Jennifer Jondreau Thompson, Ph.D., LPC
Licensed Professional Counselor
Office Hours by Appointment
Please call (860) 838-2071

The Particulars:

- Sessions last 50 minutes, 1 ½ sessions are available on request.
- There is a 24 hour cancellation policy. Payment in full is expected if you cancel less than 24 hours to your scheduled appointment.
- In the event that payment cannot be made we can discuss payment options.
- Periodically I go on vacation. During those times, one of my colleagues is available to be on-call for emergency situations. Her contact information will be given to you prior to my leaving for vacation.

Confidentiality:

- I am required to document your treatment plan. I keep these records locked and am the only one who has access to them. It is your right to ask to see your record at any time. Upon termination of our work together, I am required to keep your record on file for seven years.
- There are times when I need to consult with my supervisor or colleagues about a particular situation. When I do, I am careful not to disclose personal information so that the individual I am discussing cannot be identified.
- The following are Limits of Confidentiality: Information you and/or your child(ren) report about physical or sexual abuse of a minor or elder person; if you provide information that informs me that you are in danger of harming yourself or others; where you sign a release to have specific information shared; information shared with your insurance company to process your claims.
- If you are a minor, under 18 years old, then we will discuss the particular confidentiality issues that involve you and your parent or guardian.

I look forward to working with you.

Warm regards,

Dr. Jennifer Jondreau Thompson

I have read and understand the above statements. I understand that Jennifer Jondreau Thompson cannot guarantee results but will guide me in the direction I want to go in my healing process. I understand that it is my right to terminate at any time without penalty.

_____ _____
Client signature *Date*

Client Information Form
(To be completed by Teen)

Name:

Nickname:

Address:

Home Phone:

Your Cell Phone:

Email:

Age:

School:

Grade:

What are your interests and hobbies?

Do you belong to any clubs, sports teams, etc.? Please list

Are you employed part-time? Please provide details

What are your favorite subjects in school? Why?

What are your least favorite subjects? Why?

Are you currently taking private lessons or working with a tutor? If yes, please describe:

How do you think you learn best? ***Choose one:***

____Visual (using your eyes)

____Auditory (using your ears)

____Kinesthetic (hands-on learning)

What do you hope to gain from therapy sessions? Check all that apply:

___Better grades in school

___Improved study habits

___Get into college

___Organizational skills

___Improve social skills/more friends

___Develop healthy eating habits

___Improve your self-image

___Set and meet your goals, specify _____

___Other, specify_____

What would you like to do after high school?

What accomplishments are you proud of?

Is there anything else you would like me to know about you?

Thank you!

Information Form
(To be filled out by Parent or Guardian)

Mother's First and Last Name: _____

Father's First and Last Name:_____

Guardian Name: _____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Guidance Counselor: _____ Phone:_____

Primary Health Care Provider:_____ Phone:_____

Does your teen have Medical Conditions? If so, please include current treatment and medications

Does the teen have special accommodations per an IEP/504 plan? If yes, please describe. Attach copy if available.

Is there any family history of substance abuse?

Are you aware of alcohol or substance abuse in your teen (past or present)?

Is there anything else you would like me to know about your teen?

Thank you!

NOTICE OF PRIVACY PRACTICES
(HIPPA)

My commitment to your privacy:
I am required by law to maintain the confidentiality of health information that identifies you and to provide you with this notice of privacy practices. I reserve the right to change the practices regarding the health information I keep. If I make a material change to my privacy practices, I will give you a copy, by mail or in-person. Unless otherwise required by law, your health record is the physical property of my office, but the information in it belongs to you, and you have the right to have your health information kept confidential.

You or a person legally authorized to act for you, have a right to:

- Obtain a paper copy of this notice upon request
-

General policy on use and disclosure of your health information.
I will use and disclose your health information only with your authorization, or when I am required to do so by state or federal law, or in an emergency.

Permitted uses and disclosures: The uses and disclosure listed in the section below may be made with your one-time permission. I am not required to maintain a written accounting of the disclosures made for these purposes.

- **Treatment:** Information is used and disclosed to provide you with healthcare services. For example, I may talk with your doctor or other treatment providers about your care.
- **Disclosures to friends and family:** With your permission, we may disclose your health information to friends and family who are involved in your care.

I will not use or disclose health information without your authorization except in an emergency or when I am required to do so by state or federal law. These special circumstances are outlined below.

- **Serious threats to health and safety:** Your health information may be disclosed to avert a serious threat to public health safety, as permitted by law.
- **As required by law:** May use and disclose information for the mandatory reporting of child abuse and neglect; for judicial or administrative proceedings, if required by legal process; and as otherwise required by law.
- **Health oversight:** Information may be disclosed when required to monitor the level and quality of care you receive, for example the State of Connecticut Department of Public Health.

For more information, to make a complaint, or to exercise your rights: If you have questions, need information, believe your privacy rights have been violated, or wish to make a complaint or to exercise one of your rights described in this notice, you may contact:
Jennifer Jondreau Thompson
Center for Natural Wellness
166 Albany Turnpike
Canton, CT 06019

If you are not satisfied with the response your receive you may contact:
Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 509f
HHH Building
Washington D.C. 20201

NOTICE OF PRIVACY PRACTICES
(HIPPA)
Sign off Sheet

I, _____have received a copy of the "notice of privacy practices (HIPPA)" form. It was reviewed and any relevatn questions have been addressed. I understand that I can obtain additional copies as needed by contacting Jennfer Jondreau Thompson and requesting one.

_____ _____
Client Date

_____ _____
Parent/Guardian or legal representative (as applicable) Date

_____ _____
Jennifer Jondreau Thompson Date