

Sherry Kadair, MA, LPC, NCC
Baton Rouge Christian Counseling Center
763 North Blvd, 3rd Floor | Baton Rouge 70802
Phone: 225-387-2287 Fax: 225-383-2722

I am very pleased that you have chosen me as your counselor and are allowing me to be a tool in reaching your personal goals. Below is a brief explanation of the things that will be helpful in preparing for your first visit. Please read through and complete all paperwork.

DIRECTIONS/BUILDING ENTRANCE:

My office is on the third floor in the administration building of the First Presbyterian Church campus at 763 North Blvd (NOT North Street). There are only 2 entrances to the counseling center. **Park at a meter on 8th street and enter via the 8th street door OR park in the big parking lot on Convention (between 7th and 8th) and enter via the Chapel door.** At each of these two doors is a buzzer for the Counseling Center. Please do not buzz the church. Once you buzz the counseling center someone will unlock the door. Proceed to the third floor by way of the stairs or elevator. You may want to allow extra time to find the center on your first visit. You will find a map attached to this packet or on our website (www.brchristiancounseling.com). For additional assistance call 387-2287.

PAPERWORK:

Please review, sign and bring all the attached paperwork to your first appointment. If you do not print out the forms, please allow 20 minutes before your session begins to complete them.

SCHEDULING:

Upon scheduling, you will have an account on our scheduling software. The receptionist should give you a username and password when you call to schedule your first appointment. Additionally you will be asked for a credit card number to secure your appointment. After your first visit, please access this portal to schedule or cancel and future appointments. **As my schedule tends book several weeks in advance, you may want to schedule more than one appointment when you schedule your first.** To access the portal, visit www.therapyappointment.com and select my name.

CONFIRMATION OF APPOINTMENTS:

When you schedule, you will be asked if you prefer a text or email reminder. However, regardless of whether you receive a reminder, you are responsible for remembering your appointment.

CANCELLATIONS / NO SHOWS:

If you need to cancel, you are required to give at least 24 hours notice, preferably 48 hours or more, so that others have an opportunity to schedule. Please cancel via online portal, by leaving a voicemail, or by emailing me. Except in the case of emergencies, no shows or cancelling with less than 24 hours notice will result in a \$100 charge to your credit card on file.

FEES:

Please see the attached Policies and Procedures for my fee schedule. **If utilizing insurance, it is your responsibility to confirm the following information prior to using health insurance:** determine that I am on the provider list for your insurance, the number of sessions authorized, your co-payment, and the amount remaining on your deductible. If your deductible is not yet met, I will bill your insurance, however you are responsible for the payment in full per the contracted rate until your deductible is met. Fees/copays are due at the time of service. Payments may be made by cash (exact change only), check or credit card (Visa/MC only). My policy and the policy of BRCCC is to securely store the client's encrypted credit card number for payment purposes. It can then be used for sessions or for fees from any no shows or cancellations with less than 24 hours notice. At time of service, you may use any form of payment you wish.

You have made a brave first start by scheduling. I look forward to meeting with you!

Sherry

BATON ROUGE CHRISTIAN COUNSELING CENTER

Counselor: Sherry Kadair

DX CODE: _____

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

PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Date: _____ Birth Date: _____

Name: _____ (if a couple, please each fill out forms)

Address: _____ City/St _____ Zip: _____

Your Phone #'s: (Home) _____, (Work) _____
(Cell): _____

Email Address: _____

Your Employment/Job Title: _____

Person responsible for your bill, if different than above:

Name/Address: _____

If using Insurance, (**you also need to fill out the Insurance Questionnaire**)

Name of Ins. Co.: _____

ANY CHURCH MEMBERSHIP: _____

Briefly describe your **spiritual life:** _____

Last year of school completed: _____ or **GED** College: 1 2 3 4 Degree: _____ Other: _____

Single _____ Married _____ Separated _____ Divorced _____ Remarried _____ Widowed _____

Total number of prior marriages for you _____ for your spouse/partner _____

Spouse's name: _____ Age of spouse: _____ #of yrs. married _____

Spouse's employment: _____

WHO REFERRED YOU TO US? _____

Is it ok to call your home & leave message: Yes _____ No _____; At your work: Yes _____ No _____

Person to contact in case of an **emergency (name/phone):** _____

BRIEFLY describe your reason for seeking counseling: _____

Do you have children? _____ Yes _____ No If yes:

First Name Age Gender Relationship to you Live in your home?
(biological/step/adopted/foster)

Your Parents':(Father) Age:____ or ____ Deceased (Mother) Age:____ or ____ Deceased

Number of **Brothers**:_____ Number of **Sisters**:_____

Has anyone in your family ever had **counseling** before? If so, for what? _____

Any history of **drug/alcohol abuse** for self, father, mother, siblings? _____ Yes _____ No

If yes, please describe:_____

Any history of **physical** or **sexual abuse** to you or your brothers / sisters? _____ Yes _____ No

If yes, please describe:_____

Do you use **alcohol** or **nonprescription drugs**? _____ Yes _____ No

If yes, describe frequency and type:

Have you ever experienced any **sexual difficulties**: _____ Yes _____ No If yes, describe:

Have you ever had **counseling** before? _____ Yes _____ No

If yes, describe and list counselor, rough number of sessions, any psychiatric hospitalizations:

Describe any **major changes** that have occurred to you or your family in the last few years?
(moves, changes in number of family members, marital status, situation or income)

List any **major health problems** for which you have received treatment for in the last 24 months:

Primary Care Physician: _____ **Phone:** _____

Are you taking any **prescription drugs** at this time? _____ Yes _____ No

If yes, what type, for what purpose, and who prescribed?

