

Renée G. Miller, PsyD, MFT, Inc.
Licensed Marriage and Family Therapist

Journey Coaching and Counseling Services
18023 Sky Park Circle, Ste. G
Irvine, Ca 92614
Phone: (714) 296-8052
Fax: (949) 474-2184

COACHING AND COUNSELING SERVICES CONTRACT

This document contains important information about my professional services and business policies. Please read it carefully and note any questions you may have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

COACHING AND COUNSELING SERVICES

Coaching and Counseling are not easily described in general statements. They vary, depending on the personalities of the counselor and the client, and the particular problems you want to address in session. Your feelings about the coaching and counseling experience and your counselor are very important. I encourage you to discuss any questions, confusion, or frustrations you experience so that they do not become obstacles to your treatment. I believe you are the best authority on whether or not a treatment relationship will be helpful.

Our first few sessions will involve an evaluation of your needs and problems. By the end of the evaluation, I will be able to offer you some first impressions as to why you are experiencing the problems you have presented and what treatment I would recommend, if you decide to continue working with me as your coach and counselor. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have doubts about continuing, I will be happy to offer you a referral for another mental health professional.

Initial _____

BENEFITS and RISKS

This section includes a discussion about the benefits and risks of coaching and counseling.

The ***benefits*** may include reduced stress and anxiety, a decrease in negative thoughts and self-defeating behaviors, improved relationships, increased comfort in social, school and/or family settings, increased self-confidence, and a more hopeful attitude towards life.

The ***risks*** may include recalling or recounting painful memories and experiences, discomfort in analyzing current distress and problems, and the possibility of experiencing strong feelings of sadness, anger, fear or other difficult emotions. As your coach and counselor, I may from time to time challenge your assumptions or perceptions and offer a different perspective.

Changes in your perspective, thoughts or feelings may have unintended outcomes, including changes in personal relationships. During the course of therapy, it is often the case that you will feel worse before you feel better; this is natural and expected in any healing process.

Personal growth is sometimes difficult and slow, and sometimes easy and swift. When we sign this agreement together, I commit to helping you through the entire process of counseling. This will mean helping you to achieve the goals you initially state, but other issues or problems may arise during the course of our work together that will require further exploration and analysis. If this happens, we will work together to revise the goals as appropriate and work towards a satisfactory solution of your problems.

There is no guarantee that counseling will yield any or all of the benefits listed above. Neither is there any certainty that the risks listed above will be encountered during the course of our work together. Counseling is an open and dynamic process, and its course is dependent upon our mutual willingness to collaboratively continue the process and, to a certain extent, upon life events that cannot be foreseen.

Initial _____

CONFIDENTIALITY

In general, the privacy of all communication between a client and a counselor is protected by law and I can only release information about our work to others with your written permission. However, there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child or an elderly or disabled person is being abused, I am required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim(s), contacting the police, or seeking hospitalization for the client. If the client threatens harm to him/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have occurred from time to time in my practice. If a similar situation occurs, I will make every effort to discuss it with you before taking any action.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. You will also be provided with a copy of my HIPPA Privacy Practice for your information, which includes a more comprehensive explanation of how and when your private information may be used.

Initial _____

APPOINTMENTS AND CANCELLATIONS

Coaching/Counseling sessions last 50 minutes and are typically scheduled weekly. Appointments must be made in advance.

If you are unable to keep your scheduled appointment, I ask that you provide at least 24 hours notice. Once an appointment hour is set, this time is set aside for you, and thus, you will be expected to pay the full session fee unless you provide advance notice of cancellation.

Initial _____

PROFESSIONAL FEES

My standard fee is \$125 per 50-minute session.

In addition to appointments, I charge \$150 per hour for other professional services you may need, although I will prorate the hourly fee if I work for periods less than one hour. Payment for these services will be due at the time of billing. Other services include report writing, telephone consultations 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. If you become involved in legal proceedings that require my participation, you will be billed for the time I participate on your behalf.

Initial _____

BILLING AND PAYMENTS

Payment is expected at the time of each session, unless we agree otherwise. In certain circumstances of unusual financial hardship, I may be willing to offer a payment plan option. You will be responsible for all fees connected with my professional services due at the time of services or at termination, until all fees are paid. Unpaid fees may be subject to legal action or referral to a collection agency.

I utilize Therapy Partner, an online billing system that allows me to accept checks, cash, and **Visa/Mastercard/AMEX/Discover** Cards. An Electronic Payment Authorization form is included with this orientation packet along with an explanation of how your payments will be handled. Please complete this form today and include it with this contract. This billing system provides monthly email statements. If you would like to receive this statement, please also include your email address and you will receive a monthly statement on the 5th of each month from Therapy Partner.

Initial _____

INSURANCE REIMBURSEMENT

My wish is to dedicate my time and efforts in meeting your coaching and counseling goals. For this reason and due to the complexities of managed care, with excessive paperwork and third party decision-makers, I prefer not to subscribe to any HMO or PPO insurance panels or in any government or state run programs.

However, if you have PPO health insurance that covers mental health services provided by ***Out-of-Network Providers***, I can print an insurance ready statement at the time service is rendered or you can submit the monthly statement you will receive via email. You may use this statement to seek direct reimbursement from your insurance company. In some cases, I may be willing to submit claim forms for direct reimbursement to me. However, please understand that you are responsible for payment of services, whether or not your insurance company reimburses either of us for services rendered, in whole or in part.

