# Demographic Information:

Client Name

Parent/Guardian Name (if applicable)

Address

Address

 🗆Home 🗆Cell 🗆Work

Phone

 🗆Home 🗆Cell 🗆Work

Alternate Number

Email Address

Date of Birth/Age

**Correspondence:**

In some situations, I might need to contact you to confirm, reschedule or cancel an appointment or to obtain payment for a missed session. Please indicate which way I can contact you in the future, if needed.

🗆It is ok to leave messages at the following numbers: 🗆Home 🗆Cell 🗆Work

🗆Please do not leave messages at any above number.

🗆It is ok to correspond through mail at the above address.

🗆It is ok to correspond using the email address above.

**Coaching Information**

\*Please answer to the best of your ability.

In what area(s) of your life are you hoping to see changes through coaching? (i.e. family, work, significant other, etc.)

What are the 3 main reasons you are seeking coaching services?

What are 3 measurable goals you wish to achieve through coaching?

What are your primary coping skills (healthy and unhealthy) for when life/work/relationships get challenging and overwhelming?

What is something you want MORE of in your life?

What is something you want LESS of in your life?

What are 3 things you want to accomplish in the next 3-6 months?

**Informed Consent and Policies**

All coaching services and communication, email or otherwise, delivered by Margery Boucher, MA, MS, LPC-S (your “Coach”), are meant to help you identify the areas in your life and in your thinking that may be standing in your way. This agreement is for coaching, not psychotherapy. While coaching can work with issues such as identifying and reaching life goals and changing the behaviors that are not working well for you, coaching cannot deal with issues such as depression and anxiety. For issues such as these, you must see a Licensed Mental Health Professional in your location.

Your coach will not diagnose or treat any medical or psychological conditions. While your coach may be licensed as a practitioner she is not functioning as a licensed practitioner when offering coaching services. By signing this agreement, you are agreeing that you understand the difference in these two functions and you will get appropriate professional help for mental health issues if necessary. Margery can also provide referrals for such additional services as needed.

I understand that coaching is, at present, an unregulated industry and that my Coach is not licensed by the State of Texas or any other state. I also understand that for all legal purposes, the services provided by my Coach will be considered to be provided in the State of Texas. I understand and agree that I am fully responsible for my well-being during my coaching sessions, and subsequently, including my choices and decisions. I understand that coaching is not a substitute for counseling, coaching, psychoanalysis, mental health care or substance abuse treatment, and I will not use it in place of any form of therapy.

I understand that all comments and ideas offered by my Coach are solely for the purpose of aiding me in achieving my defined goals. I have the ability to give my informed consent, and hereby give such consent to my coach to assist me in achieving such goals. I understand that to the extent our work together involves career or business, my Coach is not promising outcomes included but not limited to increased clientele, profitability and or business success. Please free to ask questions at any time about your coach’s background, experience and professional orientation.

**Appointment Scheduling and Cancellation Policies** - In order to cancel or reschedule an appointment, you are expected to notify your coach at least 24 hours in advance of your appointment. If you do not provide at least 24 hours’ notice in advance, you are responsible for payment for the missed session.

**Coach Availability and Emergencies** - In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 or the appropriate emergency service to request assistance. Your coach is not licensed to handle these matters.

**Insurance** - Because coaching is not a medical treatment, typically insurance will not cover the cost. Some employers may cover some of the cost of coaching. It is your responsibility to pay for coaching and get reimbursed by your employer if that is the case.

**Confidentiality**

**Confidentiality** - All information obtained in the course of the professional service is confidential unless there is a compelling professional reason for its disclosure. Your coach will disclose confidential information without a specific release if it is necessary to prevent foreseeable imminent harm to the client or another. In all circumstances, coaches will be judicious in the amount of information that is disclosed. Coaches may disclose confidential information without the consent of the client only as mandated or permitted by law. When possible, coaches inform clients about the disclosure of confidential information and possible ramifications before the disclosure is made. Coaches will only disclose confidential information to third parties with the appropriate written consent. Coaches must disclose certain confidential information as required by law or if the confidential information may put the client or others at risk of harm or compromise their well-being. I understand that my Coach will protect my information as confidential unless I state otherwise in writing. If I report child, elder abuse or neglect or threaten to harm myself or someone else, I understand that necessary actions will be taken and my confidentiality agreement limited in this capacity. Furthermore, if my Coach is ordered by a court to provide information or to testify, he or she will do so to the extent the law requires.

