INFORMED CONSENT/CLIENT RIGHTS & RESPONSIBILITIES FORM

Waiver and Release of All Claims and Assumption of Risk by Client Participant

Welcome! This is a collaborative effort between us! I am committed to providing quality guidance, mental skills training, and wholistic care. If you have any questions after reading this, please contact me. You also may visit my website www.braincodecorp.com and click on privacy policies and/or the appropriate tab. This is an agreement with - Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC and governs all professional relations between the parties.

This is a lengthy and important document. It is essential you understand all parts of the informed consent. The following are legal requirements and **must be read, understood, and signed/initialed prior to start**. Please ask for an explanation if needed. If incomplete, your scheduled session time will be used for completion before beginning the session. **Our first session runs for one hour in length. Thereafter**, **we run appointments on a 50-minute schedule**. Please do not initial or sign anything you do not fully understand.

CLIENT NAME: _____ PHONE #: _____ Today's Date: _____

EMAIL: _____ DATE OF BIRTH: _____ AGE: _____

Driver's License #: _____ SS #: _____

ADDRESS: _____

_____(initial) **I grant permission to leave voice mail messages on the phone number(s) above**
_____(initial) **I grant permission to send text appointment message on the cell number above**

REFERRAL SOURCE:

IN CASE OF EMERGENCY:
Contact Name: _____ Relationship: _____
Home Phone: _____ Mobile Phone: _____
Email: _____

_____(initial) **I grant permission to contact the above emergency contact should the counselor/coach deem it necessary regarding my mental and/or physical safety and care.**

PROFESSIONAL QUALIFICATIONS/CREDENTIALS:

Anne "Kip" Rodgers Watson has provided mental and life skills training for over 25 years. She is a *Licensed Professional Counselor-Supervisor* by the State of Texas and adheres to the board's ethical guidelines. She is a *Certified Coach Practitioner* (CCP) and a *Certified High Performance Coach* (CHPC). She holds a bachelor's degree from *Texas Tech University*, a master's degree in Biblical Counseling from *Dallas Theological Seminary*, and a second master's in Sports & Exercise Psychology. She is a certified *Mental Golf Type Coach* and a national trainer for the *Positive Coaching Alliance*. As an athlete herself, Kip played women's professional tackle football for the 4-time World Champion *Dallas Diamonds* earning her Championship ring in 2008 as a player and she earned four more Championship rings as the current mental skills coach and therapist for the *Texas Elite Spartans* in the WNFC. In her youth, Kip won numerous gymnastics accolades including state and regional championships earning Hall of Fame honors at her gym. As a speaker, educator, and trainer, she has conducted workshops and keynotes to corporations, churches, school districts, and universities.

CLIENT RECORDS AND RELEASE OF INFORMATION/CONFIDENTIALITY:

Intake Form and session notes become part of the client clinical record. Records are the property of Anne 'Kip' Rodgers Watson, MA, LPC-S, CHPC. In accordance with legal requirements, adult records are disposed of five years after the file is closed. Records for a minor are disposed seven years after the client's 18th birthday. While most communication between a client and counselor/coach is confidential, the following limitations and expectations do exist:

1. A client may request specific information be sent to another individual. Prior to disclosure, the client must sign a '*Consent to Disclose'* form. Information will not be released for reasons unrelated to treatment. In the event the client is a 'relationship' rather than an individual, written consent must be obtained by all parties in the relationship prior to the release of information.
2. Client information may be released without consent in the following situations:

- Case records may be utilized for purposes of supervision, professional development, and research. In such cases, to preserve confidentiality, clients are identified by first name only.
- The counselor/coach determines the client is a danger to self or someone else.
- The client discloses abuse, neglect, or exploitation of a child, the elderly, or a disabled person.
- The client discloses sexual contact with another physician, therapist, or other possible licensed professional.
- The counselor is ordered by a court to disclose the information.
- The information is requested by your insurance company.
- The counselor is otherwise required by law to disclose information.

