Erin F. McKowen, MSW, LCSW
Baton Rouge Christian Counseling Center
763 North Blvd., B.R., LA 70802
www.brchristiancounseling.com
(225)387-2287

WELCOME LETTER

I am looking forward to meeting with you and would like to go over some necessary details to set you up for your upcoming appointment(s).

HOW TO SCHEDULE: Go to www.brchristiancounseling.com and click on the drop down "COUNSELING". Then click on "Counselors" and then on "Erin McKowen". There is a link on my bio that leads you to a page to be set up as a new client and be able to schedule your future appointments. You will not be able to schedule your initial appointment on-line, but you will be able to schedule future appointments if you choose to do so. Follow the directions to set up your account. Make sure to fill out the section labeled Biographical information.

FORMS: Print out the attached forms and bring them to your first appointment.

CONFIRMATION: On the registration Form (on line) you can elect to have your appointments confirmed through text , email, or automated phone call. Whether an appointment is confirmed or not, you are ultimately responsible for remembering your appointments and will be charged for any missed appointments.

INSURANCE: I am an in network provider for a few insurance companies. If you plan to use insurance , please fill in the insurance information when you register. If I am NOT an in-network provider for your insurance company, you may have out of network benefits. Please call your insurance company if you have any confusion on your coverage, as mental health benefits are usually different from your medical benefits. In addition, feel free to contact my insurance coordinator , Debra Duran, at (985)327-8012 or you can email her at adkins.mentalhealthbilling@gmail.com.

ERIN F. MCKOWEN, LCSW
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763 North Boulevard, Baton Rouge, La. 70802
(225) 387-2287, Fax (225) 383-2722

DECLARATION OF PRACTICES AND PROCEDURES

I am pleased that we will be working together and I am committed to helping individuals and families who contact me for professional counseling services. Please read over the following to obtain a better idea of my qualifications and our office policy & procedures. Once you have reviewed these first two pages, PLEASE SIGN AND DATE.

1. 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 eclectic in my counseling approach which means that I use a variety of theoretical approaches in an attempt to match the client. While I act as a guide to assist you in reaching your goals, it is your responsibility to make the changes necessary to accomplish those goals.
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 any questions that 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 appropriate service. A physical examination is recommended if you have not had one in the last year. I also ask that you document any medications that you may be taking.

2. Qualifications. I earned a master of Social Work degree from Louisiana State University in 1994, and am a Licensed Clinical Social Worker (La. License #3939). I originally obtained an undergraduate degree in Accounting from the University of Texas and subsequently went on to get my CPA.

3. Session Times and Fees. Counseling sessions are 50 minutes in duration with the remaining ten minutes used for rescheduling, payment and other related business. Fees are due at the time of service rendered. My initial evaluation fee is $135.00. My fee for each 50 minute individual session is $100.00. Family and marital counseling is $110.00. Group counseling fees are $50.00 for a 90 minute session, $40.00 for a 60 minute session. There will be a charge for telephone consultations, excessive phone calls and some emergency situations. Cash, credit card or personal checks are acceptable for payment. Except for Managed Care clients, third party payments are not accepted, but a receipt can be obtained for reimbursement purposes from your insurance carrier. THE FINAL OBLIGATION FOR PAYMENT LIES WITH THE CLIENT, NOT THE INSURANCE OR MANAGED CARE COMPANY. Fees are subject to change. There will be a $25 NSF charge on all returned checks.

4. Cancellation. If you must cancel a session, the office must be notified at least 24 hours in advance or you will be responsible for the FULL SESSION FEE OF $100.00/$110.00. 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 will be registered. **We aim to confirm appointments, but do not always have ample staff to do so. Responsibility for remembering appointments and clarifying appointment time discrepancies rests with the client.**

5. Code of Conduct. I am required by Louisiana law to adhere to a Code of Conduct which is determined by the Louisiana State Board of Certified Social Work Examiners.

6. Privileged Communication/Confidentiality. Confidentiality and privileged communication remain rights of all people involved in counseling, according to the State of Louisiana. I will need written consent in order to share confidential information with a third party (ie., other doctors, counselors, etc.). There may be cases where a judge may order that your counselor testify or produce counseling records. Please inform me immediately if you are involved in any litigation so we can discuss the potential risks. Certain types of litigation may lead to a court ordered release of information without your consent.

As I participate in supervision and peer supervision, I may share general, non-descriptive information (no names, etc.) in order to aid in therapy. Also note that if you are using third party insurers, such as health insurance policies, your signature at the bottom of this page allows me and my insurance coordinator to obtain and share information necessary to obtain health care benefits.

State law requires that I report to the appropriate authorities suspected cases if an individual intends to take harmful, dangerous, or criminal action against another person or against him/herself. It is the counselor's responsibility to warn appropriate individuals of such intentions. Additionally, any suspicion of child or elder abuse in any form MUST be reported. Individuals warned may include one or more of the following:
a) the person or the family who is likely to suffer the results of harmful behavior; b) the family or friend(s) of the person who intends to harm himself or someone else; c) law enforcement officials; d) the coroner.

7. Potential Counseling Risks. As a result of mental health counseling, the client may realize that he/she has additional issues which may not have surfaced prior to the onset of the counseling relationship. Also, there is a possible risk in couples and/or family counseling of one person changing and placing additional strain on the relationship(s), especially if the other(s) involved refuse to grow.

8. 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.

9. Telephone Consultations: are rarely recommended, but are available on a fee basis. The fees are the same as my reasonable and customary fees as stated in declaration # 3. It is expected that you will respect my privacy in this matter. (see declaration #3 for fees). There may also be a charge for excessive emails and texts.

10. Client Responsibilities. The client is expected to follow billing, scheduling and office procedures. In a case where I may be working with the another mental health professional, written permission must be obtained from the first professional. 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 attached form any medications he/she is taking.

I have read and understand the above information. I hereby sign in agreement and authorize the provider to release any necessary information 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: _____

Client Signature: _____ Date: _____

Signature: _____ Date: _____

Erin Mc Kowen, LCSW, MSW

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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