**Minors and Confidentiality** - Communications between coaches and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child’s coaching are often involved in their sessions. Consequently, your coach, in the exercise of her professional judgment, may discuss the coaching of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their coach.

**Electronic Communications** - You understand that the confidentiality of Electronic Communications (E.C.) cannot be guaranteed. E.C. may include, but are not limited to, email, text messages, Skype and other video conferencing, and voicemail. E.C. are inherently vulnerable and insecure and may result in the unintentional harmful disclosure of personal information. You acknowledge that you implicitly consent to Margery Boucher, MA, MS, LPC-S sending E.C. to you by: a) your inclusion of your email address on her forms, b) providing your email to her in session, or c) your sending an email, text message, or other E.C. to Margery Boucher, MA, MS, LPC-S. You acknowledge that Margery Boucher may not read or respond to E.C. until the next scheduled appointment and that you will not use E.C. for emergencies. Sessions will be held in-person, over the phone or through the Internet. Email contact regarding logistics and scheduling is welcome at mboucherLPC@gmail.com. Any coaching between sessions via written message format will occur on a secure online platform. Coaching in this manner will be done through the purchase of Telehealth Messaging Sessions. “Telehealth” is understood as an educational service within the coaching relationship.

By signing below, I acknowledge that I have read, understand, and agree with the aforementioned information.

Client or Guardian Printed Name:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_

Counselor Printed Name:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_

**PRIVACY POLICY (HIPAA)—CLIENT COPY**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE READ IT CAREFULLY.**

Margery Boucher, LPCS understands that your medical information and your health are personal. I am committed to protecting your medical information. I need this medical information to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices applies to your medical information generated and/or maintained by Margery Boucher, LPC.

This Notice will tell you about the ways in which we may use and disclose your medical information. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

Margery Boucher is required by law to:

1. Make certain that medical information that identifies you is kept private
2. Make certain that you are given notice of our legal duties and privacy practices with respect to your medical information
3. Make certain that Margery Boucher follows the terms of the Notice of Privacy Practices that is currently in effect

The following describes different ways we use and disclose your medical information. If you are receiving services for the evaluation or treatment of substance abuse or Human Immunodeficiency Virus (HIV) conditions, specific rules apply to the use and disclosure of information related to those services. Please refer to the section entitled Substance Abuse Health Information and HIV Information for those rules.

1. **For Treatment.** We may use your medical information to provide you with behavioral health treatment or services. We may disclose your medical information to psychiatrists, your primary care physician, nurses, therapists, case managers, or other behavioral health professionals who are involved in your care. For example, a psychiatrist treating you may need to know if you have allergies to certain psychotropic medications. The psychiatrist may need to contact your primary are physician to obtain that information. Margery Boucher may also share your medical information to arrange services you may need. Different departments of your provider network may also share your medical information in order to coordinate the services you need, such as medications, therapy, or case management. If you are in jail, Margery Boucher may share your medical information with necessary medical personnel to coordinate your ongoing care.