**If a third party (agent; team) hires *NeuroSport,* Anne 'Kip' Rodgers Watson, MA, LPC-S, CHPC for evaluation and assessment, clearly defined roles, responsibilities, and use of the information gathered will be written and agreed to prior to delivery of services. A *Project Confirmation Contract* indicated understanding and agreement must be signed prior to delivery of services.

If Kip and named client accidentally meet you in public, Kip or supervisee will function as if she/he does not recognize you because of the confidential relationship. However, if you approach and/or speak to Kip, you have made a choice to bring awareness to the relationship in the presence of others. **If you choose to participate by initiating contact via email or text messaging, and Anne 'Kip' Rodgers Watson responds, you understand our communication is excused from any liability of broken confidentiality in the event messages are seen by others.** In marriage or family counseling, it is exceedingly difficult to keep confidentiality within the parameters of participants. Kip offers a referral for marital therapy to protect confidentiality of the individual in counseling. We encourage open communication between spouses/partners except when determined the disclosure would be detrimental and bring harm to the other partner. **Absolutely no tape recording (audio/video) of any session is allowed without prior written permission by Anne "Kip" Rodgers Watson.**

_____ **(initial) I understand and agree with the above.**

TREATMENT MODALITY:

As an individual client, you have the right to ask questions about anything occurring during evaluation and on-going sessions. Kip is willing to discuss the *how* and *why* in choosing a certain assessment, result, and/or training/treatment plan. She is also willing to look at alternatives which may work better. We use a variety of techniques. Kip collaborates with you to find what works best for you and your stated goals. Common methods include *Cognitive Behavior Therapy* (CBT), *Positive Psychology*, *High Performance Habits*, and *Solution Focused Brief Therapy* (SFBT). Techniques are likely to include discussion, cognitive reframing, awareness exercises, self-monitoring, visualization, journaling, role play or psychodynamic exercises, drawing or use of other art techniques, assessment, and appraisal testing, reading books & relevant articles, listening to podcasts, *Right Now Media*, *YouTube,* or similar videos. Homework assignments often are given to aid in the training and learning process.

_____ **(initial) I understand and agree with the above.**

GOALS, BENEFITS, AND RISKS:

All relationships with Anne "Kip' Rodgers Watson, MA, LPC-S, CHPC are strictly professional in nature. Exceptions are in the case of sport psychology or training settings requiring interaction on-site with an athlete and/or coach, trainer, agent, team, and family member(s), or due to usual or unforeseen circumstances in the sports environment. Services rendered will be conducted in a professional manner consistent with accepted ethical standards of conduct by law. Clients should expect to set goals and receive guidance in efforts to reach those goals. Talking about thoughts, feelings, experiences, problems, and conflicts are common. Clients should be prepared to hear and receive support and encouragement as well as receive appropriate feedback and confrontation.

- Training/Coaching/Therapy has potential emotional risks. Discussing thoughts and feelings may be painful. Making changes can be scary, and sometimes disruptive to relationships, jobs, and family. The exact nature of these changes cannot be predicted.
- Clients come expecting to 'feel better' or see immediate results. Those benefits often happen. Clients should be aware the process can lead to 'feeling bad' or worse as new physical and mental insights are gained.
- Most people find in-session work and homework helpful. Improvement is significantly impacted by the effort and time put into the discussions and assignments.
- You have the right to refuse anything Kip suggests without being penalized.
- A team approach is recommended to accomplish goals. Your team can include family, friends, coaches, trainers, agent(s), and doctors.
- Expect to be pushed and challenged to change and grow.

The length of treatment/training is unique to the client and the nature of the problems(s) and goal(s) to be addressed. No promises or guarantees of outcomes can be made. All clients have responsibility for their own growth and change. Each client is accountable to work hard towards solving issues and doing the work recommended.

I, _____, the undersigned participant, hereby assume the risk and release *Braincode Corp/NeuroSport™,* Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC, as counselor/coach, consultant, officers, and employees from all liability to myself, minor, my spouse, legal representatives, heirs and assigns, whether said liability is on account of personal injury, medical expense or otherwise, arising out of my participation.

