HEALING WITH GRACE COUNSELING CENTER

Client Information

Name _____ Date _____

Gender _____ Date of Birth _____ Age _____ Marital Status _____

Address _____

City _____ State _____ Zip _____ Phone _____

Email _____ Referred By/Website _____

Highest Level of Education _____ Occupation _____ Sliding scale/Income _____

Emergency Contact Name _____ Number _____ Relationship _____

Second Party Information (Spouse, Significant Other, Parent, Legal Guardian Etc.)

Name _____ Date _____

Gender _____ Date of Birth _____ Age _____ Marital Status _____

Address _____

City _____ State _____ Zip _____ Phone _____

Email _____ Referred By/Website _____

Highest Level of Education _____ Occupation _____ Sliding scale/Income _____

Emergency Contact Name _____ Number _____ Relationship _____

Payment Information (Credit Card)

Name as it appears on card _____ Zip code (billing address) _____

Credit Card number _____ Exp Date _____/_____ Vcode _____

Your card will automatically be billed for each session & for cancellation fees (without 24-hour notice). Sign to accept:

Signature _____ Date _____

Background Information on Immediate Family Members (use back of sheet if space is needed)

Name	Relationship	Age	Living In Home Y/N

Have you had any treatment with a coach or therapist in the past? ☐ Yes ☐ No

If yes, name of psychiatrist/therapist/practitioner _____ Was it helpful? ☐ Yes ☐ No

Current Prescriptions/Medications _____

Religious Affiliations or Church _____

Do you want Spiritual/religious issues to be a part of your coaching? ☐ Yes ☐ No

Are you currently at risk of harming yourself or someone else? ☐ Yes ☐ No ☐ Unsure

Have you attempted to harm yourself in the past? (Please list dates) _____

Following is a list of common obstacles that often lead people to seek counseling. Please check all that apply:

___Anxiety	___Communication	___Self Esteem	___Depression
___Addiction	___Grief	___Eating Problems	___Insomnia
___Alcohol	___Drugs	___Weight	___Stress
___Smoking	___Gambling	___Work Problems	___Shyness
___Relationships	___Sexuality	___Panic Attacks	___Guilt
___Phobia (Please List)	___Abuse	___Trauma	___Anger
___Suicide Attempts	___Suicidal Thoughts	___Self-Harm (Cutting)	___Pain
___Low Motivation	___Sexual Problems	___Social Withdrawal	___School

Is there a family history of any of the following? Please list family member in space provided (grandparent, father, sister, etc.)

_____Alcoholism _____Drug Use _____Depression _____Anxiety

_____Suicide _____Attempted Suicide _____Medical Problems _____Psychosis

_____OCD _____ Eating Disorder _____Domestic Violence _____Abuse

In the past 2 weeks have you engaged in any of the following?

___Alcohol Frequency_____ Your strengths _____

___Marijuana Frequency_____ Your weakness _____

___Drugs Frequency_____ Your pets & names _____

___Other _____ Frequency_____ Your hobbies _____

Explain how you cope with stress _____

What do you like to do with your free time? _____

Are you currently in a romantic relationship? _____ If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____ If there are areas in your relationship you would like to improve, what are they?_____

What stressful life events have your experienced recently? _____

_____

Is there anything else that you feel is important for me to know? _____

_____

HEALING WITH GRACE COUNSELING CENTER

Client and Coach Agreement

The Relationship

My perspective as coach is that I believe you are the expert in your life/work and that you are creative, resourceful and whole. Therefore, as a coach, my responsibility is to:

- ➢ Discover, clarify and align with what you want to achieve
- ➢ Encourage self-discovery, breakthroughs and eliminating negative emotions or states
- ➢ Elicit client-centered solutions, tools, tips and strategies
- ➢ Provide an accountability partner for action
- ➢ Set goals and break them down into steps

Your responsibility as a coaching client is to:

- ➢ Commit to focusing on specific area(s) of your life/work that you desire to deepen or change
- ➢ Submit to the process by being candid and honest
- ➢ Develop specific action steps to address the issue/objective
- ➢ Follow through on agreed action steps