PLEASE CIRCLE or CHECK ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU:

Nervousness	Depression	Fear
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Problems

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

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

Sherry Kadair, LPC, NCC
Baton Rouge Christian Counseling Center
Office Address: 763 North Blvd. Baton Rouge, LA 70802
Office Number: 225-387-2287

Declaration of Policies and Procedures

Qualifications: I earned an MA degree in Counseling from Denver Seminary, a CACREP accredited program. I am licensed as a Licensed Professional Counselor (Lic # 4036) with the Licensed Professional Counselors Board of Examiners, 8631 Summa Avenue, Baton Rouge, Louisiana 70809 Telephone (225)765-2515.

Counseling Relationship: I see counseling as a process in which you and I explore and define present problem situations, develop goals and work during sessions and through outside homework assignments toward realizing those goals.

Areas of Expertise: I have a general practice but focus on adult clients. I hold a national certification as a National Certified Counselor (NCC Lic#63282).

Fee Scales: The fee for a 60 min session is \$100. The first appointment fee is \$135. I am on many insurance panels. For those without insurance, some sliding scale appointments are available. Payment is due at the time of service. Clients are seen by appointment only. Clients will be charged for appointments that are broken or canceled without 24-hour notice (see attached form).

Services Offered and Clients Served: I counsel men, women and children ages 16 and above. I use an eclectic approach tailored to meet an individual's needs and goals.

Code of Conduct: As a Licensed Professional Counselor, I am required by state law to adhere to the Code of Conduct for practice that has been adopted by my licensing board. A copy of this Code of Conduct is available upon request.

Privileged Communications: Materials revealed in counseling will remain strictly confidential except when:

- The client signs a written release of information indicating informed consent of such release.
- The client expresses intent to harm him/herself or someone else.
- There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (65 or older), or a dependant adult.
- A court order is received directing the disclosure of information. (It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures as conceivable.)
- In the event of marriage or family counseling, material obtained from an adult client individually may only be shared with the client's spouse or other family members with the client's permission.

- Any material obtained from a minor client may be shared with that client's parents or guardian.

Emergency Situations: If an emergency situation should arise, you may seek help through hospital emergency room facilities or by calling 911. If you need to contact me, leave a voice mail at the number above. I will return your call within 24 hours.

Client Responsibilities: You, the client, are a full partner in counseling. Your honesty and effort are essential to your success.

- If you have suggestions or concerns about your counseling, I invite you to share these with me so that we can make the necessary adjustments.
- If you or I come to believe that you would be better served by another mental health provider, I am happy to help you with the referral process.
- If you are currently receiving services from another mental health professional, I need you to inform me of this in order to coordinate your treatment. I may ask you to grant me permission to obtain information from or share information with that professional.

Physical Health: Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. It is also important to provide me with a list of the medicines you are currently taking.

Potential Counseling Risk: Please be aware that counseling poses potential risks. In the course of working together additional issues may surface, may become more acute, or may affect your relationships in ways you had not fully anticipated. If this occurs, please feel free to share any new concerns with me.

If you have any questions or would like additional information, please feel free to ask. I look forward to working together with you.

I have read and understand the above information.

Client/Guardian Signature _____ Date _____

Counselor Signature _____ Date _____

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Credit Card Authorization Form

Confirmation of appointments is provided as a courtesy. Keeping the appointment is the responsibility of the client. Please use the online system to schedule and cancel appointments. If it is less than 8 hours before an appointment, the online system is unavailable and you will need to call to cancel.

There will be a \$35 charge for the first missed appointment and/or appointment cancelled without 24 hours notice. Subsequently the fee will be \$100 per occurrence.

It is my policy, and the center's policy, to securely store the client's credit card number for payment purposes. It will be used for the initial session, subsequent sessions (if desired) and to bill Missed Appointment/Late Cancellation fees. A \$0.01 fee will be charged if you have no copay to store the card. Payment is due at the time of the session.

I, _____, agree to have my/our MasterCard or Visa charged the **FEE OF \$35 for first appointment missed and the FULL FEE of \$100 for all successive appointments**. Insurance does not cover missed 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"), and/or
- 3) for any balance owed 30 days past due.

Signature

Date

HEALTH INSURANCE INFORMATION

We **do not** verify coverage or call to get the information concerning your coverage for you. You must **call** the phone number(s) on your health insurance card to get the following information **PRIOR** to your first session. **Without ALL questions on this form answered by your Insurance Company you will be responsible for the full session fee.**

Client's Name: _____ Date of Birth: _____

Insured's Name: _____ SS #: _____

Name of Insurance Company: _____ Effective date: _____

Insured's ID number _____ Group Numbers: _____

Call the number on your insurance card and ask the following questions:

To what address do we mail Mental Health Claims?

