

**Pamela J. Kowal, MS., LMFT
Integrative Psychotherapist**

STATEMENT OF UNDERSTANDING FOR INSURANCE CLIENTS

CONFIDENTIALITY/DATA PRIVACY

Your visits with Pamela J. Kowal, MS, LMFT and information discussed are classified as private by Minnesota law, and the HIPAA Privacy Rule. Private information can be communicated to others only with your informed written consent. The only exceptions to this are mandated by law and include a) reporting of abuse of children or vulnerable adults; b) a situation where disclosure of information is necessary to protect against the risk of imminent serious harm being inflicted by you on yourself or another person; and c) records subpoenaed by the court. Information concerning dependent minors is accessible to parents unless it is determined that such access would be harmful to the minor.

EMAIL COMMUNICATION

Minnesota law and the HIPAA Privacy Rule does not cover email or text communication and is not considered "secure." However, if you would like to receive reminders + updates from Pamela J. Kowal or to communicate about appointments, email is the most efficient way to communicate. Providing your email address and signing below indicates that you understand the limitations to privacy in e-mail communication. Communicating via text is advisable only for immediate information about your appointment. You will also need to sign the Informed Consent for Telehealth Medicine for virtual therapy sessions.

FINANCIAL RESPONSIBILITY & FEES FOR SERVICE

Fees for service must be paid in full at the time that services are rendered. Cash, checks, credit card/PayPal and Venmo accepted. You will be charged for returned checks as determined by state law. Session fees are as follows:

**New Client Initial Consultation (60 mins) = \$225
Individual Counseling (60 mins) = \$165
Late cancellation and missed appointment fee = \$100**

CANCELLATION POLICY

I ask that you give a **24-hour business day** notice if you cannot keep your appointment. If you do not give a 24-hour notice, you will be charged \$100. Insurance does not pay this fee. This needs to be paid before scheduling or confirming your next appointment.

I have read the above information and understand my obligations:

Client Name (print): _____

Client Signature: _____

Email address: _____

Date: _____