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 $102charge 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 or 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

DX CODE: __________

Counselor: __Sherry Kadair________

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 (biological/step/adopted/foster)	Live in your home?

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**

Sherry Kadair, LPC, NCC
Baton Rouge Christian Counseling Center
763 North Boulevard, Baton Rouge, LA 70802
(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 $102. 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 ____________

Sherry Kadair, LPC

Baton Rouge Christian Counseling Center | 763 North Boulevard, Baton Rouge, LA 70802 | (225) 387-2287

INFORMED CONSENT FOR TELETHERAPY (VIDEO) COUNSELING

Prior to starting video-counseling services, we discussed and agreed to the following:

- There are potential benefits and risks for video-conferencing that differ from inperson sessions.
- Confidentiality still applies and no one will record the session without the permission of the other person.
- You will need a webcam or a smartphone/tablet for the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be in a quiet, private space that is free of distractions during the session.
- The same 24-hour cancellation rules apply to video counseling.
- We need a back-up plan (e.g., phone number where you can be reached) in case we have technical difficulties. If we get disconnected, I will continue to try to reach you. If we both initiate, we will miss each other.

  Back-up phone number: (_______) ________________________

- We need a safety plan that includes at least one emergency contact and the closest ER to your location in the event of a crisis situation.

  Emergency Contact Name:_______________________________

  Emergency Contact Number: (______) ____________________

  Closest ER:____

- As your counselor, I may determine that due to certain circumstances, video counseling is no longer appropriate and that we should resume our sessions in person.

PLEASE READ AND SIGN AND RETURN THE TELEMENTAL HEALTH AGREEMENT AS FOLLOWS:

As your client in teletherapy, I understand the limits of liability for Digital Communication, Telemental Health and Teletherapy. At the beginning of each session, I agree to disclose my current location and allow my therapist to assess for safety, security, and comfort in my environment. The virtual teletherapy sessions will be conducted through VSee Messenger, a HIPAA compliant teletherapy platform, and my Patient Health Information (PHI) will be protected within the limitations of VSee and the environment in which the services are utilized.

Email and Text Messaging: The client should be aware that they have the right to refuse digital communications with the therapist; however, this could limit communication channels and immediacy of access to reach each other in the counseling relationship. The client understands that the use of digital technology, email, text messages, online video conferencing services, software, and/or platforms may not meet HIPAA compliance standards; therefore, I understand that my therapist will protect my information to the best of their ability within the limitations of the digital and physical environment. If VSee does not work, I agree to use non-HIPAA compliant FaceTime.

There is confidentiality risk involved for both parties in utilizing digital technology Communication. I understand the risk involved in digital communication and I hereby authorize my therapist to communicate with me utilizing digital technology on the internet.

Please initial here if you agree to the teletherapy policy outlined above: _____________

Client's Signature(s): ____________________________________ Date: ____________

Print Name: ____

Counselor's Signature: ________________________________ Date: _______________

Sherry Kadair, LPC

INFORMED CONSENT FOR IN-PERSON THERAPY DURING THE COVID-19 CRISIS

Decision to Meet Face-to-Face

If we mutually decide to meet in person (Face-to-Face, hereinafter - F2F) for some or all future counseling sessions, precautions must be in place to mitigate the COVID-19 pandemic. This document contains information about those precautions and guidelines to safely meet F2F. Your signature(s) below indicates that you understand and agree to undertake these actions concerning all F2F appointments. Please read this carefully and let me know if you have any questions.

If we mutually decide to meet in person (F2F) and there is a subsequent resurgence of the pandemic, or subsequent changes in local, state, or federal guidelines, or if other health concerns arise, I may require that we meet via teletherapy. If you decide at any time that you would prefer teletherapy, I will respect that decision, provided it is clinically appropriate.

Also be mindful that if your therapist files for reimbursement for any teletherapy services, such reimbursement is determined by insurance companies and applicable law. You are responsible for payment whether services are provided via teletherapy sessions or F2F, and whether insurance companies reimburse or not.