Please note, in the event that I submit claim forms to your insurance for direct reimbursement to me and they forward the payment to you, I will debit your account on file for the amount of the insurance check paid to you. In most cases, insurance companies submit payment to the “billing party.” However, sometimes due to plan restrictions, they will only submit payment directly to the insured, even though the payment is due to the provider.

Please also note that mental health insurance plans are often limited to short-term treatment approaches and may require updates from me in order to continue approving a few sessions at a time. These often have a calendar year maximum, usually around 20 visits.

You should also be aware that most insurance companies will only approve mental health services for individuals with a mental disorder diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries of the work we are doing in session. This information will become part of the insurance company’s file, your medical history file, and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with this information once it is in their hands. I will provide you with a copy of any report I submit, if you request it.

Initial _____

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Signature or Guardian if Client is a Minor

Date

Revisions to above agreement:

I agree to revise the above agreement as follows:

Renée G. Miller, PsyD, MFT

Date

I agree to the revision(s) noted above.

Client Signature or Guardian if Client is a Minor

Date

Release of Authorization to Exchange or Release Information

I authorize Dr. Renee Miller to exchange or release information with the following persons, providers, or agencies, for the purposes indicated:

This authorization will be in effect until _____,
unless revoked by me in writing.

Client Signature or Guardian if Client is a Minor

Date



ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information and return this form to your provider. Session fees for all clinical treatment will be deducted from the account designated on this form. Forms of payment accepted: Visa, MasterCard, Discover, American Express, and cash. This form will be securely stored in your clinical file and may be updated upon request at any time.

CLIENT INFORMATION:

Client Name: _____ **DOB:** _____

Responsible Billing Party Name (as shown on Credit Card/Account): _____

Billing Address (as registered with Credit Card Company/Bank):

Mobile Number: _____ **Home Phone Number:** _____

Email: _____

Please note that we will NEVER share your email information with outside parties other than Therapy Partner for the sole purpose of sending automatic statements each month.

FORM OF PAYMENT:

Check One: Credit/Debit Card: _____ Cash _____ Check _____

ACCOUNT INFORMATION:

Card Type (Visa, MasterCard, or Discover): _____

Card#: _____ **Expiration Date:** _____

Three Digit Card Code (Located on Back of Card): _____

Client Signature

Date

Journey Coaching and Counseling Services HIPAA Privacy Practices

We have been, and always will be, totally committed to maintaining your confidentiality. We will only release information about you in accordance with HIPAA policies, state and local laws.

Treatment: Your mental health information may be disclosed to other health care professionals for the purpose of providing treatment.

Our duties as your counselor: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are required to abide by the privacy policies and practices that are outlined in this notice.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Law Enforcement: In the event of reported violence or life-threatening dangers, your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Other uses and disclosures that require your authorization: Disclosure of your mental health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you must submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual rights: You have certain rights under the federal privacy standards.

These rights include, but are not limited to:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Request to inspect protected health information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting us during normal business hours. Your request may or may not be granted, depending upon the reasoning for disclosure.

Contact person: You may contact us for further information concerning our privacy practices.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our office. If you believe that your privacy rights have been violated, you should send a letter describing the cause of your concern to our office. You will not be penalized or otherwise retaliated against for filing a complaint.

Dr. Miller will provide a copy of her HIPAA practices upon request.

If you have any questions or concerns regarding this policy, please discuss them with Dr. Miller.

Please initial here, indicating you have read and understand this policy.

| | |
|--|---|
| | WORK RELATED PROBS: |
| | DRUG, ETOH, TOBACCO USE/ABUSE HX: |
| | SURGERIES AND/OR MAJOR ILLNESSES: |
| | HX OF HEAD TRAUMA? DESCRIBE: |
| | RX: |
| | LEGAL ISSUES? |
| | FAMILY HX OF MENTAL HEALTH: |
| | PERSONAL HX OF MENTAL HEALTH: |
| | PRIOR PSYCHOTHERAPY EXPERIENCES: |
| | S/I: H/I: |
| | HX OF PRESENTING ILLNESS: |
| | MSE: |
| | DIAGNOSIS AXIS I: AXIS II: AXIS III: AXIS IV: AXIS V: CURRENT: HIGHEST LAST YEAR: |
| | TREATMENT PLAN: |
| | OTHER COMMENTS: |
| | RENEE MILLER, PSYD, MFT |

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| <input type="checkbox"/> PICA | | | | | | | | | | <input type="checkbox"/> PICA | | | | | | | | | |
| 1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/> | | | | | | | | | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY | | | | | SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | |
| 5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | | | | 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 10. IS PATIENT'S CONDITION RELATED TO: | | | | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | | | | | | a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) | | | | | a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> | | | | |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | | | | | | | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | b. EMPLOYER'S NAME OR SCHOOL NAME | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | 10d. RESERVED FOR LOCAL USE | | | | | | | | | |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>if yes, return to and complete item 9 a-d.</i> | | | | | | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | | | | | | | | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | | | | | | | | | 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | | | | | | | | | |
| SIGNED DATE | | | | | | | | | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | | | | | | 17a. NPI | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | |
| 19. RESERVED FOR LOCAL USE | | | | | | | | | | 17b. NPI | | | | | 20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) | | | | | | | | | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM I. ID. QUAL. J. RENDERING PROVIDER ID. # | | | | | | | | | | 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | 26. PATIENT'S ACCOUNT NO. | | | | | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$ | | | | |
| SIGNED DATE | | | | | | | | | | a. NPI b. | | | | | a. NPI b. | | | | |

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION