Professional Disclosure Statement

For individuals receiving counseling services from:

Matthew C Krieg, MA LPC
2040 Raybrook St SE Ste. 103
Grand Rapids, MI 49546

Counseling Services

I am dedicated to providing services with a commitment to the holistic health of the client. While many techniques used in my counseling practice stem from a cognitive behavioral philosophy, I adhere to the belief that experiences shape our lives much more profoundly than purely intellectual endeavors. Our lives consist of physical, emotional, intellectual, social, and spiritual components. I strive to utilize all these aspects of human experience to help you achieve your goals. I encourage most clients to seek healing in both individual and group counseling approaches.

Education and Experience

I have worked in the counseling field since the completion of my degree program. I received a master's degree in counseling from Grand Rapids Theological Seminary in 2011. Since my graduation I have worked in individual and group settings with people from early adolescence into adulthood.

I spent three years as a counselor and program director at 180 Youth Programs in Lodi, CA working with gang affiliated and at-risk youth and running group therapy sessions in the local junior high and high schools. Since that time I have operated in a private practice setting working primarily with issues related to sexuality, relationships, and trauma.

Confidentiality and Informed Consent

The therapeutic relationship requires complete confidentiality between client and therapist. Information about clients, including case notes and records are confidential and are the property of Caring Well Counseling LLC. In the event of my being unable to perform professional services, i.e., death or extreme disability, one of my colleagues, will safeguard your file according to state and national ethics rules and regulations.
The State of Michigan has established the following limits of confidentiality.
You should be aware of these exceptions to confidentiality:

1. You provide consent to release your records or to share information regarding your treatment;
2. You are at risk of imminent serious harm to yourself or others*;
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. You disclose sexual misconduct of a physician or therapist;
5. Information is requested by your insurance company pertinent to processing claims for payment;
6. A court order is received to disclose information (e.g. child custody or mental competency cases);
7. You file a complaint with a licensing board or in cases of a malpractice suit, records will be released to the Board and/or legal counsel.

***In the event that you are deemed an imminent danger to yourself or others, your therapist has a professional duty to contact the proper authorities. Medical and/or law enforcement officials may be notified with or without your consent.**

By signing below, you are stating that you have read and understood the rules of confidentiality.

Signature of Client (or Guardian) _____

Date _____

Counseling with Minors Age 14+
According to the Michigan Mental Health Code, MCL 330.1707, a minor 14 years of age or older, may request up to 12 sessions or four months of outpatient counseling without the consent or knowledge of the minor's parent, guardian, or person in loco parentis. The minor's parent, guardian, or person in loco parentis shall not be informed of the services without the consent of the minor unless the mental health professional treating the minor determines that there is a compelling need for disclosure based on a substantial probability of harm to the minor or to another individual, and if the minor is notified of the mental health professional's intent to inform the minor's parent, guardian, or person in loco parentis.

Patient Privacy Notice (HIPAA)
You may have the right to have us amend your protected health information. This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

How We May Use or Disclose Protected Health Information
Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians/clinicians who may be involved in your care and treatment. We may use or disclose your protected health information, as necessary, e.g., to contact you to remind you of your appointment.

For Payment - Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures
We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law - We may use or disclose your protected health information to the extent that the law requires the use or disclosure.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

By signing below, you confirm that you have read the above information regarding your Private Healthcare Information.

Signature of Client (or Guardian) _____

Date _____

Rescheduling or Canceling an Appointment
To reschedule or cancel an appointment, you must log in to your registered account at least 24 hours before the session to avoid a $40 late cancellation fee. If you are unable to reschedule or cancel online, call 616 419-4791 or email matt@caringwell.net

Cancellation Policy
You may can cancel or reschedule an appointment anytime, as long as you provide 24 hours advanced notice. If you cancel an appointment with less than 24 hours notice, or fail to show up, your credit card on file will be charged $50. I reserve for you, and all my clients, a full hour of my time for the session and clinical notes. If you cancel with less than a full 24-hour notice, I, more than likely, won't be able to fill that time slot, and I'll lose an entire hour from my work schedule.

Fee Chart
Full Session: $100 / 50 minutes
Canceled/Missed Session without 24 hour notice $40 fee
Upon request, I also have a limited amount of sliding scale spots available based on need and necessity. Please contact Caring Well Counseling LLC to inquire about sliding scale details and availability.

Payment
I accept cash, check, and most major credit cards for payment. You are responsible for the payment of your fees at the time of service.

