Informed Consent

Background and Approach to Coaching:

Thank you for choosing me, Rena Reiser, as your coach. I realize that working with me is a major decision, and you may have many questions. This document is intended to inform you of my policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and I will try my best to provide all the information you need.

I am a Certified Health Coach and Certified Intuitive Eating Counselor with over twelve years of experience in teaching and coaching adults using individual and group methods. My work is limited to coaching adults in the following areas: Intuitive Eating, life coaching, and stress management.

My eclectic background and training has enabled me to develop an approach to coaching that incorporates principles and practices drawn from Intuitive Eating, coaching, health education, acceptance and commitment training (ACT), and classic relaxation training (diaphragmatic breathing, mindfulness, visualization, and so on). I combine all of these methods in an effort to help you get unstuck, stay motivated, and meet your goals. While my approach uses some techniques drawn from ACT, I am *not a therapist* and I am *not trying to practice psychotherapy* using these techniques. Many different therapeutic techniques can be adapted for coaches and coaching clients.

Nature of My Distance-Coaching Practice:

Prior to beginning coaching, you will have a free consultation with me by telephone to assess your needs and discuss my approach, so you can make an informed decision regarding working with me. During this consultation I will explain how we will work together and the nuances of working at a distance.

if you agree to work with me, you will then fill out and return (by email) some basic forms (informed consent, client data, financial agreement, and so on), as well as submit your payment.

After sending the forms and payment, I will send you an email to schedule our first session together.

Structure of Coaching Sessions:

During our sessions together, you will be a very active participant in the coaching process. In addition to talking to me, you will be given specific audios to listen to from my program and be asked to practice techniques from those audios and our session. Your commitment to doing this work outside our live distance sessions is crucial to your success. I expect that you will do all of the listening and exercises prior to our live sessions together.

Signature: ________
Date: _______

Financial Agreement:

The fee for my program is 3 monthly payments of $425 USD or $1175 USD in full. You may pay using your credit card (in shekels at that day's exchange rate) or PayPal account (in dollars).

Payments must be received in advance of your appointments.

If you need to cancel or reschedule an appointment, please notify me at least forty-eight hours in advance; otherwise *a missed session is not made up*.

Signature: ________
Date: _______

Insurance Issues:

I do not accept third-party reimbursement from health insurance carriers. I do not accept assignment of benefits, nor do I participate in managed care insurance plans (HMO's and PPO's). If you have insurance that provides coverage for my services, I will gladly discuss the coaching services you receive from me if your insurance company calls me and you provide me with a release granting me the right to talk to them. I do not call to request authorizations. You are responsible for contacting your carrier, securing necessary forms, filling them out, and sending them back at your expense.

You are responsible for paying all coaching services in full *prior* to submitting any insurance claims.

Signature: ________
Date: _______

Coordination of Care:

It is important that all healthcare providers work together. As such, if you would like to me share information about your coaching sessions, I will need your permission to communicate with your primary care physician, therapist, or both. In the even that you grant me this permission, please be advised that I will not initiate contact with them. They must request information directly from me. Your consent is valid for one year. *Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice.*

If you prefer to decline consent, no information will be shared.

___ You may inform my physician, counselor, and so on.
___ You may *not* inforrm my physician, counselor, and so on.

Physician name: ____________________
Address: ____________________
Telephone: ____________________
E-mail: ____________________

Therapist name: ____________________
Address: ____________________
Telephone: ____________________
E-mail: ____________________

Signature: ________
Date: _______

Confidentiality and Emergency Situations:

Your verbal communication and coaching records are strictly confidential except for (1) information shared with your insurance company to process your claims (if my services are covered by your insurance), (2) information you report to me about physical or sexual abuse (I am obligated to report this to the Division of Youth and Family Services), (3) when you sign a release of information to have specific information shared with your physician or therapist, and (4) when you provide information that informs me that you are in danger of harming yourself or others. Additionally, since our sessions will take place by VOIP telephone, the confidentiality of the calls cannot be assured.

If an emergency situation occurs for which you feel immediate attention is necessary, you understand that you are to contact the emergency services in your community (911 or 101 in Israel). I will follow up those emergency services with coaching service and support.

Signature: ________
Date: _______