DISCLOSURE STATEMENT

Elizabeth R. Jones, M.Ed., LLPC, NCC
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Before signing, please read this disclosure statement in its entirety. This information helps you decide whether my services are suitable for your needs. Please discuss any questions or concerns before treatment or as they arise during your course of treatment.

Description of Practice: Elizabeth R. Jones provides professional counseling services through Ginger's Grace Therapy Company PLLC. Services are currently offered through a secure telehealth platform to individuals in the State of Michigan. Counseling services include individual, couples, and group therapy. The practice is rooted in creating a supportive, culturally responsive, and collaborative therapeutic space that encourages emotional growth, self-awareness, healing, and personal development. Counseling services may address concerns related to anxiety, depression, life transitions, stress management, self-esteem, grief and loss, identity development, relationship concerns, trauma, emotional regulation, and overall wellness. Therapeutic services are individualized to support each client's unique needs, goals, and experiences.

Credentials and Education: I am currently practicing as a Limited Licensed Professional Counselor under the supervision of Lorraine McKnight (LPC), #6401007158, in the State of Michigan. I also hold licensure as a Licensed Mental Health Counselor Associate (LMHCA) in the State of Washington, under license number MC61680865, and practice under the supervision of Emmaleen Edwards (LMHC), license number LH60301201. With six years of experience in education and mental health, I earned a Master of Education in School Counseling from Mississippi College and have met all requirements to become a National Certified Counselor (NCC). To further support my professional development and ethical practice, I participate in continuing education and maintain membership with the American Mental Health Counseling Association (AMHCA), the Michigan Mental Health Counselor Association (MMHCA), the Washington Mental Health Counselor Association (WMHCA), and Chi Sigma Iota. I adhere to the professional standards, rules, regulations, and code of ethics established by the American Counseling Association and applicable state licensing boards. Additional information on Michigan licensure is available on the Michigan Department of Licensing and Regulatory Affairs (LARA) website at https://www.michigan.gov/lara. Also, Additional information regarding Washington licensure may be found at: https://fortress.wa.gov/doh/providercredentialsearch/

Supervisor Qualifications Statement: My clinical supervision is provided by Lorraine McKnight, LPC, License #6401007158, who is a fully licensed Professional Counselor in the State of Michigan and meets the supervisory requirements outlined in Michigan Administrative Rule R 338.1781(1) and (2).

Lorraine McKnight provides clinical oversight, supervision, and consultation regarding counseling services, ethical practice, case review, and professional development in accordance

with the requirements established by the Michigan Board of Counseling.

Supervisor Signature: Lorraine McKnight

Date: 5/29/2026

Philosophy and Treatment Modality: I utilize a humanistic, integrative approach to therapy, believing that everyone has the internal strength and capacity to develop, heal, and create meaningful change. Through a collaborative, authentic therapeutic relationship, I strive to provide a culturally sensitive, supportive, and nonjudgmental environment in which clients can safely explore their experiences, emotions, and personal goals.

The three primary approaches that serve as the foundation of my therapeutic work include:

- **Person-Centered Therapy,** which encourages empathy, sincerity, and unconditional positive regard to support self-exploration and personal growth.
- **Adlerian Therapy,** which explores early experiences, social context, and the development of purpose, connection, and belonging.
- **Solution-Focused Therapy**, which emphasizes strengths and supports clients in creating realistic, goal-oriented steps toward change.

I also incorporate complementary techniques from **Cognitive Behavioral Therapy (CBT), Narrative Therapy, Gestalt Therapy, Existential Therapy, Mindfulness-Based Practices, Acceptance and Commitment Therapy (ACT), and Trauma-Informed Care** when clinically appropriate. These approaches may be used to support concerns related to anxiety, depression, trauma, grief and loss, identity development, life transitions, self-esteem, emotional regulation, and stress management. Together, we will explore what healing and growth look like for you while developing an individualized plan that supports your therapeutic goals.

Benefits and Risks: Therapy has both benefits and risks. You might notice changes in your symptoms, issues, and functioning throughout our sessions. As we explore challenging areas in your life, you might experience difficulty throughout our work. Therapy typically helps ease or heal one's issue over time, but occasionally, as you get to the root of tender issues, you may feel them even more during or after sessions than you did in the past. I cannot offer any promises or guarantee an outcome from this experience. However, as you commit to working through your vulnerabilities and building on your strengths, you will likely see improvements throughout our work and in the future.

Client's Rights and Responsibilities: Clients have the right to choose a therapist who best suits their needs and purposes. You may ask questions about treatment at any time and may choose to terminate therapy at any time. Therapy may also end when I feel another provider will better meet your needs, or in the event you are not attending and engaging in treatment to promote growth. In that case, I will make appropriate referrals. If you have any concerns or complaints, you may contact:

Michigan Department of Licensing and Regulatory Affairs (LARA)
Bureau of Professional Licensing
Investigations & Inspections Division

P.O. Box 30670
Lansing, MI 48909
(517) 241-0205

Clients also have the right to be informed of the cost of my service before receiving the service; to be assured of privacy and confidentiality while receiving services from me, and to be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

Initial Intake Sessions: The first session for all new clients is considered an intake session. Intake sessions must be 50 minutes or longer to allow time for gathering clinical history, assessment, treatment planning, review of informed consent, and completion of required documentation. Intake fees may differ from ongoing session fees based on the type of service provided. Individual and couples intake rates are listed below. Group intake fees may vary depending on the group's structure, length, and purpose, and will be discussed before enrollment.

Financial Responsibilities: Ginger's Grace Therapy currently accepts only private-pay clients for services in Michigan. At this time, insurance is not billed for the Michigan location. Payment is due at the time of service and must be submitted before the session begins.

Private pay rates are listed in the fee table below and may vary by type and length of service.

Service Type	Session Length	Fee
Individual Intake	50+ Minutes	$75
Individual Therapy	30 Minutes	$35
Individual Therapy	50+ Minutes	$75
Couples Intake	50+ Minutes	$80
Couples Therapy	30 Minutes	$45
Couples Therapy	50 + Minutes	$80
Group Counseling Intake	Varies by group	Fee discussed before enrollment
Group Counseling	Varies by group	Fee discussed before enrollment

Group counseling fees may vary depending on the length, structure, number of weeks, and size of the group size. Group fees will be discussed before enrollment, and clients will be informed of the total cost before committing to the group.

If you are unable to pay the associated fee at the time of service, please discuss this with me before your scheduled session. Future appointments may be postponed until any outstanding

balances are resolved or a payment arrangement has been discussed and agreed upon. Additional fees may apply for requested letters, documentation, forms, copying, mailing, or record preparation. Any applicable fees will be discussed with you at the time of the request.

Your appointment time is reserved specifically for you. A minimum of 24-hour notice is required to reschedule or cancel without a fee. A late-cancellation or no-show fee may be charged for cancellations made with less than 24 hours' notice or for missed appointments. This fee is assessed at my discretion.

*** Sessions may be marked as canceled if the client is not present within 10 minutes of the scheduled start time, unless otherwise discussed with the therapist before the session begins.**

For group counseling services, sessions may be canceled, rescheduled, or adjusted if attendance falls below the minimum needed to support a meaningful and effective group process. Because groups are closed and structured around a specific number of participants, attendance requirements may vary by group size and purpose. In general, if attendance is too low to maintain appropriate group engagement, therapeutic benefit, and discussion flow, the session may not move forward as scheduled. Clients will be informed of any group-specific attendance expectations, cancellation policies, and payment responsibilities before enrollment.

Quarterly Grace Cancellation Policy: Clients are allowed one courtesy late-cancellation or missed-session-fee waiver per calendar quarter. Quarters run January–March, April–June, July–September, and October–December. This courtesy waiver resets at the beginning of each new quarter and does not roll over. Any additional late cancellations, missed appointments, or no-shows within the same quarter WILL BE subject to the standard cancellation fee on file.

Services: I see clients aged 18-65. I may provide limited administrative and supportive documentation services, including, but not limited to, paperwork for disability, unemployment, custody, adoption, foster care, car accidents, and any other legal issues. The fee varies based on the quantity and the time required to complete the documentation. I DO NOT offer therapy for individuals who are court-mandated for treatment or seeking treatment in which disclosure of appointments will need to be provided to an outside entity.

Virtual Sessions: I _____ (client's name) hereby consent to engage in telehealth services. I understand that "telehealth" includes the practice of healthcare delivery, diagnosis, assessment, and treatment consultation using interactive video, audio, and/or electronic communications. Telehealth sessions will be conducted through a secure, encrypted, HIPAA-compliant platform. It is my responsibility to choose a private and secure location for sessions and to understand that, despite reasonable safeguards, technology-assisted communication poses potential risks to confidentiality. I understand that family members, employers, co-workers, or unauthorized individuals could potentially overhear or access communications if I do not utilize a secure environment.

Additionally, I agree **NOT** to record any Telehealth sessions. In the event of a technological disruption during a session, the most reliable backup method of communication will be telephone contact. I will ensure that I maintain a current telephone number on file and have access to my phone during telehealth sessions. I understand that I remain financially responsible for all services rendered, including late cancellations, missed appointments, and no-show fees.

Client Name: _____

Client Date of Birth: _____

(*If the patient is unable to consent)

Signing on behalf of: _____

Relationship to Client: _____

Print Name: _____

Signature Responsible Party: _____

Artificial Intelligence and AI-Assisted Documentation: Artificial Intelligence (AI) tools and HIPAA-compliant electronic health record platforms may be used to support clinical documentation, treatment planning, note completion, and other administrative aspects of the therapeutic process. To improve documentation accuracy and efficiency, telehealth sessions may use AI-assisted documentation technology through a secure, HIPAA-compliant platform, such as Healthie, which utilizes AI Scribe to support clinical documentation and session note completion. Information generated through these tools is securely maintained in accordance with HIPAA privacy and security standards and is used solely for therapeutic, documentation, and treatment-related purposes.

Your privacy and confidentiality remain of the utmost importance throughout the therapeutic process. AI-assisted tools are intended to support clinical workflow and documentation and do not replace professional clinical judgment, decision-making, or therapeutic care. Information will not be released or shared without written authorization unless otherwise required by law.

I have read and understood the above information and consent to the use of AI-assisted tools and HIPAA-compliant documentation platforms in my therapeutic services. I understand that my consent is voluntary and that I may discuss any questions or concerns regarding these practices at any time.

Client Name: _____

Client Date of Birth: _____

(*If the patient is unable to consent)

Signing on behalf of: _____

Relationship to Client: _____

Print Name: _____

Signature Responsible Party: _____

Assessment and Diagnostic Review: To support quality care and monitor treatment progress, clients may be asked to complete brief symptom assessments, diagnostic review forms, intake questionnaires, or treatment progress measures through a secure, HIPAA-compliant client platform, such as Healthie, approximately once per quarter or when clinically appropriate. Clients may receive email or portal notifications with instructions for completing assessments and related clinical forms. These assessments may include questions related to mood, anxiety, functioning, treatment goals, emotional wellness, or DSM-5 diagnostic criteria when clinically appropriate. The purpose of these reviews is to monitor progress over time, provide clients with meaningful insight into their growth, identify areas that may require additional support, and thoughtfully and collaboratively guide ongoing treatment planning.

Emergencies: As a private practicing clinician, I DO NOT offer crisis services. If you are experiencing an emergency or a threat to yourself or others, please call 988 or go to the nearest hospital emergency room. You may call 1.866.4CRISIS (1.866.427.4747) for urgent mental health crises.

Social Media and Electronic Communication Policy: I DO NOT offer therapy via email or text for any reason. If you are experiencing a crisis, please refer to this disclosure statement's (emergencies) section. I only accept calls for appointment cancellations or if our session connection is disrupted. You will be able to access your appointment time through your client portal. If you attempt to contact me on social media, I will decline or reject your request. Please understand that social media engagement is prohibited for my privacy and personal safety. I will not engage in your social media accounts as the client. If I see you in a public setting, I will not contact you to protect your privacy and confidentiality.

Outstanding Balances and Collections: Clients are responsible for maintaining payment for all services rendered. Payment is expected at the time of service unless another written payment arrangement has been approved. If a client's unpaid balance reaches or exceeds $300.00, Ginger's Grace Therapy Company PLLC reserves the right to pause or discontinue future services until the balance is paid in full or an approved payment arrangement has been established.

Reasonable efforts will be made to notify the client of the outstanding balance via invoices, portal reminders, email, and/or written notice. If services are paused or discontinued due to nonpayment, the therapist will make reasonable efforts to provide appropriate notice, referrals, or transition resources when clinically necessary. Services will not be abruptly discontinued if the client is in immediate crisis or at risk of harm.

Balances that remain unpaid for up to six months without payment, communication, or an approved payment plan may be referred to a third-party collections agency. If this occurs, only the minimum necessary identifying and billing information will be disclosed for collection purposes. Referral to collections may negatively impact the client's credit history. Clients are encouraged to keep their contact and billing information up to date to avoid missed notices about outstanding balances.

I acknowledge that I am financially responsible for all charges related to services provided by Elizabeth R. Jones at GINGER'S GRACE THERAPY COMPANY, PLLC, including session fees, missed appointments, late cancellations, administrative fees, or outstanding balances. Payment is expected at the time of service unless otherwise discussed. If it becomes necessary to effect collections of any amount owed, the undersigned understands that collection efforts may occur and that reasonable collection-related costs may apply as permitted by law.

Signature of Financially Responsible Party: _____

Relationship to Client: _____

Date: _____

Confidentiality and Access to Records: All information disclosed within sessions is confidential. It will not be disclosed to anyone without your written permission unless disclosure is required by law or necessary to protect you or others from harm. Clinical documentation, assessments, and therapy records are securely maintained through a HIPAA-compliant electronic health record platform. You have the right to request access to your medical records in accordance with applicable laws and professional standards. Requests for records, forms, letters, or additional administrative documentation may result in additional fees when applicable.

My signature below is an acknowledgment that I am the client or the person authorized to consent to mental health treatment for the client, and that I consent to services provided by Elizabeth R. Jones, M.Ed., LLPC, NCC, through GINGER'S GRACE THERAPY COMPANY, PLLC. I have read and understood the disclosure information and have received a copy of this disclosure form.

Client Name: _____

Client Date of Birth: _____

(*If the patient is unable to consent)

Signing on behalf of: _____

Relationship to Client: _____

Print Name: _____

Signature Responsible Party: _____