ANDREA TANG COUNSELING SERVICES, LLC
Taking Next Steps Together

1555 NW Saint Lucie West Blvd. Suite 201 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 for our 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 number is 425-830-1025; keep it handy in case 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 Pacific 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 me electronically. Your coaching services cannot be started until I receive copies of these forms for all persons receiving coaching. I have a separate Informed Consent that more thoroughly covers therapy clients.

Signed_____Date_____
Type of service you are receiving from me
Relationship Coaching

Signed_____Date_____
Type of service you are receiving from me
Relationship Coaching

Therapist/Coach/Consultant Andrea Tang

Date _____

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

# ANDREA TANG

## Relationship Coach

TODAY'S DATE: _____

NAME_____

AGE_____BIRTHDATE_____

EMAIL_____

ADDRESS_____

CITY_____ZIP CODE_____

EMPLOYER_____

HOME PHONE_____Can I leave a message (Y)___(N) CELL

PHONE_____Can I leave a message (Y)___(N) WORK

PHONE_____Can I leave a message (Y)_(N)

( ) SINGLE

( ) SEPARATED

( ) WIDOWED

( ) MARRIED/Partnered: HOW LONG?_____

( ) DIVORCED: HOW LONG?_____

( ) PREVIOUS MARRIAGES: HOW MANY?_____

SPOUSE OR

PARTNER_____AGE_____BIRTHDATE_____

HOME PHONE:_____CELLPHONE:_____

WORK PHONE: _____

EMPLOYER_____

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**_____

**<u>FINANCIAL RESPONSIBILITY:</u>**

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

**CLIENT SIGNATURE:**

_____

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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 or as per my insurance cost-share. I understand that my information will be saved on file for future transactions on my account

_____ _____

Client Signature Date

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## Assignment of Benefits and Release of Information

I hereby authorize my insurance benefits to be paid directly to Andrea Tang Counseling Services, LLC. I understand that I am financially responsible for all co-pays, deductibles, and non-covered services. I authorize the release of any medical and mental health records necessary to process insurance claims on my behalf.

_____

**Client's/Patient's Name**

_____ _____

**Signature of Client/Patient/Responsible Party** **Date**

## Acknowledgment of Self-Pay Status

I have health insurance, but I do not want my health insurance billed and have elected to pay out of pocket at the rate set by Andrea Tang Counseling Services, LLC. By signing this, my mental health records and billing information **WILL NOT** be released to my health insurance plan for any reason unless I give written permission to do so. I understand that payment is due at the time of service.

_____

**Client's/Patient's Name**

_____ _____

**Signature of Client/Patient/Responsible Party** **Date**

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# Teletherapy Informed Consent Form

I _____ (name of client) hereby consent to engaging in teletherapy with Andrea Tang, *LMHC, NCC, CCTP, CCTHP* as part of my psychotherapy. I understand that "teletherapy" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

I understand that I have the following rights with respect to teletherapy:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
(2) The laws that protect the confidentiality of my personal information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my written consent.
(3) I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my personal or therapeutic information could be disrupted or distorted by technical failures; the transmission of my personal or therapeutic information could be interrupted by unauthorized persons; and/or the electronic storage of my personal or therapeutic information could be accessed by unauthorized persons. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that a variety of alternative methods of care may be available to me (e.g. face-to-face encounters) and that I may choose one or more of these at any time.
(4) Finally, I understand there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse. I understand that I may benefit from teletherapy but that results cannot be guaranteed or assured.
(5) I understand that I have a right to access my personal or therapeutic information and copies of records in accordance with Florida law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____ _____
Signature of Patient or parent/legal guardian of patient Date