Julie Alleman, M.Ed., LPC, LMFT, LAC

Licensed Professional Counselor, Licensed Marriage and Family Therapist, and
Licensed Addiction Counselor
Baton Rouge Christian Counseling Center
763 North Boulevard
Baton Rouge, LA 70802
Phone 225-387-2287 Fax 225-383-2722

Declaration of Practices and Procedures

I am pleased that you have chosen me for your counselor, and appreciate your confidence in contacting me for assistance. This statement is designed to inform you about my background and to insure that you understand our professional relationship. **Please sign and date the last page.**

1. **Qualifications:** I earned a Master of Education in Community Counseling from Southeastern Louisiana University in 1996. I am a Licensed Professional Counselor , license #3052, and a Licensed Marriage and Family Therapist, license #971, both registered with the Licensed Professional Counselor's Board of Examiners, which is located at 8631 Summa Avenue, Suite A, Baton Rouge, La 70809 (Phone 225-765-2515). I am also a Licensed Addiction Counselor, license #970, with the Department of Health and Hospitals, Office for Addictive Disorders, Addictive Disorders Regulatory Authority, which is located at 8738 Quarters Lake Rd., Baton Rouge, La. 70809 (phone 225-922-7700).

2. **Counseling Relationship:** It is my desire to promote a warm and trusting atmosphere in which you feel free to examine patterns of relating to others and behaviors, thoughts or moods that are causing you concern. I am multi-theoretical in my counseling approach, including but not limited to Cognitive Behavioral Therapy and EMDR. Goals for therapy are always established through collaboration with you, the client. The ultimate goal of counseling is the successful resolution of the problems that are deemed most important to you through that collaborative process. I often use between-session assignments, which are a vital part of the therapeutic process. Completion of these assignments is necessary for you to obtain the most from the therapeutic experience. You must make your own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to establish custody and visitation. I will help you think through the possibilities and consequences on decisions, but my code of ethics prohibits me from advising you to make a specific decision. Your first session involves information gathering and becoming acquainted. I will obtain historical information from you and review the events that brought you to see me. Feel free to ask me any questions you may have. The nature of your need will be discussed and recommendations made concerning future appointments or outside referrals if I am unable to provide the service appropriate for you.

3. **Areas of Expertise:** My counseling practice includes individual, marriage, family, couple, and group therapy. The areas of therapeutic intervention in which I specialize in include, but are not limited to, depression, anxiety, trauma, family of origin issues, substance abuse, adult children of alcoholics, and codependency. I work with adults and adolescents ages 13 and up.

4. **Session Times and Fees:** Counseling sessions are fifty minutes in duration, with the last ten minutes used for rescheduling, payment, and other related business. Fees are due at the time the services are rendered. The Initial Evaluation cost is $120.00. The fee for each fifty minute individual, marital, or family session is $100.00. Group counseling fees are $35.00 for a 90 minute session. Cash, personal checks, and third party payments are acceptable forms of payment. Please make checks payable to Julie Alleman. The final obligation for payment lies with you, the client, not the insurance or managed care companies. Fees are subject to change. There will be a $20.00 NSF charge on all returned checks.

Cancellation: The time you schedule for appointments is reserved for you specifically. If you must cancel a session, the office must be notified at least 24 hours in advance, which will allow for the scheduling of another person who may benefit from this time, or you will be responsible for the full session fee of $100.00. If the office is not open and you need to cancel, you can leave a message in our voice mail at (225) 387-2287 and the time of the call will be registered. We aim to confirm appointments, but do not always have ample staff to do so. Responsibility for remembering appointments rests with the client.

5. **Services Offered and Clients Served:** Individual, family, couple, and group counseling are available. I primarily work with adults and adolescents.

6. **Code of Conduct/Ethics:** As a Licensed Professional Counselor (LPC) and a Licensed Marriage and Family Therapist (LMFT), I am required by law to adhere to the Code of Conduct for LPC's and the Code of Ethics for LMFT's that have been adopted by my licensing board. Copies of these codes/ethics are available to you upon request.

7. **Privileged Communication/Confidentiality:** I am required to abide by the professional practice standards for Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Louisiana law. I do not disclose client confidences and information to any third party except for materials shared during supervision without a client's written consent or waiver except when mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations. State law mandates that I report to the appropriate authorities suspected cases of child abuse/neglect, elder abuse/neglect, or disabled abuse/neglect and instances of danger to self or others when reasonably necessary to protect the client or other parties from a clear and imminent threat of serious physical harm. When working with couples, families, or groups, I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. For example, I cannot release *any* information about either or both spouses I have seen for marital therapy to an attorney without signed authorizations from both spouses. When working with a family or couple, information shared by individuals in sessions where other family members are not present must be held in confidence (except for the mandated exceptions already noted), unless all individuals involved sign written waivers at the outset of therapy. Clients may refuse to sign such a waiver but should be advised that maintaining confidentiality for individual sessions during couple or family therapy could impede or even prevent a positive outcome to therapy. Your signature at the end of this form also includes permission for audio taping of sessions.