Note: If you are more than 15 minutes late for an appointment, Caring Well Counseling LLC retains the right to cancel or reschedule your appointment, and a missed appointment fee may be assessed.

CREDIT CARD AUTHORIZATION

At Caring Well Counseling LLC we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable, including charges for late cancellation or no show fees. Your credit card information is kept confidential and secure.

I authorize Caring Well Counseling LLC to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover
Credit Card Number _____
Expiration Date _____/_____/_____ CCV Code _____ Cardholder Name
_____ Email Address
_____ Billing Address
_____ City
_____ State _____ Zip _____

I (we), the undersigned, authorize and request Caring Well Counseling LLC to charge my credit card, indicated above, for balances due for services rendered. This authorization relates to all payments for services provided to me by Caring Well Counseling LLC, including fees for late cancellation or no shows.

Client's Name (Print): _____

Client/Caregiver Signature: _____

Date: _____/_____/_____

Court Action Policy and Fees
Clients are discouraged from having Caring Well Counseling LLC subpoenaed for the purpose of litigation. We have not been trained forensically or with the expertise to appear in court. We are unable to guarantee that any testimony that we are required by law to give will be solely in your favor. We can only testify to the facts of the case and my professional opinion. I request a minimum of 72 hours notice of any court appearance so that schedule changes for my clients can be made within a reasonable time frame. If a subpoena is received without a minimum of 72 hour notice there will be an additional $250 express charge.

Court action fees are as follows:
1. Preparation Time: $150 per hour (billable in 20-minute increments)
2. Phone Calls: $150 per hour (billable in 20-minute increments)
3. Emails: $25 for every 15 minutes to read and respond
3. Filing Document with court: $100
4. Minimum charge for court appearance: $1,000 for half day $2,500 for full day
5. Attorney fees: The client agrees to pay all attorney fees and costs incurred as a result of any court action.
6. Retainer: A retainer of $1,000 is due at least 72 hours before the scheduled appearance.
7. The remainder of the costs will be billed after the court appearance and will be due upon receipt.
8. If a therapist is subpoenaed and the case is reset with less than 72 hour notice prior to the beginning of the day of the scheduled subpoena and/or testimony is not given then the client will be billed $1,000.
9. Bills for court related actions are presented to clients on a weekly basis and payment is expected upon receipt. A zero balance will need to be kept at all times.

Signature of Client (or Guardian)_____

Date_____

Therapist/Client Communication
If you need to call and leave me a message, you are welcome to do so. Generally during the week, I am either in session with clients and may not be able to answer my phone. However, I do check my messages and work hard to return calls as promptly as possible. The best method for getting through to me is via email communications. I generally check emails during normal work days and do not always check email over the weekend.
Email is not intended for emergencies or other urgent or time-sensitive matters. Email is also not intended for therapeutic or clinical material, and I ask that you refrain from including sensitive, confidential, or private information in any email communications with me as email can be relatively easily accessed by unauthorized people, which can compromise the privacy and confidentiality of such communication.

Emergency Calls
If there is an extreme life threatening emergency, call 911 or go to the emergency room of the nearest hospital. The following numbers may also be helpful:
• Crisis Hotline: 1-800-231-1127 • Suicide Hotline: 616-336-3535

Responsibility for Treatment
As with any other procedure, psychotherapy involves some risks. Whenever you make significant changes in your lifestyle, outlook or habits, your life and the lives of those with whom you are closely involved will be affected. While the purpose of psychotherapy is to make changes, you will want to consider the consequences that might arise. Whatever changes you make will be both your choice and your responsibility. If you become concerned about the course of your therapy, please let me know so that you can have the course of treatment best for you.

Complaints and Grievances
I make every effort to provide services that are pleasing to you. If you believe I have failed to provide satisfactory care or have acted unprofessionally or unethically, please let me know, so I am able to correct this.

To file a complaint or grievance, please contact:
Michigan Department of Licensing and Regulatory Affairs, Health Professions Division
Enforcement Section,
P.O. Box 30670
Lansing, MI 48909
or fax (517) 241-2635.

Agreement
I have read the above and accept the foregoing policies. A copy of this form is as valid as the original. I certify that I am over fourteen years of age and consent to the above conditions for therapy.

Printed Name of Client: _____

Signature of Client:_____

Date: _____

Signature of parent or guardian (if client is under 14):_____

Date: _____