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 Couples 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; an ability to cope with everyday stress; improved ability to communicate with your spouse/partner; and a better understanding of your partner social, emotional, and physical needs. 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. Couples therapy can often be emotionally demanding and seem overwhelming at times. 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. In couples therapy, patience and grace for yourself ***and*** for your partner are crucial elements in the healing process. Changes in behavior may happen at a slower rate than expected. Couples counseling is not a "quick fix," but rather a ***process*** that takes commitment, time, and energy before any results are seen.

Confidentiality:

Staff consultation is an important aspect of serving my clients' needs. Some cases may be discussed in a supervision session, in order to ensure you are receiving the best possible care. 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 (i.e suicidal or homicidal).
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.

Couples Counseling Rules:

Couples therapy offers a unique dynamic of 3 adults communicating about difficult issues in a 50-minute period. Often time people can feel as though they did not get sufficient time to express themselves. This can lead to frustration with the counseling process. To avoid frustration, I have set up a few rules that will help us to manage our time and make the most efficient use of our time together:

1) Do not interrupt one another (I reserve the right to interrupt only as means to improve communication or time manage).
2) NO name-calling, swearing, overt arguing, threatening, etc.
3) If I meet with you alone, please know that I have a "***no secrets policy.***"
    a. This means I will not keep information that is said in a one-on-one setting, and is considered harmful to the relationship (i.e. infidelity, cheating, sex addiction, etc), a secret from the unsuspecting partner. Secrets are incredibly damaging to a relationship and I would be doing your relationship a disservice by allowing it to happen in counseling. If there is a secret within your relationship I will be more than willing to help you in communicating the secret to your partner within the safe confines of a counseling session. My goal is to support your relationship through healthy communication and trust.
4) Please be respectful of one another's feelings and thoughts. Couples counseling is an extremely vulnerable place and in order for progress to be made trust has to be at the forefront. Trust is something that can begin from Session #1 even if it was not present in the relationship prior.

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; however, couples counseling is rarely covered by insurance. Some Employee Assistance Programs (EAPs) cover couples counseling and clients are encouraged to access this resource. If clients do not have an EAP or insurance coverage for couples counseling, private pay will be implemented to cover the cost. Please note that Marci uses a third party billing company (Premier Billing Solutions) to submit claims and collect fees.

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.

Cancellation Policy: **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 #1 Date

_____

Client #2 Date

_____

Marci Danielson, M.S., LMFT Date

Marci Danielson, M.S., LMFT

Social Media Consent

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.

E**mail:** 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 #1 signature	Date
Client #2 signature	Date
Marci Danielson, LMFT	Date

synchronicity COUNSELING

Marci Danielson, M.S., LMFT

Confidential Couples Intake Information

Name (Client #1) : _____ Date: _____

Name (Client #2): _____

Address: _____ City: _____ State: _____

Zip:_____

Client #1 Phone: _____ Client #2 Phone:_____
Leave message? ☐Yes ☐No Leave message? ☐Yes ☐No

Client #1 Email : _____ Client #2 Email:_____
Leave message? ☐Yes ☐No Contact by email? ☐Yes ☐No

Client #1 Occupation: _____ Client #2 Occupation:_____

Client #1 Birth date:_____Age:_____ Client #2 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	Spiritual/Religious	Dating	Time Management
Self-Esteem	Sexuality	Verbal Abuse	Sexual Harassment
School/Educational	Depression/Sadness	Trust	Marriage/Spouse/Partner
Assertiveness	Suicidal Thoughts	Sexual Abuse	Stress
Addiction	Alcohol or Drug Issues	Career	Divorce/Break up
Appearance/Weight	Loneliness	Work Stress	Relationship issues
Expressing Feelings	Anxiety/Panic	Perfectionist	Money/Financial Issues
Grief/Loss	Worry/Fear	Shyness	Childhood Issues

Meeting People/Friends	Anger/Rage	Sleep	PTSD
Parenting	Hopelessness	Family	Traumatic Event
Guilt	Helplessness	GLBT issues	Boredom
Homesickness	Stalking		

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#1 Date

_____ _____

Client #2 Date

_____ _____

Marci Danielson, LMFT Date

Permission for Digitally Recording and Videotaping Therapy Sessions

Therapist's Explanation:

As a primary tool in Gottman Method Couples Therapy, and in order to augment your therapy work, I use videotape feedback as part of therapy sessions. This means that I may ask to videotape you during specific dialogues or exercises, or during entire sessions. We will play back these tapes in sessions to help you see patterns of behavior between the two of you and to help you process conflicts. By viewing the videotapes in sessions, it allows us to "stop action" and process how you might approach a conflict in a more productive way. It also allows you to witness your progress as your relationship becomes more satisfying to both of you.

