Client Registration

Manz & Stacey

Coaching & Counseling

Last Name _____ First Name _____ MI _____

Address _____City _____ State _____ Zip_____

Home Phone _____ Work _____ Cell _____

Email Address _____

Date of Birth _____ Male _____ Female _____

Okay to leave messages at each number? Yes _____ No _____

Preferred means of confirming appointment:

Text _____ Email _____ Phone _____ Voicemail _____

Would you like to receive our e-newsletter? Yes _____ No _____

Primary Care Physician _____

Student? Yes _____ No _____

School _____ Grade _____

Occupation _____ Employer _____

Emergency Contact_____ Relationship to you _____

Phone Number _____

Client Insurance Form
(Complete only if using insurance)

Manz & Stacey
Coaching & Counseling

We are a small practice with limited back office help and put the responsibility on you to know your insurance benefits. Most plans have a deductible and even if psychotherapy services are covered, you may need to pay full price for counseling services until your deductible is met. Also, please be aware that some of the services we provide may not be "covered services". Please contact your insurance company and confirm your benefits prior to our work together. You are responsible for all bills that are not paid by insurance.

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 _____ Male _____ Female _____

Employer _____ Primary Insured Name _____

Authorization Number _____ 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

Manz & Stacey

Coaching & Counseling

The state of New Mexico requires us to give you the option of providing us with an Advance Directive for Mental Health Treatment. This directive would inform us of your wishes should you become incapacitated and designates an individual of your choosing to give directions for your care.

It is extremely unlikely that an individual receiving outpatient mental health care should become incapacitated to the extent 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 _____

Information for Clients

Manz & Stacey

Coaching & Counseling

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.

I received my MA in Behavioral Health/Family Therapy from the University of Houston/Clear Lake in 1991 and have been in practice since that time including private practice, homebased family therapy for an agency, clinical practice and program development for Navajo Nation Department of Behavioral Health. I have experience with traditional healing and western psychotherapy. I have completed training in Eriksonian Hypnosis, EMDR, Somatic Experiencing (SE) and Organic Intelligence as well as other brain-based trauma modalities. I am licensed as a Marriage and Family Therapist in New Mexico, license #0068702.

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. e 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 832-630-3022 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.

PAYMENTS & INSURANCE REIMBURSEMENT: The standard professional fee for individual counseling services is $150 per 60-minutes. Time spent in excess of 60-minutes may be charged proportionally We accept credit cards, debit cards, health savings account, cash, or checks. We offer a $20 discount on a one-hour service when payment is made in the same day. Payment is expected at the end of each session unless alternative arrangements have been agreed upon. Most of our treatment modalities for couples therapy and trauma work are rendered in 90-minutes sessions. Insurance does not cover this. The rate for a 90-minute session is $190. The rate for a 120-minute session is $240.

Telephone conversations greater than 10-minutes in length, reading & writing of reports, and consultation with other professions will be charged at the same rate unless indicated and agreed upon otherwise. Please notify is if any problems arise during the course of therapy regarding your ability to make timely payments.

We accept limited insurance plans. Typically, health insurance covers 50-60 minutes of psychotherapy only if there is a diagnosable mental illness. Not all conditions/problems dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibly to verify the specifics of your coverage, obtain any required pre-authorizations, pay the co-pay at the time of service, and pay for all services rendered which are not covered by your insurance company. Our practice can submit a direct claim to your insurance company if we have an “in-network” contract with them or provide you with a superbill that you may submit to insurance companies that we are not contracted with.

If your account is overdue and there is no written agreement on a payment plan, we can use legal or other means (courts, collection agencies etc.) to obtain payment.

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. e mediator shall be a neutral third party chosen by agreement of you and your therapist. e 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 led. 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.

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.

SOCIAL MEDIA FRIENDING & FOLLOWING: I do not accept personal friend requests from current or former clients. Social media is an open platform, and please be aware that herein I will not acknowledge and or reply to any expressions made in a way which would identify one as a client of my practice. I take confidentiality very seriously, and please be aware that there is a risk to your privacy if you do choose to follow my business social media accounts. Please feel free to follow any of these accounts at your discretion.

REVIEWS: It is unethical for me to solicit any reviews of me or my practice on social media or internet websites. If you do choose to write something, please keep in mind that you may be sharing personally revealing information in a public forum.

CLERICAL INTERACTIONS: If you need to contact me between sessions, the best way to do so is by phone or over email. Please do not contact me with administrative issues or those regarding our work together over any social media platform.

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

Name (Print) _____

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

Manz & Stacey
Coaching & Counseling

You <u>may</u> refuse to sign this acknowledgement

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

Name (Print) _____

Signature _____ Date _____

<u>For Office Use Only</u>

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

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented obtaining the acknowledgement

_____ Other (please specify)

Authorization of Exchange of Information

Manz & Stacey

Coaching & Counseling

You <u>may</u> refuse to sign this acknowledgement

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):

_____

_____

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

The 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 laws.

I hereby authorize exchange of medical and mental health information with my primary care physician;

Yes _____ No _____

This authorization shall remain valid until _____

Name (Print) _____

Signature _____ Date _____

JEAN MANZ COACHING & COUNSELING, LLC
Notice of PRIVACY PRACTICES
Effective Date: August 01, 2016

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. Also to give you this Notice about our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we make the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information. to provide you with treatment to physicians, psychiatrists, psychologists or other healthcare provider providing treatment to you, including discussing or sharing your PHI with trainees and interns.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

Other disclosures. Your consent isn't required if you need emergency treatment provided we attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information on inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expensed such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you **$0.50** for each page, **$25.00** per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but no before April 14, 2003. If you request this accounting more than once

in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing}. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS and COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative location, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Jean Manz

Address: 5101 College Blvd., Suite 5044

Farmington, NM 87402

Telephone: 505-716-7995

E-mail: jean@jeanmanz.com

Request for Transmission of Protected Health Information by Non-Secure Means

Manz & Stacey
Coaching & Counseling

I, _____
(name of client)

Authorize: Charles Stacey, LMFT
5101 College Blvd
Farmington NM, 87402

TO TRANSMIT TO ME BY NON-SECURE MEDIA THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

Information related to the scheduling of meetings or other appointments Information related to billing and payment

It is very important that you are aware that computer e-mail, texts and e-fax communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of the communication. Although email that I send you is encrypted on my end, it is always possible that your email provider does not have encryption and that the email or text can be seen or sent to non-authorized persons.

Please notify Jean Manz Coaching, LLC if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts, e-fax or phone messages, it will be assumed that you have evaluated the risks and made an informed decision. Jean Manz Coaching will view it as your agreement to take the risk that such communication may be intercepted and your desire to communicate on such matters will be honored. Please do not use texts, e-mail or voice mail for emergencies.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

Name (Print) _____

Cell Phone Number _____

E-mail Address _____

Signature _____ Date _____