GROUP/TEAM INSTRUCTION/WORKSHOPS:

Confidentiality and appropriate ethical standards of behavior remain in effect for all group and workshop sessions conducted in the office or out on location. Each member is responsible for upholding confidentiality with the information shared by Kip, and/or other clients in attendance. No insurance will be accepted for group or *CHPC* coaching. We design the classes to be educational and interactive. She expects participants to engage and respect the process.

_____ **(*initial*) I understand and agree with the above.**

EMERGENCY/CRISIS CARE:

KIP DOES NOT provide a 24-hour crisis hotline counseling service. Should you experience an emergency necessitating immediate mental health or legal attention, call 9-1-1 or go to the nearest emergency room for assistance. If Kip is away from the office for an extended time, other arrangements can be made, or an alternative counselor will cover her practice and be assigned in her absence.

_____ **(*initial*) I understand and agree to the above.**

TELEHEALTH:

This practice offers individual sessions, group sessions, and assessments via telehealth. Telehealth is the delivery of healthcare services when the therapist/sports psychology professional and client are not in the same physical location using various technologies. Generally, the risks and benefits of telehealth are similar to those of in-person sessions. There are additional risks, however. First, although we use secure platforms with industry-standard encryption and security, there is no way to guarantee this is completely failure-proof. **As with any technology, there is a chance of a security breach affecting the privacy of personal and/or medical information.** Second, since you will be completing sessions in your own home, we cannot guarantee the same level of privacy you have when you are in the office. This means you are responsible for making sure you are in a restricted area where disruptions (e.g., others coming into the room or hearing what you say) are minimized as much as possible. To reduce risks to confidentiality, it is suggested all video or telephone sessions occur in a private room with no one else present and you wear headphones/earbuds to limit the possibility of other people overhearing confidential information.

It is important you understand, acknowledge, and agree to the following statements:

- When you engage in a telehealth experience for yourself, you understand the session contains personal identifying information and protected health information.
- You understand the therapist/sports psychology professional will be at a different location from you.
- You understand you have the right to withhold or withdraw your consent to the use of telehealth services at any time during the session without affecting your right to future care, coaching, or treatment.
- You have been informed of and accept the potential risks associated with telehealth, such as failure of security protocols that may cause a breach of privacy of personal and/or medical information.
- You understand the laws that protect privacy, and the confidentiality of medical information also apply to telehealth, and no information obtained in the use of telehealth identifying you will be disclosed to other entities without your consent or as may be allowed by law.
- You have been given the opportunity to discuss questions relative to your telehealth experience, security practices, technical specifications, and other related risks.

_____ **(*initial*) I understand and agree to the above.**

SCHEDULING:

Office and virtual hours are Monday - Friday. It generally works best to schedule out your sessions in advance. Kip often has a waiting list of clients each week seeking an appointment. **Please understand during day/evening hours, Kip is generally in session and cannot answer the phone. Please leave a message with preferred days and times with your name and phone number or email.** Please do NOT use *Facebook or Instant or Direct Messenger* to communicate. It is best to email or call to schedule, change, or cancel a session. If your call is not returned within 48 hours, or if you need an emergency session, please contact Kip again and/or go to the nearest Emergency Room. Please understand and respect family and personal time away from the office unless it is a last resort.

PHONE/EMAIL/TEXT:

Emergency phone sessions are at no charge for a time less than 10 minutes per week. Charges will be prorated for additional minutes as per session rate unless it is a scheduled session. **If phone sessions/consultations conversations/email conversations carry over 10 minutes, your account will be charged $32.00/15 minutes.** Please note *Personal Health Information* according to HIPAA will not be discussed through text messages. If such information needs to be discussed, we will ask you to call our office. Confidentiality and client information CANNOT be fully protected when communicating via email and text. While our office uses HIPAA protected emails and password protected phone operations, given the nature of email, text, and phone, you assume all risk and liability for PHI released on your end of communication. Please refer to the *Privacy Practices* page for full details.

_____ **(*initial*) I understand and agree with the above.**

REFERRALS:

Should you and/or Kip believe a referral is needed, our office will provide some alternatives, including programs and/or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives. We encourage you to remain until you mutually agree services are no longer of benefit to you, the client. You, the client, always have the right to terminate at any time.

CLIENT RIGHTS:

As a client, you have complete control and may end coaching/therapy at any time although it is requested you participate in a termination/discharge session. You also have the right to refuse or discuss modification of any techniques or suggestions you believe might be harmful. Services will be rendered in a professional manner consistent with the current ethical practices promulgated by the *Ethical Codes* for the *Texas State Board of Examiners of Licensed Professional Counselors* and the HIPAA security and privacy rules. If at any time or for any reason you are dissatisfied with services, please let Kip know so existing issues can be worked through in a proper manner. If your concern is not addressed to your satisfaction, you can express that concern to the *Texas State Board of Examiners of Professional Counselors.*

Texas State Board of Examiners of Professional Counselors
333 Guadalupe Street, Suite 3-900
Austin, TX 78701
www.bheck.texas.gov

_____ **(*initial*) I understand and agree with the above.**

PARENT RIGHTS:

If a minor's parents are divorced or separated, a current copy of the court documents are required to begin services. Kip shares all information with both parents unless otherwise legally informed of parental restriction. If there is a reason one parent is not involved, this must be discussed and verified prior to coaching/counseling services. It is up to the divorced/separated parents to agree without Kip's involvement on how payments are to be made for services. **We expect parents to keep their own payment receipts for services. We only retain a payment was made, not by whom.** Payment arrangements must be agreed upon between parents, in your divorce decree, or with your respective attorneys. Payments are required at the time of service.

_____ **(*initial*) I understand and agree with the above.**

AFFILIATES:

Anne 'Kip' Rodgers Watson is an affiliate with several companies and receives monetary compensation. She offers recommendations for books, supplements, and products. While recommendations may be made to use such programs and products, you have the right to refuse and/or select which programs and nutritional products or services are correct or of interest to you. Similarly, you assume all risk while training at home without proper supervision or physician approval prior to use of services or products. It is highly recommended you seek a physician's approval prior to committing to any type of service or new nutritional and supplementation. You agree to be fully responsible for monitoring any service or supplement and expressly agree to assume all risks.

_____ (***initial***) **I understand and agree with the above.**

RECORDS:

Should you request a copy of your counseling records, please be aware a $25.00 record preparation fee will be incurred and a *'Release Authorization of Records'* form must be signed. If records are subpoenaed, this does not indicate an automatic release of records, and Kip may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client's best interest.

_____ (***initial***) **I understand and agree with the above.**

LATE/NO SHOW FEES:

We recognize both your time, and Kip's time are valuable. Please know a **FEE of $125 is charged for all scheduled sessions that are canceled, broken, or missed without a 24-hour advanced notice.** Exceptions are made in emergency situations. Voice messages received 24 hours before the appointment are adequate notice for cancellations. **Our office is not willing to run a balance unless payment plan arrangements have been made prior to appointments/testing and a current credit card is on file.** If fees go unpaid for a period of more than 6 months, then balance due goes to collections. If that becomes necessary, you agree you are waiving your rights to confidentiality of services with a counseling business and/or its representative to a collection agency. **All balance due fees MUST BE PAID WITHIN 6 MONTHS of service.**

_____ (***initial***) **I understand and agree to the above.**

INSURANCE & PAYMENT RESPONSIBILITY: *VERY IMPORTANT*

Currently Anne 'Kip' Watson, MA, LPC-S, CHPC is in network with BCBS. **All in-network insurance appointments are scheduled during the hours of 9:00am and 5:00pm Monday-Thursday.** Our office will submit claims with your insurance either in-network or out-of-network as a courtesy service. We will make a copy of your insurance card at your first session to be kept on file. You are responsible for providing our office with updated cards/changes when they occur. **If *Client Insurance Form* is not in place prior to appointment, you will be responsible for the full fee for the session.**

Any unpaid insurance amounts not received 60 days from the date of claims submission will be charged to your credit card on file regardless of expected insurance payment. If a charge is made on your card and insurance subsequently pays, then credit will be issued.

You, the client, should understand having insurance is no guarantee of insurance reimbursement. An insurance policy is a contract between you and the insurance company. Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC contracts with you, and when you sign the *Legal Consent* to treatment, this obligates you to pay for services rendered. **All clients or parent(s) or legal guardian(s) are responsible for payment at the time of service for self-pay clients. Insurance clients' deductible or copay is due at the time of service.** Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC will not charge for undelivered services unless as noted above for late cancelations, no-show appointments. If your payment is not received within the allotted time, then proper and necessary third-party action for collection will be taken. **If you are having a challenging time paying for therapy, please discuss it with Kip and office staff.** The fee for a returned check is $35. A *Superbill* is provided on request for direct reimbursement with carriers.

_____ (***initial***) **I understand and agree to the above.**

COURT APPEARANCE:

A court fee for appearance is $350 per hour (portal to portal) for preparation, wait, testimony, and travel time. A retainer fee of $1500.00 is due at the time of subpoena is served. Please request and read the supplemental *Court Testimony Agreement and Information* and discuss it with Kip immediately if you see potential for court testimony. Kip does not participate in any disability claims, workman's compensation, or litigation or employment disputes.

_____ (***initial***) **I understand and agree with the above.**

By my signature, I, _____ (print name), am affirming I have read and completed the entire informed consent, intake papers, considered it carefully, asked questions, and understand it. I have been fully oriented to the services of - Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC. I have been given a full verbal and/or written explanation. I understand my rights and responsibilities as a client and Anne "Kip" Rodgers Watson's responsibilities to me. I agree to services with Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC. I know I can end services at any time, and I can refuse any requests or suggestions made. I have read this entire *Waiver and Release and Assumption of Risk* document and fully understand its terms. I further state I am of lawful age and legally competent to sign this consent and release. I understand the terms herein are contractual and not a mere recital. I have signed this document as my own free act.

No handguns are allowed on the premises. No use of alcohol or illegal drugs is permitted at this office or at training sites.

Client **Signature:** _____ Date: _____

Client Name **(please print)** _____

Parent/Guardian **Signature:** _____ Date: _____

Parent Name **(please print):** _____

PAYMENT & FINANCIAL AGREEMENT

Client fees are established prior to evaluation, assessment, and on-going services. All fees are due in full at the time of a scheduled session. Upon request, receipts and/or monthly statements from Anne 'Kip' Rodgers Watson or named supervisee for each payment will be provided. **Appointments for additional sessions cannot be made until your balance is paid or other payment arrangements have been made with Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC. She will not extend credit to clients and will not write off account balances for past due payments. If a payment plan is necessary, then a current credit card must be kept on file to process agreed upon charges.** You are expected to adhere to the payment arrangements.

CERTIFIED HIGH PERFORMANCE COACHING: *not billable to insurance	**FEE:**
• **6 months/weekly individual sessions + *Braincode Personal Impact Report***	**$6200**
• **6 months/ weekly group sessions (minimum 4/group) + *Braincode Personal Impact Report***	**$3000/person**
• **Workshops**	**please inquire**
• **Keynotes and Speaking**	**please inquire**

NEUROSPORT PERFORMANCE ACADEMY: *not billable to insurance **(Sports Psychology/mental skills and life skills training)**	**Fee:**
• **Individual Athlete Assessment Includes:**	**$825/athlete**
✓ Initial consultation & Intake session	
✓ Online *NeuroSport Braincode* assessment	
✓ Results analysis session (*Athlete Report, Stress Management Report, Career Report*) and *Improvement Plan*	
• **One-on-one 45-60-min mental performance enhancement training sessions:**	**$200.00/each**
• **Email/phone/text Consultation** (billed in 15-minute increments)	**$32.00/15 min**
• **Team workshops for athletes, coaches, parents, leaders**	**please inquire**
• **PACKAGE OPTIONS:** Post-assessment Packages:	
✓ 12-Sessions (20% discount):	**$1920**
✓ 8-Sessions (15% discount):	**$1360**
✓ 6-Sessions (10% discount):	**$1080**

CLINCIAL THERAPY SESSIONS:	**Fee:**
• **Initial Intake session + Improvement Plan**	**$225.00**