In addition to in-session use, I may wish to use the videotapes to receive consultation from Drs. John or Julie Gottman or an independently practicing clinician who has received training from The Gottman Institute, or to provide such training. This may occur during the time of treatment or thereafter for purposes of peer review, education and quality assurance. During this process, your name will be kept confidential. In addition, all matters discussed in consultations will remain completely confidential within the Gottman Institute staff. The videotapes are not part of your clinical record and will be used for no other purpose without your written permission and they will be erased when they are no longer needed for these purposes.

These tapes are my property and will remain solely in my possession during the course of your therapy. Copies may be sent to the Gottman Institute for the purposes noted above. Should you wish to review these tapes for any reason, we will arrange a session to do so. These materials will remain in locked facilities at all times.

****

Clients' Agreement

I understand and accept the conditions of this statement and give my permission to have my therapy sessions videotaped or digitally recorded. I understand I may revoke this permission in writing at any time but until I do so it shall remain in full force and effect until the purposes stated above are completed.

_____Date_____

Client #1 (*Signature)*

_____Date_____

Client #2 *(Signature)*

_____Date_____

Therapist *(Marci Danielson, M.S., LMFT*

Marci Danielson, M.S., LMFT

Payment Contract for Services

Name(s): _____

Address: _____

City: _____State: _____Zip: _____ Phone:_____

Bill to:
Person responsible for payment of account:_____

Address: _____

City: _____State: _____Zip: _____ Phone:_____

Employer:_____ Phone:_____

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

PART ONE: FEES FOR PROFESSIONAL SERVICES

I (we) agree to pay **Marci Danielson, LLC** , hereafter referred to as the provider, a rate of **$90.00** for individual counseling and **$100** for relationship or family counseling for a standard 50 minute session, and **$120** for individual and **$150** for relationship and family counseling for an 80 minute session. Phone consultations lasting longer than 15 minutes will incur a **$25** per 15 minute charge (i.e. 45 minutes = $75).

Payment is expected at time of service

A fee of **$45.00** is charged for missed appointments or cancellations with less that 24 hours' notice.

Additional fees may be charged for services not covered by insurance, such as extra report writing time, and any other services not covered by insurance.

A portion of Nichole Jordan's appointments are reserved for individuals requiring payment arrangements or sliding scale fees based on individual financial circumstances.

PART TWO: ALL CLIENTS

Payments, co-payments, and deductible amounts are due at the time of service.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Signature of Person responsible for account: _____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

Marci Danielson, M.S., LMFT

Preauthorization for Charges for Services

I _____ authorize Marci Danielson, M.S., LMFT to keep my signature on file and to charge my debit or credit card for:

___ Co-pay, deductible or session fees declined coverage by insurance policy. This total amount cannot exceed $ _____.

___ Recurring charges for ongoing treatment session fees as per amounts stated in the signed Payment Contract for Services.

___ No Show/Late cancel fee $45 as stated in signed Payment Contract for Services.

I understand that Marci Danielson, M.S., LMFT will notify me when charges are applied to my credit card and that she will protect the credit card information included below with the same high level of security required by HIPAA regulations and Standards set for by the American Counseling Association for confidential health care information.

I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic.

Client's name: _____

Cardholder's name: _____

Cardholder's billing address: _____

City: _____ State: _____ Zip: _____

Cardholder's phone number: _____ Cardholder's email address: _____

Charge card number: _____ Expiration date: _____

CSC (3 digit code on back of card) _____

Cardholder's signature: _____Date: _____/_____/_____