synchronicity COUNSELING

Marci Danielson, M.S., LMFT

COUNSELING GUIDELINES, RIGHTS AND RESPONSIBILITIES

The mission of the counselors at Synchronicity Counseling is to offer a holistic, non-judgmental approach to therapy with an understanding that all human beings experience individual challenges. The counselors each hold the belief that people can find a way to heal, transform and grow. They have made a commitment to work collaboratively with clients to discover the insight and strength to achieve that goal. Each Counselor is a private practitioner doing business as Synchronicity Counseling and therefore maintains sole responsibility and liability for their practice.

Counseling Process:

Sessions are typically 50 minutes in length. Frequency of sessions varies depending upon issues presented, client preferences, etc., and will be established during consultation with your counselor. **The termination of counseling can be determined by you or your counselor at any time**. My primary purpose is to help you become effective in dealing with concerns that influence your ability to achieve success in pursuit of personal goals. I want to help you explore your concerns, provide support, and incorporate your goals into a plan for the future. In order to provide these services efficiently, your active participation is required. Oftentimes, your effort is needed inside of, and outside of session, to gain the most benefit from what is discussed in session.

Client Rights and Responsibilities:

- You have the right to be informed of the counselor's licensing status and clinical experience, including the limitations and restrictions of services.
- You have the right to be informed of the purpose, goals, techniques, procedures, limitations, potential risks, and benefits to counseling.
- You have the right to request to be seen by another counselor if dissatisfied with the counselor assigned to you.
- You have the right to terminate counseling at any time.
- You have the right to ask questions about techniques and strategies used during counseling.
- You have the right to refuse any services and to understand the implications of refusal.
- You have the right to actively participate in the development of a plan for self-improvement.
- You have the right to expect fair and equal treatment in all circumstances.
- Counseling records are the property of Marci Danielson, M.S., LMFT. However, you do have the right to the information contained within your records. If information from your record needs to be transferred to a third party, a release of information must be signed and submitted. If engaged in couples counseling, authorization must be signed and submitted by both parties before information will be released.

Benefits of Counseling:

Benefits of counseling may include: an improved ability to relate to others; a clearer understanding of self, your values and/or goals; increased productivity; and an ability to cope with everyday stress. There are no guarantees that counseling goals will be achieved.

Risks of Counseling

While benefits are expected from the counseling process, there may be periods of increased anxiety or confusion, which may affect significant relationships, your job and your understanding of self. Therapy often times needs to go deep. Rather than turning away from our suffering, healing sometimes requires an exploration into the depth of the wounds that fuel our beliefs, feelings, and behaviors. It is impossible to predict the extent to which you experience these changes. You and your counselor will work together to maximize the benefits of the counseling process.

Confidentiality

Staff consultation is an important aspect of serving my clients' needs. These cases will be discussed with non-identifying information, unless you have given consent. Otherwise, information about you that is obtained during a counseling session will not be revealed to anyone outside of Synchronicity Counseling without your consent, except in the following situations where disclosure is required by law:

1) Where there is a reasonable suspicion, or report, of abuse to children or elderly persons.
2) Where you present a serious danger to yourself or others.
3) If a judge through a court orders a counselor to do so.
4) In the case of law enforcement emergency or a national security issue as determined by the government.

Counselor Credentials:

Marci Danielson obtained a Bachelor's of Science (B.S.) in Psychology (with an emphasis in Abnormal Child Psychology) from Washington State University. From there she obtained a Master's of Science (M.S) in Clinical Counseling Psychology from California State University, San Bernardino. Marci worked in California as Marriage and Family Therapist Intern (MFTI) until 2009 when she moved to Idaho and obtained licensure as a Licensed Marriage and Family Therapist (LMFT).

Costs:

The cost for individual counseling is $90 and couples counseling $100 for a typical 50-minute session. Sessions that are scheduled for 80 minutes will be charged $120 for individual and $150 for couples. Sessions scheduled for longer than 80 minutes will incur further additional fees. Phone consultations lasting longer than 15 minutes will also incur a fee of $25 per 15 minutes (i.e. 30 minutes on the phone will be $25) to be paid at the next session.

Marci currently is a provider for a few insurance companies and Employee Assistance Programs (EAP's). If you desire to use your insurance or EAP, please know that Marci uses a third-party billing company (Premier Billing Solutions) to process billing claims. You may receive correspondence from them.

In the case of a returned check for insufficient funds, a $20 fee will be assessed to cover bank processing fees. Your counselor may choose to utilize a third party collection agency if you default on the terms of the payment option and fail to pay the full balance due.

<u>Cancellation Policy:</u> If you must cancel an appointment please call at least 24 hours in advance to allow me to reschedule another client who needs my services. *Appointments not cancelled or rescheduled within this time limit will result in a charge of $45 for that missed session.*

By signing below you agree that you have read this document, you have been given an opportunity to ask whatever questions you deem necessary, you have received a copy of the Privacy Notice, you agree to the terms of service, and wish to begin treatment.

_____ _____

Client Date

_____ _____

Parent/Guardian (if client is minor parent/guardian signature required) Date

_____

Marci Danielson, LMFT Date

Marci Danielson, M.S., LMFT

Social Media Consent

Contacting me

Phone and text: If you need to contact me between sessions you may call me via cell phone 208-989-0333 and leave a confidential voicemail. Please be aware that I may not be able to immediately answer or respond to your phone call/voicemail as I am in session during business hours. Your voicemail will be responded to as soon as possible or by the next business day. I only return calls after business hours (after 5 pm and not on Saturdays or Sundays) unless it is urgent. If it is an emergency please call 911 or visit your nearest emergency room. Please be aware that text messages are ***not*** a secure form of communication and are not encrypted. Clients may text me for scheduling purposes only. No serious or personal information please.

Email: I do accept communication by email and make every effort to keep it confidential, however, please be aware that any information disclosed in email is ***not*** secure or encrypted. It is better to reserve email for scheduling purposes, as it is not a secure form of communication.

Yellowschedule.com: I currently use an online scheduling company called yellowschedule.com. This allows clients to schedule with me without having to call, text, or email me. You can book up to 2 weeks in advance. There is no such thing as "HIPPA compliant software;" however, Yellowschedule is secure and encrypted. Please use your first name, last initial, and phone number and/or email for reminders.

Social Media-Facebook-LinkedIn: I utilize several social media websites for personal and professional purposes. Please know that I will ***not*** accept friend requests or professional connections, as this conflicts with protecting your confidentiality and privacy. Please do not comment on my pages or websites, as this does not ensure your confidentiality.

I consent that I have read and understand the above statements that may impact my confidentiality and privacy due to the nature and type of communication I choose to use with my therapist. I understand that my therapist will do all that she can to protect my privacy and confidentiality.

Client signature Date

Marci Danielson, LMFT Date

synchronicity COUNSELING

Marci Danielson, M.S., LMFT

Confidential Client Intake Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip:_____

Primary Phone: _____ Secondary Phone:_____
Leave message? ☐Yes ☐No Leave message? ☐Yes ☐No

Work Phone: _____ Email:_____
Leave message? ☐Yes ☐No Contact by email? ☐Yes ☐No

Occupation: _____ Best time/day to contact you:_____

Birth date: _____ Age: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Education Level:
☐ 8th Grade or Below ☐ High School ☐ Some College ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

Have you been in counseling/therapy before? ☐Yes ☐No
If yes, when: _____ Did it help? ☐Yes ☐ Some ☐No

Reason for therapy?_____

Have you or a family member ever attempted suicide?_____

Please list all medications you take: _____

Physician's Name: _____ Phone number: _____

Psychiatrist's Name: _____ Phone number: _____

Do you have any physical disabilities or chronic illnesses? (please list):_____

_____

Please circle any of the following that are currently troubling you:

Alcohol/Drug use	Eating Problems	Physical Abuse	Communication with Partner
Motivation	Self-Esteem	Sexuality	Verbal Abuse
Sexual Harassment	School/Educational	Assertiveness	Suicidal Thoughts
Sexual Abuse	Stress	Dating	Addiction
Alcohol or Drug Issues	Marriage/Spouse/Partner	Spiritual/Religious	Career
Appearance/Weight	Depression/Sadness	Loneliness	Work Stress
Time Management	Expressing Feelings	Anxiety/Panic	Perfectionist
Money/Financial Issues	Hopelessness	Grief/Loss	Worry/Fear
Shyness	Childhood Issues	Divorce/Break up	Meeting People/Friend
Anger/Rage	Sleep	PTSD	Parenting
Guilt	Helplessness	GLBT issues	Boredom
Traumatic Event	Homesickness	Stalking	Trust
Relationship issues	Family		

1) Emergency Contact:_____ Relationship:_____
Phone:_____

2) Emergency Contact:_____ Relationship:_____
Phone:_____

How did you hear about Synchronicity Counseling?
_____

Marci Danielson, M.S., LMFT

Limits of Confidentiality in Counseling

The counselors at Synchronicity Counseling abide by the ethical codes established by the American Counseling Association and as well as the rules and statutes governing the practice of counseling in the State of Idaho. These ethical codes and legal statutes require counselors to report to responsible persons or state agencies when clients indicate any of the following situations:

- **That the client intends to harm self**
- **That the client intends to harm someone else**
- **Information as to direct involvement in child abuse or neglect**
- **Information as to direct involvement in abuse of the elderly.**
- **In the case of a law enforcement emergency or a national security issue as determined by the government.**

In addition, Marci Danielson, M.S., LMFT will report to responsible persons or state agencies when clients indicate any of the following situations.

- **Report of domestic violence, as defined in Idaho State Statutes**

Confidentiality may be limited as mandated by the courts or, in the case of minors, when parents may have access to counseling information.

By signing below, I indicate that I understand my limits of confidentiality and I am aware of the situations where the counselor must breach my right to confidentiality in the counseling relationship, with or without my permission.

_____ _____

Client Date

_____ _____

Parent/Guardian (signature required if client is a minor) Date

_____ _____

Marci Danielson, LMFT Date

Marci Danielson, M.S., LMFT

Insurance Billing Agreement

Name_____

Date of birth_____ SSN _____

Insurance Company_____

Policy Holder's Name _____ID number_____

Policy Holder's date of birth_____SSN _____

Policy Holder's employer_____

Primary Care Physician's Name_____

Phone Number _____

May this Physician be contacted for continuity of care? _____Yes _____No

Be advised that by signing for me to bill your insurance company you understand that auditors from that company have the right to come in and inspect and read your file. All of your diagnostic information is submitted to them after each session. Confidentiality is not preserved when insurance companies are billed. If you do not wish for me to bill your insurance company you will be responsible for the full cost of services at each session. In addition, by signing this document your agree to take full financial responsibility for any session fees where coverage was declined by your insurance company.

_____ Client accepts the above statement and wishes to bill insurance

_____ Client declines to have insurance billed and agrees to pay the full amount for each session.

_____

Client/Parent or Guardian Signature Date