Do I have **mental health** out-patient benefits? Yes _____ No _____ (if no stop here)

Is (give counselors name) on my provider list? Yes _____ No _____

If not, do I have any **"out of network"** benefits? Yes _____ No _____
(Write what those benefits are on the back of this form)

Do I have a deductible? Yes _____ No _____

If applicable, how much of that deductible have I met? N/A _____ or \$ _____

What is my co-payment for **mental health**? \$ _____ per session

(If applicable) do I have marital counseling benefits? Yes _____ No _____

Is prior authorization needed for counseling? Yes _____ No _____

Authorization number? _____ how many sessions are authorized? _____

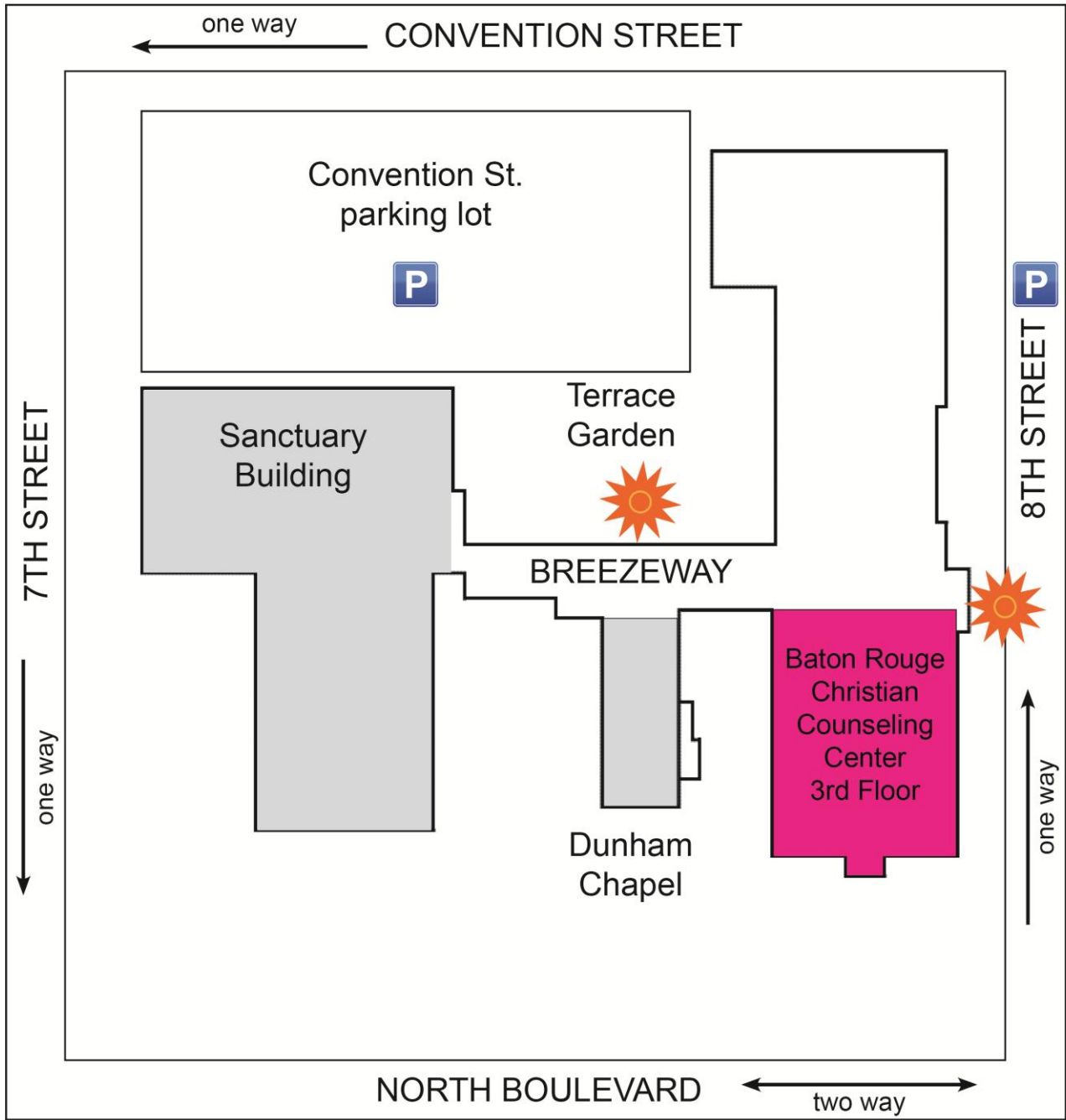
SIGN BOTH PLACES BELOW

I authorize the release of any medical or other information necessary to process claims.

SIGNED: _____ DATE: _____

I authorize payment of medical benefits to the counselor who provided the service.

SIGNED: DATE: _____



 Enter at either the 8th Street entrance or the Convention Street Chapel Breezeway entrance.

 Parking available in the Convention St. lot (free) or on 8th Street (metered).