General Principles

- An agreement for payment for services, will be established prior to the commencement of the relationship. Form of payment, procedures for canceled appointments, and initial length of commitment will also be stipulated.
- Coaching is a confidential relationship. Be assured that I will keep all information strictly confidential, except in those situations where such confidentiality would violate the law.
- Coaching assumes that each person in the relationship is guided by his or her values and beliefs – e.g. Christianity, Buddhism, Hindu, Jewish, etc. In making this disclosure, I am seeking to be open and honest and do pledge to respect the different values and beliefs of others. I will not seek to impose my values on another, proselytize, condemn, or refuse coaching services to people who do not share similar values and beliefs.

The Agreement

1. As a client, I understand and agree that I am fully responsible for my physical, mental and emotional well-being during my coaching calls/sessions, including my choices and decisions.
2. I understand that "coaching" is a Professional-Client relationship I have with my coach that is designed to facilitate the creation/development of personal, professional or business goals and to develop and carry out a strategy/plan for achieving those goals.
3. I understand that coaching is a comprehensive process that may involve all areas of my life, including work, finances, health, relationships, education and recreation. I acknowledge that deciding how to handle these issues, incorporate coaching into those areas, and implement my choices is exclusively my responsibility.
4. I understand that coaching does not involve the diagnosis or treatment of mental disorders as defined by the American Psychiatric Association. I understand that coaching is not a substitute for counseling, psychotherapy, psychoanalysis, mental health care or substance abuse treatment and I will not use it in place of any form of diagnosis, treatment or therapy.
5. I promise that if I am currently in therapy or otherwise under the care of a mental health professional, that I have consulted with the mental health care provider regarding the advisability of working with a coach and that this person is aware of my decision to proceed with the coaching relationship.
6. I understand that certain topics may be anonymously and hypothetically shared with other coaching professionals for training OR consultation purposes.
7. I understand that coaching is not to be used as a substitute for professional advice by legal, medical, financial, business, spiritual or other qualified professionals. I will seek independent professional guidance for legal, medical, financial, business, spiritual or other matters. I understand that all decisions in these areas are exclusively mine and I acknowledge that my decisions and my actions regarding them are my sole responsibility.

_____Initials

<u>Confidentiality</u>

Any information obtained in the coaching setting cannot be released without your prior written consent except in the following situations according to Nevada State Regulations and HWGCC regulations:

a. Cases of suspected child or elder abuse or neglect.
b. Cases of potential harm to self or others or a need for immediate hospitalization – medical/mental health concerns
c. Cases of legal claims or defense required by state of federal law or court ordered by a judge.
d. Cases under investigation by a board of examiners as part of an investigation or hearing.
e. If you are under the age of 18 in the State of Nevada, parents have access to information in regard to their child's medical records.
f. HWGCC's clinical director and administration, along with clinical supervisors, have access to information for supervision of interns and administrative purposes.

It is Healing with Grace Counseling Center's and my coach's policy to maintain confidentiality throughout the coaching process; therefore, my coach will not acknowledge any clients in a public area unless first approached by client.

_____Initials

HEALING WITH GRACE COUNSELING CENTER

Fees and Cancellation Policy
Sessions are normally 55 minutes long. The charge per session is the agreed upon price of _____ is due at the time of service. Fees can be paid by cash, check or major credit card. Please give a 24-hour cancellation notice to avoid a session fee for the missed appointment and to allow others to receive help in your place. Returned checks will incur a $30 fee per occurrence.

_____Initials

Emergencies
I understand that my coach is not a 24-hour crisis intervention provider. If I am faced with a mental health emergency, I agree to call 911 or go to my local emergency room.

_____Initials

Security
I understand that there are cameras facing the front and back doors to the center for surveillance for client and staff protection.

_____Initials

Court Appearances
I understand that my coach will not appear in court unless mandated by the court. If a coach has to appear in court, they will be compensated for the court appearance, travel time, and preparation time which will be agreed upon ahead of time.

