**LIFE COACHING AGREEMENT**

**Dr. Torin T. Sanders, LCSW (www.torinsanders.com)**

**1832 Harmony Street \* New Orleans, LA. 70115**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Start date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of sessions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ground rules:**

1. **Client and Dr. Sanders will meet at regularly agreed upon day and time. If client is unable to meet, he/she must give Dr. Sanders a notice of 24 hours or the fee will be charged for the session.**
2. **If the session is video-based, the client must logon to the website at the agreed upon day and time (client must also complete the video consent form).**
3. **Client agrees to pay the agreed upon session fee on time via internet or in person.**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

1. **I understand that coaching is a professional relationship that is designed to facilitate the creation/development of personal, professional, and/or business goals and to develop and carry out a strategy/plan for achieving those goals.**
2. **In understand that I am fully responsible for my well-being during my coaching sessions, including my choices and decisions.**
3. **I understand that coaching is not a substitute for therapy, mental health care, or substance abuse treatment, and I will not use it in place of any form of therapy. I understand that professional referrals will be given if needed.**
4. **I understand that if I am currently in therapy or under the care of a mental health professional, I will have consulted with that person regarding the advisability of my receiving coaching services. Additionally, I will inform my coach of this relationship.**
5. **I will not use coaching in lieu of professional medical advice, legal counsel, accounting assistance or business consultation, and for each of these areas I understand I should consult the appropriate professionals. I acknowledge that all decisions on dealing with such issues lie exclusively with me.**
6. **I understand that social work services are generally confidential in nature with certain limitations. I acknowledge that these limitations have been explained to me.**
7. **I agree to complete an evaluation of the coaching process and notify Dr. Sanders immediately of any concerns.**

**I have read and agreed to the above.**

**Client signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Copy given to client on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**