HERITAGE BEHAVIORAL HEALTH CONSULTANTS

1325 Campbell Rd, Houston, TX 77055 713-365-9015 heritage@heritagebehavioral.com

Julie Summers, M.A., LPC-S
Taylor Garcia, M.A., LPC
Julie Ottosen, M.A., LPC
Jasmine Boone, Ed.D., LPC
Jennifer Hofman, M.A., LPC
Charles Reed M.A., LPC
Elizabeth Warren, M.A., LPC
Sarah Jane Paton M.A., LPC
Jill Early, M.Ed., LPC
William Kao, M.A., LPC
Allie Sauls, M.A., LPC
Jennifer Welch, M.A. LPC
Ana Ince, M.Ed., LPC
Angela Jones, Ph.D., LPC
Paige Cryer, M.A., LPC
Hannah Barnes, F.M.C.H.C., Certified Birkman Consultant (*Under supervision of Julie Summers, M.A., LPC-S*)
Farrin Velasco, M.A., LPC-Associate (*Under supervision of Julie Summers, M.A., LPC-S*)
Shannon Owen, M.A., LPC-Associate (*Under supervision of Julie Summers, M.A., LPC-S*)
Emily Rucker, Behavior Specialist, Life Coach

Welcome to the practice of Heritage Behavioral Health Consultants. We are pleased you have chosen our office and will assure you that we are working with you in a caring and professional manner. Please take a few moments to read our office policies and do not hesitate to ask any questions you may have. These policies are further detailed in the Notice of Privacy Practices following this form.

OFFICE HOURS

Regular support staff hours are from 8:00am to 7:00pm Monday through Friday. Each coach sets his or her own schedule and will work with you to schedule a mutually agreeable time. Telehealth sessions are also offered via Zoom. SESSIONS Full sessions are 45 minutes and half sessions are 25 minutes long. In order to ensure that your time is respected and waiting time does not interrupt your schedule or ours, every effort is made to start and stop on time. Extended sessions can be arranged when necessary, that will include an additional fee.

CANCELLATIONS

There is no charge for missed appointments IF APPOINTMENT IS CANCELLED AT LEAST 24 HOURS IN ADVANCE.WE DO CHARGE FOR APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE. In the event you need to cancel, please communicate this directly to your coach via email or text.

PRIVACY PROCEDURES

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), Heritage Behavioral Health Consultants is required to: 1) maintain the privacy of your health information, 2) provide you with a Notice to our legal duties and privacy practices with respect to the information that we collect and maintain on you, 3) abide by the terms of the Notice, 4) notify you if we are unable to agree to a requested restriction, 5) accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. Please refer to our Notice of Privacy Practices for detailed information.

FEES

Payment is due at the time of service rendered in the form of cash, check or credit card. We do not file insurance in this office. It is the policy of this practice to turn delinquent accounts over to collection after 90 days. If it becomes necessary to do this, there will be an additional 10% charge to the outstanding balance.

SERVICE TERMINATION

You acknowledge that the services provided by me to you are voluntary. You or your coach may elect to terminate services after appropriate and therapeutic termination occurs for any reason.
RIGHT TO REFER Coaches reserve the right to refer clients to higher levels of professional care such as doctors, nutritionists, or therapists if it appears necessary according to their judgment, resources, and experience.

SCOPE OF PRACTICE

Coaching sessions must stay within the coach's scope of practice, which does not include any expertise or ability to advise or treat clients in the fields of medicine, nutrition, exercise, or mental health therapy.

COACHING SERVICES AGREEMENT

I _____ (client), agree by my signature below, that I acknowledge the following and would like to initiate health coaching.

• I affirm that I am at least 16 years of age or older.
• I understand that participation is voluntary and I may withdraw at any time by notifying my coach via phone or email.
• I am aware that the first coaching session will be 60 minutes and follow-up sessions will be 25 or 45 minutes.
• I am aware that health coaching will take place with Heritage Behavioral Health Consultants at Common Desk Post Oak or via Zoom at a day and time that is mutually agreed upon.
• I understand that I am expected to make all calls on time and will contact my coach at least 24 hours in advance if an unavoidable conflict arises.
• I am aware that I will receive health coaching from a Functional Medicine Certified Health Coach.
• I am aware that coaches are not healthcare providers and coaching does not replace seeing a licensed physician.
• I understand that this coaching relationship is in no way to be considered or construed as psychological counseling or any type of therapy or medical intervention.
• I understand that coaching is its own unique process that draws upon strategies for goal attainment and my health coach will guide me towards reaching my health and wellness goals.
• I am aware that coaching results cannot be guaranteed.
• I affirm that I am fully responsible for the choices and decisions in my life and am responsible for my own results.
• I agree that it is my responsibility to tell my coach what works and what does not work, and to be honest about how I would like to be coached.
• I understand that the coach may release me from coaching for any reason, including but not limited to, inappropriate conduct of my doing.
• I agree to hold the coach free of all liability and responsibility for any actions or results for adverse situations created as a direct or indirect result or specific referral or advice given by the coach.
• I understand that if I contact my coach between sessions, my coach may take up to 24 hours to respond to me.

This agreement may be extended or terminated by mutual agreement. The coaching services provided to me will include a supportive, comprehensive process for attaining health and well being goals. Topics that I may choose to talk about include nutrition/diet, exercise, sleep, stress management, time management, work goals, relationship goals, finding meaning/purpose, and health challenges.

As a client, I understand and agree that I am fully responsible for my well-being during my coaching sessions, including my choices and decisions.

CONFIDENTIALITY: As a matter of ethics, my coach, by the signature below, affirms that he/she will maintain strict confidentiality about all information shared by me. The only exception is if my coach has reasonable cause to believe there are threats of serious harm to myself or others. My coach is then obligated to report the situation to the proper agent. Our signatures on this agreement demonstrate the intent to fulfill the intentions and requests above and reflect a complete understanding of the services provided.

I HAVE READ AND FULLY UNDERSTAND THE COACHING SERVICES AGREEMENT AND AGREE TO ITS TERMS.

Patient's Full Name (please print): _____

Signature:_____

Date: _____

Coach's Full Name: _____

Signature: _____

Date: _____

CLIENT INFORMATION

Date: _____

Coach Name: _____

Patient's Name: _____

D.O.B.: _____ Sex: M_____ F_____

Patient's Address: _____

City: _____ State:_____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

Employer: _____ Work Phone: _____

Emergency contact: _____ Phone #: _____

Referred by: _____

Would you like to keep your credit card info on file for ease of payment: ☐ Yes ☐ No

Card Holder Name: _____

Credit Card No.: _____

Exp. Date: _____ CVV Code: _____ (3-digit code on back of card) Credit

Card Billing Address: _____

Signature: _____

FURTHER INFORMATION

Current medications: _____

Name Dosage and Reason for Taking: _____

_____

Is there anything else you feel is important for your coach to know that we have not asked about on these forms?

_____

BY SIGNING THIS, I ACKNOWLEDGE AND AGREE THAT I HAVE READ ALL POLICIES AND PROCEDURES IN THIS PACKET IN THEIR ENTIRETY AND THAT ALL INFORMATION I HAVE RECORDED HERE IS TRUE. I ALSO AGREE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES AND AGREE TO ITS TERMS.

Patient Signature: _____

Date: _____