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

Mark McVicker, MFTI
Phone: 714-292-0585

Under the Supervision of
Renee Miller, PsyD, MFT
714-296-8052

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.

SERVICES PROVIDED BY A MARRIAGE AND FAMILY INTERN

As a Marriage and Family Intern, I am under the supervision of a Licensed Mental Health Professional, whose name and phone number is noted above. I am provided with regular supervision, at which time I may discuss your case to ensure that your treatment plan is appropriate. At some point, my supervisor may require audio- or video-taping of a session. Prior to this occurring, we will discuss any questions or concerns you may have with this process. The recording created from this session will only be viewed during supervision and will be immediately destroyed thereafter. Please note that the recording will be securely stored until reviewed and destroyed by my supervisor.

Taping of sessions is helpful as it allows my supervisor to “look into” a session without sitting in on it so that he or she may provide further training as needed.

If you have any questions or concerns about your treatment with me, I encourage you to discuss them with me. If you feel that I have been unable to adequately address your questions or concerns, you may contact my supervisor directly to discuss them further.

Also, in the event of an emergency or unexpected absence, you may be contacted by my supervisor if the situation requires such communication.

Initial _____

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 HIPAA 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 on a weekly basis. 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 (or as close to that as possible). 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 $_____ per 50-minute session.

In addition to appointments, I charge $_____ 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 an online billing system that allows me to accept electronic checks, cash, and **Visa/Mastercard/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.

If you would like a Monthly Statement of Charges and Payments, please also include your email address and one will be sent on the 5th of each month from Therapy Partner, our payment processing system.

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. Also, many mental health insurance plans do not typically cover services provided by registered clinical interns.

If you have PPO health insurance that covers mental health services provided by ***Out-of-Network Providers***, and you would like to seek reimbursement from them, I can print an insurance ready statement for you.

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 you for services rendered, in whole or in part.

Also, mental health 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.

Should your insurance cover services provided by me, you should also be aware that most insurance companies will only approve mental health services for individuals with a mental disorder diagnosis. I may 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:

_____ _____

Counselor Signature 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 Journey Coaching and Counseling Services and its employees 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:_____

***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.

_____

INTAKE INFORMATION

Intake Date	**NAME:** **ADDRESS:** **HOME PHONE:** **CELL PHONE:** **WORK PHONE:** **EMERGENCY CONTACT NAME AND PHONE:**
	DOB: **AGE:** **ETHNICITY:**
	EDUCATION:
	MARITAL STATUS: **NO OF YEARS IN RELX:**
	QUALITY OF RELATIONSHIP:
	NO/AGE OF CHILDREN:
	Who may I thank for referring you to this office? **Name:** **Address:** **Other referral source:**
	FOR PROVIDER USE ONLY
	FAMILY OF ORIGIN STATUS:
	PRIMARY CAREGIVER AS A CHILD: BIRTHORDER:
	CHILDHOOD HX:
	ABUSE HX:
	OCCUPATION: YRS AT CURRENT JOB:

	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:
	Therapist: