ANDREA TANG COUNSELING SERVICES, LLC
Taking Next Steps Together

260 NW Peacock Blvd. Suite 102 Port Saint Lucie, FL 34986 O: (772) 999-1438 F: (772) 361-6861 E: info@atangcounseling.com

Informed Consent for Coaching

I offer online individual and relationship coaching and consultation as a part of my practice. In deciding if these services could benefit you, it is important that you understand the differences between coaching, consultation, and therapy.

- Therapy occurs in my office in Port Saint Lucie, Florida or else online with clients on site at other locations where I am physically present.
- Consultation and coaching can both occur in my office, or online, regardless of where the clients reside.
- When doing therapy, I am obligated to make a diagnosis, develop a treatment plan, and share that with my client.
- Consultation and coaching do not involve mental health assessment, diagnosis, or treatment.

Coaching:

• When I serve as a coach, I work with individuals, couples, and relational systems. This may include providing information and resources, sharing of my expertise and experience, teaching and coaching of structured exercises and providing homework to support ongoing skill-building outside of our meetings. The goal of coaching is to help the client(s) identify their own goals and help them access the resources and skills they need to reach those goals. If at any time during coaching work I feel you would benefit from help beyond the scope of my coaching, I will refer you to the appropriate type of helping professional for additional support.

Therapy:

• When I serve as a therapist, I work with individuals, couples, and relational systems. In addition to coaching techniques, this also often includes deep work with family of origin issues, past trauma, and healing modalities for mental health concerns. If at any time during therapy I feel you would benefit from help beyond my scope of practice, I will refer you to the appropriate type of helping professional for additional support.

Online services:

- I have a HIPPAA compliant version of the Zoom videoconferencing software which is quite reliable and private. You will need to ensure your own privacy in your choice of location forour meetings. You will also need to download the free app, and a fast internet connection will be helpful. In case of technological problems, we can shift to the use of a telephone.

There are some significant advantages to working online:

- We can span great distances easily, including working with groups of people who are in remote locations from one another.
- You can choose the location of our meetings on your end, ensuring your comfort and privacy. Many people love the comfort of meeting in their own living room.
- Despite the screen between us, it can feel very closely connected. There isn't a room full of distractions, just a screen.

There are also some unique challenges related to meeting online:

- While I do use a HIPPAA compliant platform that has reliable functionality, there is always the risk of hacking on my end or on your end. While unlikely, it is important that you are aware of this risk.
- Our video connection depends on internet infrastructures far beyond my control or yours. I use a high-speed direct connection and can help you troubleshoot your connection, however there is always the possibility that there will be outages or other problems beyond our control.
- If the technology is cumbersome or insufficient, pleases be prepared to shift to phone for the remainder of the meeting. My personal cell is 808-330-5340; please keep it handy incase of a sudden need to shift to phone.
- Time zones can be very challenging. Please make sure you know how to access a world clock and figure out the correct time for our meeting. I'm in Eastern Standard Time, USA.

Limits to Confidentiality:

Information about coaching and therapy clients may be released to those outside of my practice only for any of the extremely rare following reasons:

- A completed Release of Information is authorized by the client(s) in writing
- A valid court order mandates the release of records
- The client poses a significant danger to themselves or others
- There is reason to believe that there has been abuse of a child, or of an elderly, vulnerable, or disabled person.

Consent:

- Please print a copy of this agreement, sign it, and return it to info@atangcounseling.com

- Coaching services cannot be started until the office receives a signed copy of these forms for all persons receiving coaching. *There is a separate Informed Consent that more thoroughly covers therapy clients.*

Signed _____ Date_____
Type of service you are receiving from Andrea Tang
Relationship Coaching

Signed _____ Date_____
Type of service you are receiving from Andrea Tang
Relationship Coaching

Therapist/Coach *Andrea Tang, EdS, LMHC, NCC* Date_____

* Every person 18 years of age and older who is receiving services by should sign this form.