1. **For Payment.** We may use and disclose your medical information so that the treatment and services you receive may be billed and payment may be collected from appropriate payers, such as an insurance company or a third party. For example, we may need to give your network provider medical information about treatment you received at the hospital so the hospital can receive payment. Your network provider may share your medical information with your insurance company or a third party payer to check that you qualify for services, or to obtain approval for the services requested.
2. **For Health Care Operations.** We may use and disclose your medical information for business activities. These uses and disclosures are necessary for administrative functioning and to ensure our members receive quality care. For example, we may use your medical information to review a network; provider’s services and to evaluate their performance in caring for you. We may combine medical information about many members to decide what additional services Margery Boucher should offer, what services are needed, and whether certain new treatments are effective. We may use and disclose your medical information to access Margery Boucher’s compliance with the Texas Department of Health Services, or the Joint Commission on Accreditation of Healthcare standards. For example, this disclosure may be required to evaluate the quality of services we provide or to resolve a specific treatment issue you have raised.
3. **Individuals Involved in Your Care.** We may release your medical information to a family member actively involved in your care and treatment as allowed under Texas state law and in accordance with Margery Boucher’s policies and procedures. This information is limited and **will not be disclosed without first obtaining your written authorization**.
4. **Substance Abuse Health Information.** All medical information regarding substance abuse is kept strictly confidential and released only in conformance with the requirements of federal law (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3) and regulation (42 C.F.R. part 2). Disclosure of any medical information referencing alcohol or substance abuse may only be made with your written authorization. A general authorization for the release of medical or other information is not sufficient for this purpose.
5. **HIV Information.** All medical information regarding HIV is kept strictly confidential and released only in conformance with the requirements of state law (Subtitle D, Title 2, Health and Safety Code, Chapter 85, section 85.115). Disclosure of any medical information referencing HIV status may only be made with your written authorization. A general authorization for the release of medical or other information is not sufficient for this purpose.
6. **Special Circumstances.** Federal and state laws allow or require Margery Boucher to disclose your medical information in certain special circumstances that include, but are not limited to the situations described below.
	1. **Public Health (Health and Safety for you and / or others).** We may disclose your medical information for public health activities. We may use and disclose your medical information to a public health authority, when necessary, to prevent a serious threat to your health and safety or the health and safety of the public or another person. These activities generally include the following:
		* To prevent or control disease , injury or disability
		* To report births or deaths
		* To report child abuse or neglect
		* To report reactions to medications
		* To notify people of recalls regarding medications they may be using
		* To notify a person who may have been exposed to a disease or may be a risk for contracting a disease
		* To avert a serious threat to the health or safety of a person or the public
		* To notify the appropriate government authority if we believe a member has been the victim of abuse, neglect or domestic violence. We will make this disclosure when required or authorized by law.
	2. **Research**. Under certain limited circumstances, we may use and disclose your medical information for research purposes. For example, a research project may involve the care and recovery of all members who receive one medication for the same condition. All research projects are subject to a special approval process. We will obtain your written authorization if the researcher will use or disclose your medical information.
	3. **Health Oversight Activities**. We may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the behavioral health care system, government programs, and compliance with civil rights laws.
	4. **Lawsuits and Disputes**. If you are involved in a lawsuit or legal action, we may disclose your medical information in response to a valid court or administrative order, a valid subpoena, a discovery request, or other lawful process that complies with state law and Providence of Texas policies and procedures.
	5. **Law Enforcement**. We may not release your medical information to a law enforcement official except in response to a valid court order, subpoena, warrant, summons, or similar lawful process that complies with state law and Margery Boucher’s procedures.
	6. **Coroners, Medical Examiners and Funeral Directors**. We may release your medical information to a coroner or medical examiner. This may be necessary for identification or to determine a cause of death. We may also release your medical information to funeral directors as necessary to carry out their duties.
	7. **National Security and Intelligence Activities**. We may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
	8. **Protective Services for the President and Others.** We may disclose your medical information to authorized federal officials so they may provide protection to the President or other authorized persons.
	9. **As Required By Law.** We may disclose your medical information when required to do so by federal, state, or local law.
* **Right to Access.** You have the right to inspect and copy medical information that ay be used to make decisions about your care. To inspect and copy your medical information contact Margery Boucher. If you request a copy of the information, you may receive one copy each at no cost. For any additional copies during the same year, you may be charged a fee for the costs of copying, mailing, or other supplies associated with your request. Your request to inspect and copy your medical information may be denied in certain limited circumstances. If you are denied access to all, or any part, of your medical information, you may request that the denial be reviewed. Information regarding how to initiate the review process will be provided in writing at the time of any denial of access to your medical information.
* **Right to Amend.** If you feel that your medical information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as your medical information is kept by Margery Boucher. To request an amendment, your request must be made in writing and submitted to Margery Boucher. You must provide a reason that supports your request. We may deny your request if you ask us to amend information that:
	1. was not created by us, unless the person or entity that created the information is no longer available to make the amendment
	2. is not part of the medical information kept by or for Providence of Texas
	3. is not part of the medical information which you would be permitted to inspect or copy; or
	4. is accurate and complete.
* **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures of your medical information to others outside of Margery Boucher’s office. The accounting does not include information disclosed as a part of treatment, payment, or health care operations. The accounting does not include disclosures that were authorized by you in writing. To request this accounting, you must submit your request in writing to Margery Boucher. Your request must state a period of time for the accounting that may not be longer than six years.
* **Right to Request Restrictions.** You have the right to request a restriction on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree, we will comply with your request, unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Margery Boucher’s office. In your request, you must tell us what information you want to restrict, and to whom you want the restriction to apply.
* **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location if you believe that you will be otherwise endangered. For example, you can ask that we only contact at a certain telephone number or address. To request confidential communications, you must make your request in writing to Margery Boucher. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
* **Right to Paper Copy of This Notice.** You have the right to a paper copy of this privacy notice. You may ask us to give you a copy of this privacy notice at any time by requesting it from Margery Boucher.