8. **Litigation Limitation:** Given that certain types of litigation (such as child custody suits) may lead to the court ordered release of information without your consent, it is expressly agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.) neither you or any attorney, or anyone else acting on your behalf, will call Julie Alleman to testify in a deposition or in court or any other proceeding, nor will a disclosure of any information contained in the chart, including but not limited to the psychotherapy notes, as defined and protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) be requested.

9. **Emergency Situations:** In case of emergency, call 911, the Crisis Intervention Center (The Phone) at (225) 924-3900, a psychiatric hospital, and/or go to the nearest emergency room, if warranted.

10. **Client Responsibilities:** You are expected to follow billing, scheduling and office procedures. If you have been seeing another mental health professional it is expected that you get permission from them or terminate the counseling relationship. If permission is allowed I would ask that you grant me authorization to share information with this professional so that we may coordinate our services to you. If you have suggestions or concerns about the counseling services that you are receiving please share these with me so that the necessary adjustments or referrals can be made. In addition, you are expected to follow through on any homework assignments in order for the therapeutic experience to be beneficial. Throughout the exploration process, issues may arise that are not

within my realm of expertise. It may be necessary to refer you to a therapist with the training and expertise appropriate for you. This will be discussed with you should these issues arise.

11. **Physical Health:** Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical within the last year, it is recommended that you do so. Also, you agree to list any medications that you are taking on the intake form and who your primary care physician is.

12. **Telephone Consultations:** Telephone consultations are rarely recommended, but are available as scheduled on a fee basis.

13. **Potential Counseling Risks:** As a result of mental health counseling, you may realize that you have additional issues which may not have surfaced prior to the onset of the counseling relationship. If this occurs, please feel free to share these new concerns with me. Also, there is a possible risk in couple or family counseling. If one partner changes, an additional strain may be placed on the relationship(s) if the other(s) involved refuse to grow. Marital or family conflicts may intensify as feelings are expressed.

I have read, or have had read to me, and understand the above information. I hereby sign in agreement and authorize this provider to release information to my primary care physician as needed. I also hereby sign in agreement and authorize this provider to release any information necessary to obtain assignment/payment of health care benefits from third party insurers, such as health insurance companies, HMO or PPO plans, or EAP programs, for the above services.

_____ _____

Client's Signature Date

_____ _____

Julie Alleman, M.Ed., LPC, LMFT, LAC Date

If the client is a minor, parental authorization is needed:

I _____ give permission for Julie Alleman, M.Ed., LPC, LMFT, LAC to conduct therapy with my (relationship) _____ (name of minor)_____

BATON ROUGE CHRISTIAN COUNSELING CENTER - Intake form for Children

TO HELP WITH YOUR CHILD'S FIRST SESSION, PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETELY AS YOU CAN.

PLEASE NOTE: ALL INFORMATION IS CONFIDENTIAL

Date_____ **Child's Age**_____

Child's Birthdate_____

Name of Child_____

Parent's Name_____

Address_____**ZipCode**_____

Residence Phone_____

Person responsible for the bill: _____ same as above or:

Name_____

Mailing Address_____

Father's Occupation_____

Work phone_____

Mother's Occupation_____

Work phone_____

Name of School_____

Grade_____ **Teacher**_____

Any Church Membership_____

How often does the family participate in some type of religious activity?_____
_____
_____

Briefly describe your family's spiritual life:_____
_____
_____

Who referred you to us?_____

Family Physician_____

Person to contact in case of emergency_____

Name_____ **Phone number**_____

List all members of the family (including anyone living in the house) by name and their age:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Has your child or any member of your family ever had counseling before? _____ yes _____no

If yes, describe and list counselor._____

_____

What concerns you most about your child?_____

_____

_____

When did the problem start or when did you first notice it?_____

_____

_____

Has your child's eating or sleeping habits changed?_____

_____

_____

What would you like your child to get out of counseling?_____

_____

_____

What have you tried so far?_____

_____

_____

Describe your child's personality - focus on strengths._____

_____

_____

_____

_____

Have there been any physical and/or psychological stressors in your child's life - moves, separations, deaths, abuse, etc.?_____

_____

_____

At what age did these occur?_____

_____

_____

How does your child react to stress?_____

_____

_____

Has anyone in the extended family had a similar personality and/or problems?