Risks of Opting for In-Person F2F Services

Although there are potential benefits for in-person F2F counseling, there are also risks. You understand that by attending F2F sessions, you would be assuming the risk of exposure to the coronavirus, or other public health risks, and that this risk may increase if you travel by public transportation, cab, or ridesharing service.

In consideration of the services of Baton Rouge Christian Counseling Center (hereinafter BRCCC) and my therapist, I hereby agree to release, indemnify, defend and discharge both BRCCC and my therapist, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:

I have been offered by BRCCC and my therapist to conduct the therapy session remotely via Zoom or other online means, however, I desire a face to face therapy session. I am aware of the risk of infection with COVID 19 and I understand that such risk simply cannot be eliminated without completely avoiding a face to face therapy session.

I expressly agree and promise to accept and assume the risk of infection with COVID 19 existing in a F2F therapy session. My participation in a F2F therapy session at BRCCC and with my therapist is purely voluntary, and I elect to participate in spite of the risks.

Your Responsibility to Minimize Your Exposure

To obtain counseling in person (F2F), and signing this document, you will take the following precautions which will help keep all of us (you, me, our families, my staff, and other clients) safer from exposure, sickness and possible death. Failure to adhere to these safeguards, may result in our starting or returning to a teletherapy arrangement.

- If you reasonably believe that you have recently been exposed to, are infected with, or have symptoms of the coronavirus, you will cancel your F2F appointment or proceed using teletherapy.
- You will wait in your car or outside until no earlier than 5 minutes before your appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will wear a mask in all areas of the office (I, and my staff will too). Clients agree to:
  - bring their own face mask that covers their nose and mouth,
  - wear the face mask upon entering the building,
  - continue to wear the face mask until entering the counseling session, (face masks are not required during the counseling session, unless your therapist deems them necessary), and
  - wear a face mask after the session while exiting the building.
- You will adhere to the safe distancing precautions we have set up in the waiting areas and offices.
- You will keep a distance of 6 feet from all other persons and there will be no physical contact (i.e. no shaking hands) with me, other clients, or with my staff.
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- You will not bring guests and/or non-client children to BRCCC.
- You will take steps between F2F appointments to minimize your exposure to COVID-19.
- If you have a job, other responsibilities, or activities that put you in close contact with others infected with COVID, you will notify me immediately.

- If a resident of your home tests positive for the coronavirus infection, you will notify me immediately. Continuing treatments will be conducted via teletherapy until quarantine is over.
- To minimize contact with support staff, you will do all scheduling of appointments either online through the Therapy Appointment software, or over the phone with support staff.
- To minimize the exchange and handling of payment(s), you will have your credit card information on file with BRCCC at least one day prior to the counseling session.

I reserve the right to change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, you will be notified about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I are Sick

You understand that I am committed to keeping you, me, my staff, all clients, and all of our families safe from the spread of this virus. If you show up for an appointment and I, or my office staff believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by teletherapy as appropriate.

If I, or my staff, test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I am required to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for your visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature(s) below shows that you agree to and will abide with these terms and conditions. By signing this document, I acknowledge that I waive my right to maintain a lawsuit against BRCCC and my therapist on the basis of any claim that I released herein. I also agree to pay BRCCC and my therapist attorneys' fees and costs in enforcing this agreement.

___________________________	___________________________
Client	Date
___________________________	___________________________
Client (if couple, both sign)	Date
___________________________	___________________________
Therapist	Date

Written incorporating sample-informed-consent-form-1 from APA-1
Dee Adams, PhD, LPC, LMFT; LCC
Director BRCCC
May 18, 2020

X\BRCCC Covid CLIENT consent form

Sherry Kadair, LPC, NCC
Baton Rouge Christian Counseling Center
763 North Boulevard, Baton Rouge, LA 70802
(225) 387-2287 *(24 hour voice mail)*