- **Email/phone/text Consultation** (billed in15-minute increments) **$32.00/15 min.**
- **Individual session** **$200.00**
- **Family session** **$225.00**

INSURANCE VERIFICATION INFORMATION:

Client's Name: _____ Client's Birth Date: _____ Client's SS #: _____

Client's Address: _____

City, State, Zip _____

Home Ph.: _____ Work Ph.: _____ Cell Ph.: _____

Email: _____

Insurance Policy Holder:

Name: _____ Birth Date: _____

Insured's SS #: _____

Relationship to Client: _____ Employer: _____

Medical Insurance Company: _____ **Mental Health Insurance (if different):** _____

Medical Ins Phone #: _____ Mental Health Phone #: _____

Group #: _____ **Subscriber or Member ID #:** _____

FORMS OF PAYMENT ACCEPTED: cash, *Venmo*, *Zelle*, credit cards, or check made out to **Anne 'Kip' Rodgers Watson.**

Name on Card (*Please print clearly in caps*)

Billing Address

City, State, Zip code

Payment: VISA MasterCard Discover Amex Check *(circle one)*

Credit Card #:
Expiration:
CVV (3-digit code on back, or 4-digits on front of Amex):

_____
Signature and Date (by signing you authorize us to charge your credit card or deposit your check)

AGREEMENT SIGNED:
I have read, understand, and assume financial responsibility for the payment of all charges rendered. I understand that Anne "Kip" Rodgers Watson, MA, LPC-S, CHPC will file insurance claims as an in-network or out-of-network provider on my behalf when requested. **As a non-provider, Anne "Kip" Rodgers Watson can supply a *Superbill* when requested for me to submit to my insurance company for direct reimbursement. All self-pay rates will be paid to Anne "Kip" Rodgers Watson prior to services.** I agree with the payment information as stated above in this document.

Client Signature: _____ **Date:** _____

Parent or Legal Guardian: _____ **Date:** _____

HIPAA PRIVACY FORM

Consent for Use and Disclosure of Health Information

Client Name: _____ DOB: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____ - _____ - _____ Driver's License #: _____

Parent Name if Client is Minor: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the *Privacy Practices* before you decide whether to sign this *Consent*. Our *Privacy Practices* provides a description of our treatment, payment activities, healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information (PHI). A copy of our *Privacy Practices* is located on our website www.braincodecorp.com. We encourage you to read it carefully and completely before signing this *Consent*. We reserve the right to change our *Privacy Practices* as described. If we change our practices, we will issue a revised *Privacy Practices* form which will contain the changes. Those changes may apply to any of your PHI we maintain. You may obtain a copy of our *Privacy Practices*, including any revisions at any time by contacting:

Contact Person: Anne Kip' Rodgers Watson, M.A., LPC-S, CHPC
Telephone: 214-543-4108
E-mail: kip@braincodecorp.com
Address: 2770 Main Street, suite 137 (Caddo Office building) Frisco, TX 75033

Right to Revoke: You will have the right to revoke this *Consent* at any time by giving us written notice of your revocation submitted to the *Contact Person* listed above. Please understand revocation of this *Consent* will not affect any action we took in reliance on this *Consent* before we received your revocation. We may decline to treat you or to continue treating you if you revoke this *Consent*. All our communications become part of your clinical record. Records are the property of Anne 'Kip' Rodgers Watson, MA, LPC-S, CHPC. Adult client records are destroyed after five (7) years following closure of the file. Guardians or conservators do have access to child-client files and will need to sign for consent of services (joint custody cases, only one guardian/conservator is needed to sign for consent of the child). Minor client records are disposed of seven years after the client's 18th birthday. Should you request a copy of your counseling records, please be aware that a $25.00 record preparation fee will be incurred and a '*Release of Records'* form must be signed. If records are subpoenaed, this does not indicate an automatic release of records, and we may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client's best interest.

Identified Client or Parent Signature: _____ Date: _____
Relationship to Client if Minor: _____

Identified Person(s) allowed to share medical records:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____