Client Registration

Last Name ____________________ First Name ________________________ MI ____

Address ______________________ City ______________ State ______ Zip ______

Home Phone _______________ Work _________________ Cell ________________

Email Address ____

Date of Birth ______________________ Male ☐ Female ☐

Ok to leave messages at each number? Yes ☐ No ☐ If not, please explain:

____

Preferred means of confirming appointment: Would you like to receive our e-newsletter?

Text ☐ Email ☐ Phone Call/Voicemail ☐ Yes ☐ No ☐

Primary Care Physician ____

Student: Yes ☐ No ☐ School _____________________________ Grade _______

Occupation ________________________ Employer ___________________________

Emergency Contact Name ____

Relationship to You _____________________ Phone Number ___________________

How did you hear about my services? ______________________________________

Jean Manz Coaching and Counseling, LLC
Jean Manz • MA, LMFT • jean@jeanmanz.com

Client Insurance Form

Last Name ____________ First Name ______________ MI ___

Responsible Party Information:

Last Name ____________ First Name ______________ MI ___

Address ____________ City __________ State _____ Zip _____

Home Phone __________ Work __________ Cell __________

Email Address ______________________________

Date of Birth ______________________________

Employer ______________________________

Primary Insured Name ______________________________

Authorization # ______________________________

Insured ID ______________________________

Insurance Billing Address ______________________________

I authorize release of information to process claims and assignment of insurance benefits to be paid to Jean Manz Coaching and Counseling.

Signature ______________________ Date __________

Advance Directive for Mental Health Treatment

The State of NM requires us to give you the option of providing us with an Advance Directive for Mental Health Treatment. This directive would give us your wishes should you become incapitated and designates an individual of you're choosing to give directions for your care.

It is extremely unlikely that an individual receiving outpatient mental health care should become incapacitated to the exited requiring an Advance Directive

If you desire to complete an Advance Directive, please inform us and we will provide you the form

☐ I wish to provide an Advance Directive for Mental Health Care

☐ I do not wish to provide an Advance Directive for Mental Health Care

Signature ______________________________ Date ________________

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Information for Clients

I am happy that you have come to work with me. When you come for counseling you are investing in yourself. Below are some things you should know. I invite you to ask me any questions you have at any time during our work together.

My education includes an M.A. in Education from San Diego State (1991) and the completion of a 2 year post-graduate program in Marriage and Family Therapy from the Denver Family Institute (1998). I have been a licensed practicing mental health therapist for over 20 years. I am licensed as a Marriage and Family Therapist in the State of New Mexico, license number 0101581.

CONFIDENTIALITY: Generally speaking, the information provided by and to you during our sessions is legally confidential and cannot be released without your consent. There are exceptions to this confidentiality: if I suspect child/elder abuse or neglect or if I believe you are a danger to yourself or others, then I am obligated by law to break confidentiality to get help. Disclosure may be required pursuant to a legal proceeding.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct, only the minimum necessary information will be communicated to the carrier. We have no control over, or knowledge of, what insurance companies do with the information s/he submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

CONFIDENTIALITY OF E-MAIL AND CELL PHONE COMMUNICATIONS: It is very important to be aware that email and all phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Please notify me at the beginning of treatment if you decide to avoid or limit in any way the use of e-mail or cell phone communication.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regards to many matters which may be confidential in nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) , neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or any other proceedings, nor will a disclosure of records of our sessions be requested.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message during business hours on my cell phone at 505-716-7995 and I will return your call as soon as possible. If an emergency situation arises where you or someone you know is in danger, call the police (911) or go to your nearest Emergency Room.

TELEPHONE & EMERGENCY PROCEDURES (CONTINUED): Phone contacts that are meant as check-in's to facilitate our therapy, and are less than 15 min in length, are not billed. Phone consultations longer than 15 min may be billed at $25 per 30 min.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $150.00 per 55 minute session at the end of each session unless other arrangements have been made. We offer a 20% discount if you pay your fee on the date of service. We accept credit cards, debit cards, cash and/or personal checks. Telephone conversations, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify us if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, we will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement, if you so choose. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, we can use legal or other means (courts, collection agencies, etc.) to obtain payment. Your insurance policy is a contact between you and your insurance company. We are not a party to that contract. Please be aware that some of the services we provide may be "not-covered services." Yu are responsible for obtaining prior authorization if required by your insurance plan.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of you and your therapist. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in San Juan County, NM in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, we can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF COUNSELING: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concern that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Therapy requires your active involvement, honesty, and openness. Talking about unpleasant feelings or events can result in your experiencing discomfort or strong feelings of anger, sadness, worry, etc. or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at or handling situations that can cause you to feel upset.

THE PROCESS OF COUNSELING (CONTINUED): Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. There is no guarantee that therapy will yield positive or intended results. The approaches that I use may include behavioral, cognitive-behavioral, existential, psychodynamic, system/family, developmental or psychoeducational. If you have any unanswered questions about the procedures used in the course of our therapy please ask.

TREATMENT PLANS: Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you their working understanding of the problem, treatment plan, therapeutic objectives, and their view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

TERMINATION: After the first couple of meetings, I will assess if I can be of benefit to you. If I cannot be of help, I will provide you with a referral. You may seek a second opinion or terminate our coaching relationship at any time.

DUAL RELATIONSHIP: Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs my objectivity, clinical judgement, or therapeutic effectiveness. It also can never be exploitative in nature.

CANCELLATION & NO SHOW POLICY: Since scheduling of an appointment involves reserving time specifically for you, a minimum of 24-hour notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, a $25 FEE will be charged for all no shows or cancelled appointments without 24 hour notice.

I have read the above Agreement and Information and I understand them and agree to comply with them.

____

{ Please Print Name }

____

{ Signature}

____

{ Date }

____

{ Therapist's Signature }

____

{ Date }

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

____

{ Please Print Name }

____

{ Signature}

____

{ Date }

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

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Authorization for Exchange of Information

COORDINATION WITH YOUR PRIMARY CARE PHYSICIAN: Coordination and exchange of information with your Primary Care Physician may be necessary in order to provide you with optimal care.

This disclosure of information and records authorized by the Client is required for the following purpose:

To improve the quality of medical and mental health treatment

The specific uses and limitations of the types of medical information to be discussed are: (be as specific as you choose to):

____

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I understand that I have a right to receive a copy of this authorization, I have the right to revoke this authorization at any time unless the Provider has taken action in reliance upon it and that any revocation or modification of this authorization must be in writing.

Therapist shall not condition treatment upon the Client signing this authorization and the Client has the right to refuse to sign this form.

The client understands that information used or disclosed pursuant to this authorization continues to be protected by The HIPAA Privacy Rule, and applicable New Mexico law.

I hereby authorize exchange of medical and mental health information with my Primacy Care Physician: ____

This authorization shall remain valid until: ____

Client's signature: ____

Date_____________________