Psychotherapy Innovations, PLC
1130 E. Missouri Ave, Suite 780, Phoenix AZ, 85014
Office: 602-777-6156 Fax: 602-513-7303

CLIENT POLICIES AND PROCEDURES

Welcome to coaching; I look forward to working together. There are a few guidelines that clients are expected to maintain. Please feel free to bring up any questions.

Fee Clients are required to pay the consultation fee at the time of the appointment. Payment may be made by cash, check, debit card or credit card.

Procedure Clients will call or arrive on time. Come with updates, progress and current challenges. You may call, email or text between sessions if you need "spot coaching," have a problem, or cannot wait to share a win. Please keep this additional contact brief (about five or ten minutes). If you leave a message please indicate whether you would like a call back or if you are just sharing. It is necessary for the client to implement the coaching that is given to feel that coaching is a success. You have hired a coach to do things differently than you ever have before. If you choose to not use the coaching and keep doing what you have always done, you will get the results you have always gotten.

Video Your coach utilizes the HIPPA compliant doxy.me platform to support your video sessions. If you choose to utilize video sessions, your coach will send you an email that explains how to utilize this platform. Please note that there are potential risks to this technology that may include interruptions, unauthorized access and technical difficulties. Either the provider or client can discontinue the video session if it is felt that the videoconferencing connections are not adequate for the situation. Additionally, in order to have the best results from video sessions, it is recommended that you are in a quiet place with limited interruptions at the start of session.

Problems I want you to be satisfied with our relationship. If an issue should ever arise, please bring it to my attention. I promise to do what is necessary to have you be satisfied.

LIFE COACHING AGREEMENT

PLEASE PRINT CLEARLY

THIS SHEET MUST BE FILLED IN COMPLETELY

Date:_____ Client's Social Security#_____

Client's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Telephone (Primary)_____ (Secondary)_____

Email_____

Birthdate ____/____/____ Age_____ Gender_____ Race_____

Name of Spouse/Guardian_____ Phone_____

Address_____ City_____ State_____ Zip_____

Person Responsible for Payment_____ Social Security #_____

Signature of Person Responsible for Payment **X**_____ **(Must be signed for services to begin)**

Referred by:_____

Emergency Information

Name (1)_____ Relationship_____ Phone_____

Address_____ City_____ State_____ Zip_____

Name (2) _____ Relationship_____ Phone_____

Address_____ City_____ State_____ Zip_____

Emergency Information

Physician_____ Phone _____

Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____ City_____ State_____ Zip_____

Current Medications _____

Allergies _____

Employment Information

Client/Guardian: Place_____ Phone_____ Hrs_____

Spouse: Place_____ Phone_____ Hrs_____

CONSENT FOR COACHING SERVICES

1. As a client, I understand and agree that I am fully responsible for my well-being during my coaching calls, including my choices and decisions. I am aware that I can choose to discontinue coaching at any time. I recognize that coaching is not psychotherapy and that professional referrals will be given if needed.

2. I understand that “life coaching” is a relationship I have with my coach that is designed to facilitate the creation/development of personal, professional or business goals and to develop and carry out a strategy/plan for achieving those goals.

3. I understand that life coaching is a comprehensive process that may involve all areas of my life, including work, finances, health, relationships, education and recreation. I acknowledge that deciding how to handle these issues and implement my choices is exclusively my responsibility.

4. I understand that life coaching does not treat mental disorders as defined by the American Psychiatric Association. I understand that life coaching is not a substitute for counseling, psychotherapy, psychoanalysis, mental health care or substance abuse treatment and I will not use it in place of any form of therapy.

5. I promise that if I am currently in therapy or otherwise under the care of a mental health professional, that I have consulted with this person regarding the advisability of working with a life coach and that this person is aware of my decision to proceed with the life coaching relationship.

6. I understand that information will be held as confidential unless I state otherwise, in writing, except as required by law.

7. I understand that certain topics may be anonymously shared with other life-coaching professionals for training or consultation purposes.

8. I understand that life coaching is not to be used in lieu of professional advice. I will seek professional guidance for legal, medical, financial, business, spiritual or other matters. I understand that all decisions in these areas are exclusively mine and I acknowledge that my decisions and my actions regarding them are my responsibility.

I have read and agree to the above.

Client signature_____ Date _____

PSYCHOTHERAPY INNOVATIONS, PLC
PAYMENT POLICY

_____ All payment for psychotherapy is due on the same day of service. This provider accepts cash, personal checks and credit/debit cards. Individuals that do not attend therapy with the financially responsible party must bring payment with them or have the responsible party leave a credit card on file. Outstanding balances will not be carried forward unless the client has made a previous arrangement with their therapist.

_____ All clients are required to leave a credit card on file to address missed session/late cancellation fees and/or to pay their session fee if that is desired.

_____ I,_____, hereby authorize Psychotherapy Innovations PLC, to charge my credit card as payment for my individual, family and/or group sessions on the same day the service is rendered for the amount or balance due and/or for missed/late cancel fees, including a 4% additional fee for the credit card transaction. If I do not wish to pay my session fee with my card kept on file, I understand a card will still be kept on file to be used for any missed/late cancel session fees incurred per the policy outlined in the Psychotherapy Innovations PLC cancellation policy.

Type of Card: Visa MasterCard Amex Discover

Credit Card Number: _____

Expiration Month & Year: _____

CSC (three digits on back of card)_____

Name of Cardholder: _____

Credit Card Billing Address: _____
(if different than one provided)

Authorized Signature of Cardholder_____

I acknowledge the payment policy described above, and assume full responsibility for all charges. I agree to honor and abide by the terms of payment.

Client Signature:_____ Date_____

PSYCHOTHERAPY INNOVATIONS, PLC

CANCELLATION POLICY

_____ If you fail to cancel a scheduled appointment within a reasonable time-frame, we cannot use this time for another client. This is a loss for all parties concerned. Therefore, you will be billed for the entire cost of your missed appointment.

_____ With the client's signature, it is understood by the client that a full session fee (not just the co-pay if you are utilizing insurance) is automatically charged for missed appointments/no shows and cancellations with less than a 24 hour notice. This fee includes an additional 4% debit/credit card transaction fee.

_____ The only exception to this is when a sudden serious illness has occurred (requiring a doctor's appointment or hospitalization and documentation to support this) or there has been an extreme emergency. Extreme emergencies must be crisis type events that are unexpected, unavoidable and unforeseeable. Car difficulties or issues with obtaining child care do not constitute an extreme emergency.

_____ Your therapist reserves the right to modify this cancellation policy to 48 hours notice based on the circumstances of the late cancellation. Further, Monday appointments must be cancelled by the end of business day on Friday at 3:00 PM. Cancelling via voicemail or email on Saturday and Sunday will be considered a late cancellation because we do not have staff available on those days to receive your call or read your email and then fill that cancelled session time with another client.

_____ In the event of excessive cancellations within a short period of time, your therapist reserves the right to change the cancellation policy. You will be informed as to why the new policy was put in place, and the details of the new cancellation policy.

Thank you for your consideration regarding this important matter.

Client/Guardian
Signature_____

Date_____