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? _________

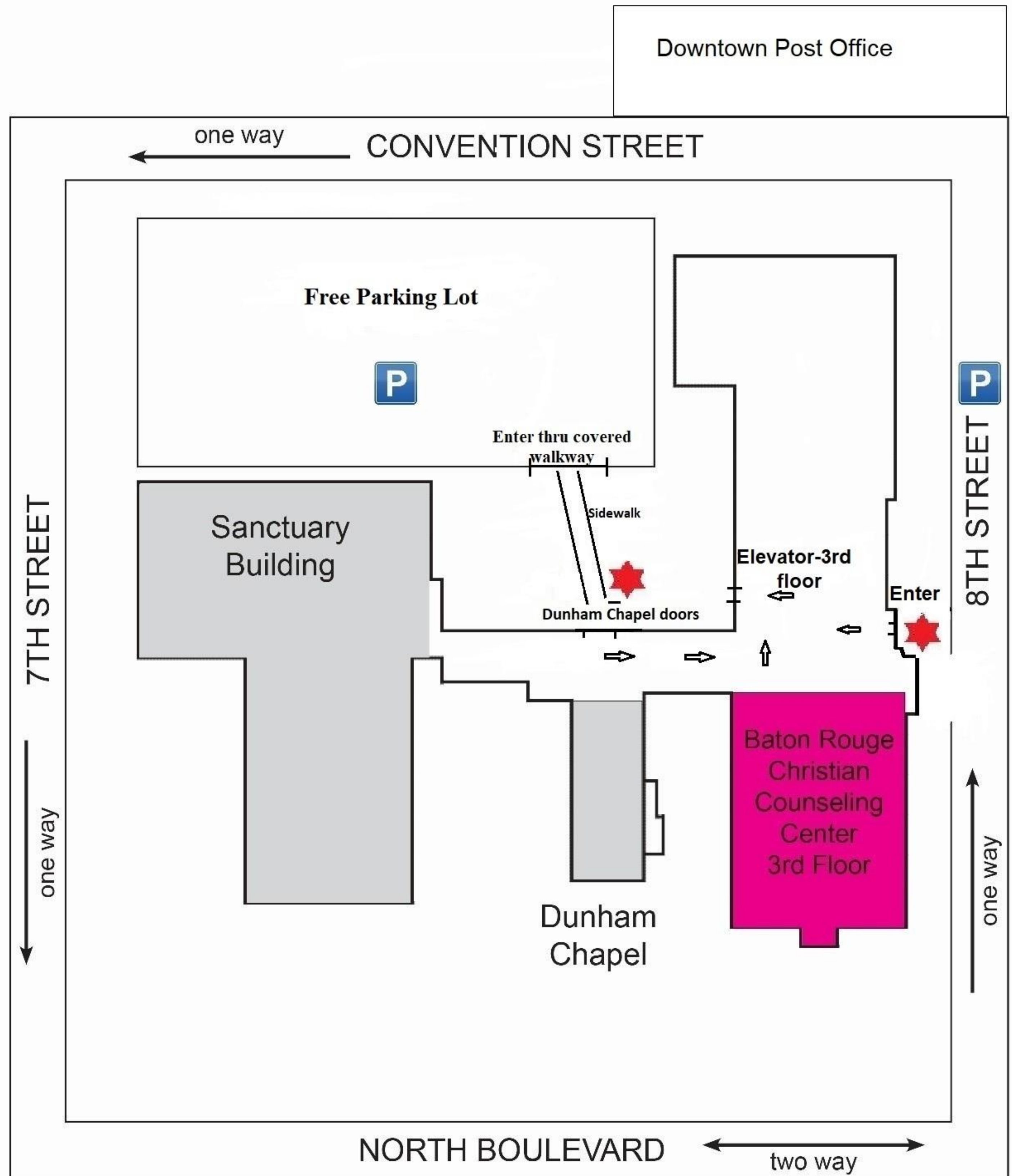
SIGN BOTH PLACES BELOW

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. Buzz appropriate box.

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