Margery Boucher reserves the right to change this notice. Margery Boucher reserves the right to make the revised notice effective for your medical information that Margery Boucher already have about you, as well as any information we will receive following the revision. Margery Boucher will post a copy of the current notice. The notice will contain the effective date at the bottom of each page. Margery Boucher will make you aware of any revisions by posting the revised notice in all the above locations. Other uses and disclosures of your medical information not covered by this notice will be made only with your written authorization. If you provide us with written authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, Margery Boucher will no longer use or disclose your medical information for the reasons covered by the authorization. I hereby acknowledge that I read and understand my privacy rights, the aforementioned HIPPA information, and was offered a copy of the above information.

Printed Name of Client

Client/Parent/Guardian Signature Date

Clinician Signature Date

# Release of Information Disclosure Form

By signing this form, I authorize the disclosure of information for ,

to the following person/organization: (client’s name)

Name/Organization

Address

Phone Number Fax Number

This form also allows the aforementioned person/organization to provide Margery Boucher, MA, MS, LPC with information to assist in the treatment of the client.

|  |  |
| --- | --- |
| *Margery Boucher, MA, MS, LPCS**3110 Webb Ave. Ste 160**Dallas, TX 75202* | *Phone: 214-982-0026* |

A. Unless otherwise specified below, any and all information regarding this client can be disclosed to assist in the treatment of the client. This can include, but is not limited to diagnosis, treatment, prognosis, chemical dependency, and/or medical knowledge including HIV health information.

Please indicate if you **do not** want specific information disclosed:

B. The intended purpose of the release of information is for **continuity of care**. If other purpose, explain:

C. This authorization will expire upon **conclusion of treatment**, unless otherwise specified below and/or revoked by signing and dating below:

D. Clinician Margery Boucher **cannot guarantee** that the individual/organization contacted through this release of information will not disclose some or all of the information provided. The said individual/organization might not be bound by the same legal obligation to confidentiality as the treating clinician.

By signing below, I indicate that **I have read, understand, and agree** with the aforementioned information. I was given the opportunity to ask questions and was not forced or coerced into singing this document.

Printed Name of Client

Client/Parent/Guardian Signature Date

 Clinician Signature Date

**Concierge Collaborative, LLC**

Margery D.E. Boucher, MA, MS, LPC-S

3110 Webb Ave. Ste 160

Dallas, TX 75205

LIC #68192

EIN #47-2163289

NPI #1487686184

**Credit Card Authorization**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Concierge Collaborative, LLC the permission to charge the following credit card:

Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of card: Visa MC Discover AmEx Other: \_\_\_\_\_\_\_\_\_\_\_

Card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVV/Security code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the above card to be charged for the following purpose(s):

Intake Individual Coaching Travel Expenses

Couples Coaching Collaboration

Concierge Services Group/Team Coaching

Supplies Coaching

By signing below, I acknowledge that this release is valid when signed and that I may revoke consent at any time.

Printed Name of Client

Client/Parent/Guardian Signature Date

 Clinician Signature Date

\*\*A non-refundable $100 deposit is required upon scheduling an intake. That amount will be used towards your initial intake appointment. IF you do not show for your appointment or cancel and do not reschedule, that deposit will not be refunded.