Marcy Houston
Mental Wellness Center of the Lowcountry

Coaching Agreement

Contact Information: Mental Wellness Center of the Lowcountry's physical location and mailing address is at 25A Marshellen Drive, Beaufort, SC 29902 Clients are seen by appointment only from Monday through Friday. Feel free to leave a confidential voicemail at 843-325-2223 or email message at mentalwellnesscenterlc@gmail.com Messages are checked Monday through Friday.

Personal Qualifications: Marcy E Houston is a Integrative Health Coach trained at Duke Integrative Medicine.

Fees: Fees for professional services are rendered at the time of services. The goal of the initial session is to set the context for coaching, establish ground rules for the coaching partnership and to expel your vision for optimal health and wellness. This session is scheduled for 1 hour at a flat fee of $120. Each session thereafter is 45 minutes at a rate of $70.00 per session. Appointments may be successfully canceled as late as 24 hours prior to the scheduled time. If this is not done, you will be charged $50.00 for a missed appointment.

Cash, credit cards or personal checks made to Mental Wellness Center of the Lowcountry, LLC are accepted as payment.

Confidentiality: I recognize that in the course of our work, you may give me the following: future plans, health information, financial information, job information, goals, personal and other proprietary information. I will not divulge any information shared during the coaching relationship without your permission. There are however some limits to this confidentiality. I am mandated by standards through Duties to Warn to breach confidentiality if you report: 1) you are threatening self-harm or suicide, 2) you are threatening to harm another or homicide, 3) a child has been or is being abused or neglected, and/or 4) a vulnerable adult has been or is being abused or neglected. If you would like your protected health information released to another party, you must sign a specific Release of Information from.

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Participants Rights and Responsibilities

You have the right to:

1. Privacy with respect to your past, present and future goals and vision.
2. Know the limitations of confidentiality.
3. Understand how to give permission to release or obtain information about your treatment, as well as how to revoke the permission.
4. Be involved in planning your goals.
5. Have services provided in a way that fits your individual characteristics, needs and abilities.
6. Refuse or discontinue services.
7. Be treated with dignity, respect, and kindness; free of abuse.

You have the responsibility to:

1. Behave in a manner which maintains the coaching environment and is respectful of other in session.
2. Participate fully in each session.
3. Be honest and willing to grow

_____ _____

Signature of client Date

_____ _____

Printed name Clinician Signature

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Authorization for Release of Information

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that authorization is voluntary and that I may revoke it any time by submitting my revocation in writing to the entity providing the information.

Participant's Name _____ Last 4 of SSN _____

List all persons/organizations authorized to provide/receive the information (with their phone number) from an/or between Mental Wellness Center of the Lowcountry, LLC:

_____

Specific description of information to be used or disclosed (including date): _____

_____

_____

Specific purpose of the disclosure: Continuity of Care

This authorization will expire: _____

I authorize the release of any medical or other information necessary for continuity of care.

_____ _____

Signature of client Date

_____ _____

Printed name Clinician Signature