_____

_____

_____

What has been your biggest struggle with this child?_____

_____

_____

Do both parents work outside the home?_____

How is alcohol handled in the home?_____

_____

Does either parent use alcohol or drugs? _____yes _____no

If yes, describe frequency and type_____

_____

Does your child have any speech difficulties? _____yes _____no

If yes, explain_____

_____

Does your child have any physical handicaps? _____yes _____no

If yes, explain_____

_____

Does your child have any hearing or vision difficulties? _____yes _____no

If yes, explain_____

_____

_____

Does your child have any special fear? _____yes _____no

If yes, explain_____

_____

_____

Does your child like to read?

_____none _____little _____moderately _____much

When your child is doing homework, do you help him? _____yes _____no

If yes, explain what you help him with and how long it takes you to help him.

_____

_____

What age did your child enter school?_____

Did your child attend nursery school? _____yes _____no

Did your child attend kindergarten? _____yes _____no

Has your child skipped any grades? _____yes _____no

Has your child repeated any grades? _____yes _____no

Has your child changed schools? _____yes _____no

If yes, list schools and years attended:_____

_____

What subjects in school does your child like best?_____

_____

What subjects in school does your child dislike?_____

_____

If separated, divorced, or unmarried:

Does your child see the other parent? _____yes _____no

Briefly describe child relationship with other parent?_____

_____

Briefly describe child relationship with step-parent?(if applicable)_____

_____

Is your child taking any prescription drugs at this time? _____yes _____no

If yes, what type, what purpose, and who prescribed it?_____

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NOTICE OF PRIVACY PRACTICES CONSENT FORM

Effective April 14, 2003 a federal regulation, commonly known as the "HIPAA Privacy Rule", requires that we must provide all of our clients with a detailed notice, in writing, of our privacy practices. We have this lengthy "*Notice of Privacy Practices*" available in our waiting room and it is also on our web site: www.brchristiancounseling.com. A written copy of this policy is available upon request.

I understand that as a condition to my receiving treatment, Baton Rouge Christian Counseling Center may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this office. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, and which I have had the opportunity to review.

I understand that the privacy practices described in the "*Notice of Privacy Practices*" may change over time, and that I have a right to obtain any revised Privacy Notices, if requested.

I also understand that I have the right to request BRCCC to restrict how my health information is used or disclosed. BRCCC does not have to agree to my request for the restriction, but if BRCCC does agree, BRCCC is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent in writing, at any time. My revocation/withdrawal will be effective except to the extent that BRCCC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

Last Name, First Name:_____

BRCCC Appointment Confirmation Consent Form

In accordance with BRCCC's policy, there is a charge for missed appointments that are not cancelled with 24 hour's notice.
(*whether appointments are confirmed or not*)

I, _____, do NOT want my appointments confirmed.

I, _____, hereby give permission to have my counseling appointments confirmed.

Our preferable choice!

_____ E-mail:_____@_____
(INITIAL)

_____Telephone number(s): (____)_____HOME
(INITIAL)
(____) _____CELL

(____) _____WORK

If someone else -ANYONE else, presently or in the future, answers at ANY of these phone numbers listed above
OR
If voicemail / answering service/answering machine picks up:
_____ It ***IS*** permissible to leave a message, OR

*Note-BRCCC may show up on your caller ID.

_____ _____
Signature of Client **Date**

_____ _____
Signature of Spouse (if applicable) **Date**

NOTE: DUE TO FLUCTIATIONS IN STAFF, WE ARE NOT ALWAYS ABLE TO CONFIRM APPOINTMENTS.
Remembering appointments is the responsibility of the client.

Policy for Cancellations & "No Shows"

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(225) 387-2287 *(24 hour voice mail)*

I, ____, agree to have my/our
Print Name(s)
MasterCard or Visa charged the **FEE OF $35 for first appointment and the FULL FEE of $100 for all successive appointments:**

1) for any session not cancelled with ***at least*** 24 hour notice, and/or
2) for any appointment I/we neglect to appear ("no show")
3) for any balance owed 30 days past due.

____ ___________________
Signature Date
~~~~~~

BRCCC's policy is that payment is due at the time of the session.

Confirmation of appointments is provided as a courtesy, when there is ample staff to do so.
Keeping the appointment is the responsibility of the client.

All new or returning clients will need to have a credit card number on file before scheduling their first or a new appointment.

Credit cards numbers will be securely locked and kept confidentially along with other client data.

PLEASE FILL IN THE INFORMATION BELOW		
CARD TYPE MasterCard ☐ **MASTERCARD** VISA ☐ **VISA** DISCOVER NETWORK ☐ **DISCOVER**		
CARD NUMBER:	**SECURITY CODE:**	**ZIP CODE:**
CARDHOLDER NAME:	**EXP DATE:**	
SIGNATURE:	**AMOUNT: Maximum $100.00 for missed appointments or ANY balance due past 30 days**	
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