_____Initials

Documents and Letters
I understand there is an hourly fee of $75, with a minimum charge of one hour per request, for documents, letters or reports that I require from my coach. Your coach requires 10 business days' notice with a prepayment of fee. Prepayments are non-refundable and are valid for one (1) calendar year from date of payment.

_____Initials

Insurance
I understand that Healing with Grace Counseling Center and my coach does not accept insurance.

_____Initials

Telecoaching (Initial if this form of coaching may be utilized)
Though I do my best to protect your confidentiality of electronic messages, please note that I cannot guarantee confidentiality under circumstances that include use of Internet services (Doxy.Me, VSee, Skype, Facetime, etc.), cellular phone or text messages.
I understand that using this medium of telecoaching is not entirely secure. I will not hold Healing with Grace Counseling Center nor my coach responsible should there be a breach in security on the Internet or phone. I understand that I am responsible for information security on my computer. _____Initials

I understand telecoaching services are not appropriate treatment modality for everyone and should not continue if my coach and I feel it is counter-productive. My coach will suggest other options if needed. I understand that fees and cancellation policy is the same in telecoaching as in-person coaching. _____Initials

Electronic Communications
I authorize Healing with Grace Counseling Center and my coach to send emails and/or text messages regarding appointments.

_____Initials

I have read and fully understand the nature and limits of the above statements and agree to participate in counseling under these conditions.

Signature_____ Date_____

HIPPA Privacy Statement

I. Uses and Disclosure for Treatment, Payment, and Health Care Operations

Healing with Grace Counseling Center may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. We are required by law to maintain the privacy of health information and to provide you with our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the Revised Notice of Privacy Practices by sending you a copy in the mail upon request at your next appointment.

II. Uses and Disclosures Requiring Authorization
We may use of disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing psychotherapy notes. “Psychotherapy notes” are notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent Nor Authorization.
We may use of disclose PHI without your consent or authorization in the following circumstances: (1) Child Abuse/Neglect; (2) Elder Abuse/Neglect; (3) Health Oversight (Nevada Licensing Board requesting records); (4) Judicial or Administrative Proceedings (Judge Court Order); (5) Serious Threat to Health or Safety to self or others; (6) Workers Compensation (if you file a claim)

Client Printed Name: _____

Signature: _____

(If a child or adolescent under age 18, parent or legal guardian must sign)

HEALING WITH GRACE COUNSELING CENTER

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This informed consent document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

DECISION TO MEET FACE-TO-FACE

We have agreed to meet in-person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision as long as it is feasible and clinically appropriate.

RISKS OF OPTING FOR IN-PERSON SERVICES

By coming to the office, you are assuming the risk of exposure to COVID-19 (or other public health risks). This risk may increase if you travel by public transportation, cab, or ridesharing services.

YOUR RESPONSIBILITY TO MINIMIZE EXPOSURE

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our families, other therapists/practitioners in the office and other clients) safe from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting/returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- I will only keep my in-person appointment if I am symptom free.
- I will take my temperature before coming to each appointment. If it is elevated (100 m Fahrenheit or more), or if I have other symptoms of COVID-19, I agree to cancel the appointment or proceed using telehealth. If I cancel for this reason, my therapist or practitioner will not charge me the normal cancellation fee.
- I will wait in my car or outside Healing with Grace Counseling Center until no earlier than 5 minutes before our appointment time, unless your therapist/practitioner instructs you otherwise.
- I will wash my hands or use alcohol-based hand sanitizer when I enter the lobby of Healing with Grace Counseling Center.
- I will adhere to safe distancing precautions that are set up in the lobby and therapy rooms. For example, I will not move the furniture from its current layout.
- I will keep a distance of 6 feet from others and there will be no physical contact (e.g. no shaking hands) with me or other people present in the office.

