jennie klein, PhD
clinical psychologist

49 Locust Avenue, Suite 103 * New Canaan, CT 06840
Phone: (434) 242-9880
Email: drjennieklein@gmail.com

Welcome to my practice! Please read the information provided below about my policies and your rights as a client, and feel free to ask questions.

Appointments and Cancellations
If you cannot make your scheduled appointment, please notify me at least 24 hours in advance. If you miss your therapy session, and you have not notified me at least 24 hours in advance, you will be required to pay the full cost of the session. Please keep in mind that insurance companies do not reimburse for missed appointments.

Professional Fees
Initial assessment/intake visits are $525 for a 90-minute session. My session fee is $350 for a 50-minute individual appointment. The fee for a couple/family therapy session is $390 for a 60-minute appointment. In addition to appointments, I charge a $300 hourly fee for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

Billing and Payment
Payment by cash, check, or Venmo is expected at the time of your appointment. I do not accept insurance directly; however, your health insurance company may reimburse your treatment. I will provide you with a monthly bill of service, which you can submit to your insurance provider for reimbursement as outlined by your plan.

If your account has not been paid in full for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Client Records
The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Patients will be charged an appropriate fee for any time spent in preparing information requests.

Confidentiality
Clients are assured of confidentiality, which is protected by ethical practice and law. In general, the law states that all communications between a licensed practitioner and his/her clients are confidential. Also, any information that is shared for any reason requires your consent. You should be aware, however, of the following exceptions to the professional responsibility for maintaining confidentiality:

- If a judge orders the release of certain records in a court case;
- If your insurance company is reimbursing your treatment, they have a right to know your working diagnosis, dates of service and certain other information in order to approve the payment of benefits;
- If I have reason to suspect that a child or elderly person is being abused or neglected, I am legally obligated to report this information to the appropriate authority;
- In circumstances in which, to the best of my professional judgment, I believe that you may be a danger to yourself or another person;
- If you were to make your mental health an issue in a court case;
- If your account is overdue and arrangements for payment have not been negotiated, a collection agency may be provided with dates of service, type of service, and total amount due.

Contacting Me
My telephone number is (434) 242-9880. Note, however, that I am often not immediately available by telephone. I generally will not answer the phone when I am with a client. I monitor my voicemail frequently. I will make every effort to return your call on the same day you make it, except on weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Text messaging is an unsecure and impersonal mode of communication for therapy. Therefore, please only text me to set or change appointment times or ask specific questions. I will make exceptions to this policy if we have agreed upon a DBT coaching relationship.

Termination
A client may initiate termination of therapy at any time. At the time of termination, at least one-week notice is suggested so that a final session can be scheduled.

I have read the above and I hereby agree to be directly responsible to Jennie Klein, PhD for charges incurred. I understand the above and will comply with these guidelines.

Client/Legal Guardian Signature_____ **Date** _____

Client Intake Form

Name:_____

Name of parents/guardian (if under 18 years):_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Birth Date: _____ /_____ /_____ Age: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/ages:_____

Home and/or Cell Phone:_____
May I leave a message?
□ Yes □ No

Email Address:_____
May I email you? □ Yes □ No

Referred by (if any): _____

Are you (or family members I will be seeing) currently taking any **prescription medication?**
□ Yes □ No

Please list:

Family Mental Health History:

Please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Bipolar/Manic Depression	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish during your time in therapy?

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AUTHORIZATION FOR EXCHANGE OF MENTAL HEALTH INFORMATION

I, _____, authorize Dr. Jennie Klein to exchange

mental health information about [*self OR full legal name of child and birth date*]

_____ with the following providers:

The purpose of this release is for:

- ☐ Collaboration with other involved individuals/professionals
- ☐ Continuity of care related to discharge planning
- ☐ Billing and payment of bill
- ☐ At client's request, or state reason_____

NOTICE

Dr. Klein and other treating professionals, hospitals, and health plans are required by law to keep your mental health information confidential. This Authorization will expire 12 months after the date of my signing. This Authorization may be revoked in writing at any time. The revocation will take effect when Dr. Klein receives it, except to the extent that Dr. Klein has already relied on this Authorization.

_____
Printed Name

_____
Signature

_____
Date

Jennifer Klein, PhD
NOTICE OF PRIVACY PRACTICES
Mental Health Programs

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Dr. Klein is federally mandated to maintain the privacy of your medical information and wants you to know about her practices for protecting your health information. She is required to abide by the terms of this notice. The medical information she records and maintains is known as Protected Health Information or PHI. She will not use or disclose your PHI without your permission except as described in this notice.

USES AND DISCLOSURES:
It is Dr. Klein's policy to obtain written authorization for release of information prior to making a disclosure. You may revoke an authorization at any time, except to the extent that she has already acted on it.

Dr. Klein may use your Protected Health Information (PHI) without authorization for:

- *Treatment*, e.g., share information with other providers involved in your care
- *Payment*, e.g., share information with your health plan so that they will pay for your treatment
- *Individuals Involved in Your Care or Payment for Your Care*. When appropriate, Dr. Klein may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. She also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
- *Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services*. Dr. Klein may use and disclose Health Information to contact you to remind you that you have an appointment. She also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Other permitted disclosures of Protected Health Information (PHI) without authorization might include:

- Disclosures required by law, e.g., to the Department of Children and Families when a law requires that she report suspected abuse or neglect
- For research, audit or evaluations
- Public Health, e.g., mandated reporting of disease, injury or vital statistics
- To avert a serious threat to the health or safety of you or others
- As a response to a court order, e.g. a judge orders specific portions of your record
- If deceased, limited information to coroners, medical examiners or funeral directors

WHAT ARE YOUR RIGHTS? YOU HAVE THE RIGHT TO:

- Request restrictions on certain uses and disclosures of your Protected Health Information (PHI)
- Receive reasonable confidential communication of PHI, e.g. that you be contacted in a certain way or at a certain place
- Inspect and copy your medical record by written request, with some exceptions. Dr. Klein reserves the right to deny the request, to which you may make a further appeal.
- Request an amendment of your medical record. Dr. Klein reserves the right to deny the request, to which you may make a further appeal.
- Receive an accounting of Dr. Klein's disclosures of your PHI during the six years prior to your request. Accountings of disclosures start as of September 15, 2016 and are unavailable prior to that time.
- Amend information if you think what Dr. Klein has on record is incorrect.
- Receive a paper copy of this notice.

SPECIAL REGULATIONS REGARDING DISCLOSURE OF PSYCHIATRIC, SUBSTANCE ABUSE, AND HIV-RELATED INFORMATION:
For disclosures concerning health information relating to care for psychiatric conditions, substance abuse or HIV-related information, special restrictions may apply. For example, Dr. Klein generally may not disclose this specially protected information in response to a subpoena, warrant or other legal process unless you sign a special authorization or a court orders the disclosure. A general release of your health information will not be sufficient for purposes of disclosing psychiatric, substance abuse or HIV-related information.

Psychiatric Information. Dr. Klein will not disclose records relating to a diagnosis or treatment of your mental condition between the patient and psychiatrist, or which are prepared at a mental health facility, without specific written authorization or as required or permitted by law.

HIV-Related Information. HIV-related information will not be disclosed, except under limited circumstances set forth under state or federal law, without your specific written authorization. As required by Connecticut law, if Dr. Klein makes a lawful disclosure of HIV-related information, she will enclose a statement that notifies the recipient of the information that they are prohibited from further disclosing the information.

Substance Abuse Treatment. If you are treated in a specialized substance abuse program, information which could identify you as an alcohol or drug-dependent patient will not be disclosed without your specific authorization, except where specifically required or allowed under state or federal law.

CHANGES TO THIS NOTICE:
Dr. Klein reserve the right to change this notice and make the new notice apply to Health Information she already has as well as any information she receives in the future.

HOW YOU CAN REPORT A PROBLEM?
If you believe your privacy rights have been violated, you may file a complaint with:

- Connecticut Department of Public Health: 800-842-0038; 410 Capitol Avenue, Hartford, CT, 06120
- Connecticut Legal Rights Protection: 860-262-5030 or toll-free 877-402-2299; P.O. Box 351 Silver Street, Middletown, CT 06457
- State of Connecticut, Department of Children and Families: 800-842-2288; 505 Hudson Street, Hartford, CT 06106
- State of Connecticut, Department of Mental Health and Addiction Services (DMHAS), Office of HealthCare Information (OHI): 860-418-6901

All complaints must be made in writing. You will not be penalized for filing a complaint.

I HAVE READ THE POLICY ABOVE AND UNDERSTAND MY RIGHTS: _____(Initial)