

Joel Gilbert, MSW, LCSW
Baton Rouge Christian Counseling Center
763 North Boulevard, Baton Rouge, Louisiana 70802
Phone: 225-387-2287 Fax: 225-383-2722

Declaration of Practices and Procedures

I am pleased that you have chosen me as your counselor. The purpose of this statement is to inform you of my background and to insure that you understand our professional relationship.

1. Counseling Relationship: In an effort to promote a positive therapeutic environment, it is my desire to provide a safe and open atmosphere in which you feel free to examine your thoughts, emotions, and patterns of behavior which are of concern to you. It is my desire to establish a counseling relationship based on mutual respect, trust, and honesty. My approach to counseling is multi-theoretical in nature, but is primarily based in Cognitive-Behavioral and Rational-Emotive theory. After a thorough assessment, goals are established through collaboration with the client. The ultimate goal of therapy is the successful resolution of the problems that are deemed most important by the client. Clients must make their own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to set up custody and visitation. It is my goal to assist you in the problem solving process; however, my code of ethics does not allow me to advise you to make a specific decision.

As a Christian counselor, I believe God is able and eager to help facilitate emotional and spiritual growth. I seek God's guidance through the Holy Spirit and use Scripture and prayer when appropriate. It is not at all necessary that you share my view. I will respect your spiritual beliefs and am willing to explore your personal belief system as you give direction.

2. Qualifications: I received my Master of Social Work degree from Louisiana State University in 2009. I earned a Bachelor of Science in Psychology from Louisiana State University in 2007. I am a Licensed Clinical Social Worker, license number: 10585.

3. Areas of Expertise: My areas of specialization include the treatment of depression and anxiety, grief and loss, couples counseling, relational issues, communication issues, anger management, parenting, and sex education. I work with both individuals and couples. I also work with clients who present with mood and/or personality disorders.

4. Session Fees: Fees are \$110.00 for the initial session and \$ 90.00 per each 50 minute session thereafter. Payment can be made by check ,cash, Visa, or MasterCard and is due at the time of service. Fees are payable to Joel Gilbert, LCSW. (NOTE: When paying with cash you must have exact fee or you will be issued a credit toward your next visit).

5. Explanation of the types of services and client population: Individual, child, adolescent, marriage, and family counseling are available. Counseling with children is available within the context of family therapy. Group counseling is offered as needed.

6. Code of Ethics: I am required by state law to adhere to the Louisiana Code of Conduct for Louisiana Licensed Clinical Social Workers. Copies of this code are available upon request.

7. Privileged Communication/Confidentiality: I am required to abide by the professional practice standards and Louisiana law. I do not disclose client confidences and information to any third party except for materials shared during supervision without clients 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. Certain types of litigation may lead to the court-ordered release of information without your consent.

When working with individuals, 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. When working with a family or couple, information shared by individuals in sessions, when 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.

8. Potential Counseling Risks: As a result of mental health or couples/family counseling, the client may realize that he/she has additional issues which may not have surfaced prior to the onset of the counseling relationship. These issues may present possible risks in a couple or family in counseling. If one partner changes, additional strain may be placed on the relationship if the others involved refuse to change. Marital or family conflicts may initially intensify as feelings are expressed.

Fees are subject to change. There will be a \$20 NSF charge on returned checks.

Cancellation: If you are unable to keep an appointment, the office must be notified at least 24 hours in advance or a fee of \$35 will be assessed for the first cancellation, then the full \$90 fee will be assessed thereafter. 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 your 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.

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. Telephone Consultations: are available on a fee basis; it is expected that you will respect my privacy in this matter.

11. Client Responsibilities: The client is expected to follow billing, scheduling and office procedures. It is expected that he or she will terminate any previous counseling relation or get permission from the prior therapist. It is suggested that the client have a complete physical examination if he/she has not had one within the past year. Also the client agrees to list on the intake form any medication he/she is taking. I have read and understand the above information and have received a copy of it. I hereby sign in agreement and authorize the provider to release any information necessary to obtain assignment of health care benefits for the above services and to release information to my primary care physician, as needed.

Client Signature _____ Date _____

Joel Gilbert, MSW, LCSW _____ Date _____

If client is a minor, parental authorization is needed: I, _____,

give permission for Joel Gilbert, LCSW 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!

(INITIAL) E-mail: _____ @ _____

(INITIAL) Telephone number(s): (____) _____ HOME

(____) _____ 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 FLUCTUATIONS IN STAFF, WE ARE NOT ALWAYS ABLE TO CONFIRM APPOINTMENTS.

Remembering appointments is the responsibility of the client.