ANDREA TANG
Relationship Coach

TODAY'S DATE: _____

NAME: _____ AGE: _____ DOB: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____

Can I leave a message (Y)____(N)____ Can I leave a message (Y)____(N)____

EMPLOYER: _____ WORK PHONE: _____

Can I leave a message (Y)____(N)____

SPOUSE/PARTNER NAME: _____ AGE: _____ DOB: _____

PARTNER CELL: _____ WORK PHONE:_____ EMPLOYER: _____

( ) SINGLE ( ) MARRIED/Partnered: HOW LONG?_____

( ) SEPARATED ( ) DIVORCED: HOW LONG?_____

( ) WIDOWED ( ) PREVIOUS MARRIAGES: HOW MANY?_____

PLEASE DESCRIBE ANY PRIOR THERAPY YOU HAVE RECEIVED. INCLUDE DATES, NAME(S) OF THERAPIST AND NATURE OF PROBLEM.

_____

_____

_____

_____

PLEASE DESCRIBE THE PRESENT PROBLEM:

_____

_____

_____

_____

PLEASE DESCRIBE ANY HEALTH PROBLEMS.

_____

_____

_____

_____

ARE YOU TAKING ANY MEDICATION? ( ) YES ( ) NO

Medications: _____

_____

_____

DO YOU HAVE TROUBLE SLEEPING ( ) YES ( ) NO

ARE YOU CURRENTLY BEING TREATED FOR ANY PHYSICAL OR PSYCHOLOGICAL ILLNESS? ( ) YES ( ) NO

DESCRIBE:

_____

_____

NAME OF PHYSICIAN(S)_____

NAME OF CURRENT INDIVIDUAL COUNSELOR: _____ PAST COUNSELOR? _____ WHEN? _____

FINANCIAL RESPONSIBILITY:

I HEREBY ACKNOWLEDGE FULL RESPONSIBILITY AT THE TIME OF SESSION FOR PAYMENT OF SERVICES RENDERED IRREGARDLESS OF INSURANCE COVERAGE.

CLIENT SIGNATURE(S)/DATE:

_____

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Credit Card Authorization Form

Please complete all fields so that we may run your card for your teletherapy services. This authorization will remain in effect until services terminate or authorization is revoked by notifying the office. You may cancel this authorization at any time by contacting Andrea Tang Counseling Services at 772-999-1438 or emailing tyoung@atangcounseling.com

Credit Card Information

Cardholder Name (as shown on card): _____

Card Number _____ **CVV** _____

Expiration Date (mm/yy): _____ **Billing Zip Code** _____

I, _____, authorize Andrea Tang Counseling Services, LLC to charge my credit card above for agreed upon session fees plus a 3% convenience fee. I understand that my information will be saved on file for future transactions on my account.

_____ _____

Client Signature Date

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I, _____ (Name) Date of Birth, _____

hereby give my permission to Andrea Tang Counseling Services, LLC to release or request from a third party, information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be Released/Requested upon request to the following: **(client to leave this blank)**

_____

____ Treatment Plans

____ Progress/Process Notes

____ Health / Medical Records (if applicable)

____ Letter(s) of Progress

____ Bio Psychosocial Evaluation / Assessment

____ Other (Specify):

(In the case of notes documenting or analyzing the contents of conversation during a private counseling session i.e., process notes, such records may be protected from disclosure under the HIPAA Privacy Rule).

_____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Andrea Tang Counseling Services, LLC.

_____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Andrea Tang Counseling Services, LLC will not base my treatment or payment whether I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524 (with reasonable charge).

_____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Andrea Tang Counseling Services, LLC. Andrea Tang Counseling Services, LLC will not be held liable for information disclosed to another party per the client's request.

_____ (initial) I understand that Andrea Tang Counseling Services, LLC will release only the minimum amount of information necessary to fulfill a request. This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/ declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death). This agreement is subject to revocation in writing at any time.

_____ _____ _____ _____

Signature Client/Next of Kin/Guardian Date Signature Therapist Date