy. If a contact of more than 10 minutes is necessary, a fee will be charged at my usual hourly rate.

If you are unable to reach me when you feel the need for some emergency help, Freedman & Associates also has a 24-hour on-call therapist who can be reached by calling **(360) 325-3999**. There is no charge for on-call contacts less than 10 minutes; over 10 minutes will be charged at the usual hourly rate.

In the case of a life-threatening emergency please call **911**, go to the **Emergency Room**, or call the 24-hour Crisis Line at **1-800-584-3578**.

**COMPLAINTS:**

If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to The Examining Board of Psychology, Dept. of Health, P.O. Box 47869, Olympia WA 98504, or call them at (360) 236-4928.

---

*By signing below, I attest that I have read, understood, and agreed to these policies, and have received my own copy of this disclosure statement. I also give Freedman & Associates my permission to release to my insurance company any medical or other information necessary to receive payment for my sessions.*

---

Client's Signature

---

Dr. Gronholt's Signature

---

Date

---

Date

**Please read the attached Notice of Privacy Practices for more information about your privacy rights and initial here to acknowledge that you received a copy of the Notice: \_\_\_\_\_**