- I will try not to touch my face or eyes with my hands. If I do, I will immediately wash or sanitize my hands.
- If I bring my child, I will make sure that they follow all of these sanitation and distancing protocols.
- I will take preventative steps in-between appointments to minimize my exposure to COVID-19.
- If I have a job that exposes me to other people who are infected, I will immediately tell my therapist/practitioner.
- If I commute or partake in other responsibilities or activities that put myself in close contact with others (beyond my immediate family), I will let my therapist/practitioner know.
- If I travel out of the state of Nevada, I will let my therapist/practitioner know.
- If a resident in my home tests positive for COVID-19, I will immediately tell my therapist/practitioner and we will begin or resume treatment via telehealth.

By signing this document, you agree to the above precautions. Your therapist/practitioner and/or Healing with Grace Counseling Center may change the above precautions if additional local, state, federal orders or guidelines are published. If that happens, I will notify you of any changes.

MY COMMITMENT TO MINIMIZE EXPOSURE

Healing with Grace Counseling Center has taken steps to reduce the risk of spreading COVID-19 within the office. Please let me know if you have questions about these efforts.

IF YOU OR I ARE SICK

I am committed to keeping you, me, other therapists and practitioners in the office and all of our families safe from the spread of this virus. If you show up for an appointment and I, or other therapists/practitioners in the office believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I or other therapists/practitioners in the office test positive for COVID-19, I will notify you so that you can take appropriate precautions.

YOUR CONFIDENTIALITY IN THE CASE OF INFECTION

If you have tested positive for the COVID-19, we may be required to notify local health authorities that you have been in the office. We may also be required to notify local health authorities that you have been in the office if another person who has entered the office has tested positive. If we must report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. We will also inform you of our report.

Since there are multiple therapists and practitioners in the office, this information may be shared with the other therapists and practitioners to ensure their safety, the safety of their clients, and the safety of their families.

By initialing here, you agree with these limits to confidentiality for in-person sessions during Covid-19 Public Health Crisis: _____

INFORMED CONSENT

This agreement supplements the general informed consent that we agreed to at the start of our work together.

By signing below, you agree to all of the above conditions.

_____	_____
Written Name of Client	Date
_____	_____
Signature of Client	Date
_____	_____
Signature of Therapist	Date

RELEASE OF LIABILITY FOR COUNSELING SERVICES

FOR AND IN CONSIDERATION OF the receipt of information and counseling services from Robert Allen (name of therapist/practitioner) provided at ***Healing with Grace Counseling Center*** located at 2637 W. Horizon Ridge Suite 100, Henderson, NV 89052 (referred to as HWGCC hereafter), the undersigned, being legally competent and fully authorized and empowered to do so, does **hereby RELEASE, ACQUIT, AND FOREVER DISCHARGE HWGCC, ITS CLINCIAL DIRECTOR AND ALL PARTICIPATING COUNSELORS AND INDEPENDENT CONTRACTORS CONNECTED WITH HWGCC**, from any and all actions, courses of action, claims, demands, injuries, damages, costs, loss of service, expenses and compensation, on account of any and all known and unknown contracting of coronavirus, COVID-19 and/or any other virus/diseases related to the aforementioned "coronavirus" to any person or property resulting from or arising out of or related to counseling services and administrative services provided by HWGCC, its clinical director and/or independent contractors in any way affecting the undersigned parties from this date forward. The undersigned understands that by choosing to meet in-person for therapy at HWGCC's offices, when an alternative, free HIPAA compliant option for teletherapy has been offered to them, the undersigned understands that they are increasing their contact with others outside of their immediate household and increasing their risk of contracting COVID-19.

It is further understood and agreed that this waiver and release constitutes an admission and acknowledgment by this undersigned that they have received no warranty, guarantee, or promise that they are safe from contracting coronavirus and/or COVID-19 at HWGCC, the clinical director, its independent contractors or any other persons associated with HWGCC.

This release contains the entire agreement between the parties hereto, and the terms of this waiver and release are contractual and not mere recital. The undersigned further states they have carefully read the foregoing release, know the contents thereof, are fully competent, and sign the same as their own free act and deed.

_____ _____

Client's full written name Date

_____ _____

Client's signature Date