Stacy House, LPC-S

Baton Rouge Christian Counseling Center

763 North Boulevard, Baton Rouge, LA 70802

(225) 387-2287

WELCOME LETTER AND INFORMATION

Thank you for choosing me as your therapist, I am looking forward to meeting you. Below is an explanation of the things you'll need to know to be prepared for our first visit:

DIRECTIONS: See the attached map. My office is on the third floor of the red brick administrative building on the First Presbyterian Church campus at 763 North BOULEVARD (not Street) in downtown Baton Rouge. We are across Convention Street from the downtown Post Office. The church takes up a whole city block, bordered on 4 sides by North Boulevard (grass down the middle), Convention, and 7th and 8th Streets. In that block, we are in the red brick building closest to the Interstate. Either park at a meter on 8th Street and enter via the 8th Street door OR park in the big free parking lot on Convention and enter via the Chapel door. We can only buzz you in at 2 doors. Buzz the Counseling Center and someone will ask who you are here to see and then unlock the door. The counseling center is located on the 3rd floor. Both an elevator and stairs are available. You may want to allow extra time to find us for your first session, especially given Baton Rouge's traffic. Printing out these directions and/or bringing the map that is attached will help.

SCHEDULING: For your convenience, you can schedule online via www.therapyappointment.com. You may have set up your own account or the receptionist can give you a username and password when you call to schedule your first appointment. After your first visit, please access this portal to schedule or cancel any future appointments. To access the portal, visit www.therapyappointment.com and select my name. The first time you can only schedule one appointment, after that as many as you wish. To get a jumpstart, or because of travel, some people elect to schedule 1 ½ or 2 sessions for the first visit, or later visits. This is particularly helpful for couple counseling.

PAPERWORK: Please review, sign, and bring all the attached paperwork to your first appointment. Please do not print back to back. If you do not print out the forms, please allow 20 minutes before your session begins to complete them so you won't lose any of your therapy time. If you run late, you lose minutes. If I run late, you will always get all of your time. If you're coming as a couple then I need both of you to fill out all of the forms.

FEES: The fee per 50 minute session is $102. The first evaluative session is $120. The fee for 1 ½ sessions is $150 (75 minutes) and a double session of 90-100 minutes is $200.

PAYMENT: It is the BRCCC policy that payment must be made at the time of service. You can pay with check, cash, Visa/MasterCard, or Discover -- whichever is best for you.

CREDIT CARD ON FILE: To secure your appointment, we must have your credit card number on file prior to your arrival for the first session. It is safely secured through encryption. You can call our office at (225)387-2287 with a credit card number and we will charge a penny to your account, or you can login to your account on TherapyAppointment.com and do it yourself:

1. Login and click where it says “View or pay online statement”

2. Go to “Do you want to make a payment?”

3. Go to: “Please charge a _____to a new charge card

4. Fill in the name on the card, street address, and zip code

5. Click “Submit payment to charge card”

6. Verify by clicking “Yes”

7. Put in your credit card number, expiration date and 3-4 digit security CVV code from the back

8. Then click on “Process”

DONE ! Your credit card information is safely stored and encrypted in our system

INSURANCE: I will file with your insurance and am in network with Blue Cross Blue Shield, United Healthcare/Optum, Aetna, And Gilsbar. It is your responsibility to verify benefits. We can give you a receipt with a diagnosis for you to file for reimbursement via "out of network" benefits. You can see if you have mental health benefits by calling your insurance company and asking some questions that we have listed on a form on our website, under FORMS:

CONFIRMATION OF APPOINTMENT: On the Registration Form in your account online you can elect to have your appointments confirmed through text, email, or automated phone call. However, whether an appointment is confirmed or not, you are still responsible for remembering your appointments and will be charged if you miss. Reminders can be sent to up to 2 cell numbers or 2 email addresses – but not to texts AND emails.

CANCELLATIONS: If you ever need to cancel - I need at least 24 hours notice, preferably 48 hours. Cancellation within the remaining 24 hours will result in a charge. I really appreciate your understanding so I can schedule other clients in need of counseling. We have voicemail 24 hours a day, 7 days a week. If you need to cancel within the 24 hours, you can’t do that online – you have to call.

WAIT LIST: If you now, or ever, want an earlier appointment and nothing is available – email, message through the online scheduler, or call and ask to be put on my waiting list. We’ll call you if something opens up earlier. I sometimes email out notice of last minute cancellations. If you think you'll need more sessions, you may want to not wait until your first appointment to schedule more sessions so that you can get the times you want. The system only lets you schedule your first appointment – if you want more, call.

COMING AS A COUPLE: I generally meet with a couple together first, then one session with each person individually, then back together as a couple from then on. If this isn’t possible, I can be flexible. And for future sessions if one can’t come it’s OK to come alone. If you have any questions, please email me or give me a call. Please know that I'm looking forward to meeting you!

STACY HOUSE, LPC-S

Baton Rouge Christian Counseling Center

763 North Blvd, Baton Rouge, LA 70802

(225) 387-2287 ● (225) 383-2722 fax

www.brchristiancounseling.com

POLICY FOR CANCELLATIONS, NO SHOWS, AND CREDIT CARD AUTHORIZATION

It is my policy, and the BRCCC's policy, to securely store the client's credit card number for payment purposes. Credit card numbers will be securely locked and kept confidentially along with other client data. 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 to store the card and credited back to you at the first session. Payment is due at the time of the session. Please initial below:

_____I/We agree to have my/our credit card charged for $.01 and kept on file for payments

initials **and agree to a charge of full fee ($102 per therapy hour) for appointments missed:**

1) For any session not cancelled with at least 24 hours notice.

2) For any appointment I/we neglect to appear ("no show")

3) For any balance owed 30 days past due. My card will be

charged for the amount of the remaining balance due.

_____I understand that any card on file, whether listed below or encrypted in our software

initials **program, can be used**

☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMERICAN EXPRESS

CARD NUMBER: _____

SECURITY CODE:_____

ZIP CODE:_____

CARDHOLDER NAME: _____

EXP DATE:_____ SIGNATURE:_____

BATON ROUGE CHRISTIAN COUNSELING CENTER

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 website: 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**

BATON ROUGE CHRISTIAN COUNSELING CENTER

To help with your first session, please provide the following information as completely as you can.

PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL

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

Date:_____ Birth Date:_____ Age: _____ Counselor_____

Address:_____ City/St_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email Address:_____

Your Employment/Job Title:_____

Person responsible for your bill, if different than above:

Name/Address:_____

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 or how did you find us?

_____

Is it ok to call your home/cell & leave message: Yes___ No___ At your work: Yes___ No___

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

Please State Your Goals for Therapy:

1._____

2. _____

3.

_____

Do you have children? ____Yes ____No If yes:

First Name Age Sex Relationship to you Live in your home?

(biological/step/adopted/foster)

_____

_____

_____

_____

_____

_____

Father's Name_____ Age:_____ or __ Deceased

Mother's Name_____Age:_____ or __Deceased

Number of Brothers:_____ Number of Sisters:_____ Birth Order: ____ of _____# of children

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?

_____
_____

_____

Additional Comments:

While you were growing up, during your first 18 years of life:

Yes No 1. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

Yes No 2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

Yes No 3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or have oral, anal, or vaginal sex with you?

Yes No 4. Did you often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

Yes No 5. Did you often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No 6. Were your parents ever separated or divorced?

Yes No 7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No 8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No 9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No 10.Did a household member go to prison?

Put a number next to any item which you experience. 1=mildly, 2=moderately, 3=severely

<u>Emotional Concerns</u>

____feeling anxious or uptight

____excessive worrying

____not being able to relax

____feeling panicky

____unable to calm yourself down

____dwelling on certain thoughts or images

____fearing something terrible about to happen

____avoiding certain thoughts or feelings

____having strong fears

____worrying about a nervous breakdown

____feeling out of control

____avoiding being with people

____fears of being alone or abandoned

____feeling guilty

____having nightmares

____flashbacks

____troubling or painful memories

____missing periods of time - can't remember

____trouble remembering things

____feeling numb instead of upset

____feeling detached from all or part of body

____feeling unreal, strange or foggy

____feeling depressed or sad

____being tired or lacking energy

____feeling unmotivated

____loss of interest in many things

____having trouble concentrating

____having trouble making decisions

____feeling the future looks hopeless

____feeling worthless or a failure

____being unhappy all the time

____dissatisfied with physical appearance

____feeling self critical or blaming yourself

____having negative thoughts

____crying often

____feeling empty

____withdrawing inside yourself

____thinking too much about death

____thoughts of hurting yourself

____thoughts of killing yourself

____frequent mood swings

____feeling resentful or angry

____feeling irritable or frustrated

____feeling rage

____feeling like hurting someone

Behavioral and Physical Concerns

____not having an appetite

____eating in binges

____self induced vomiting for weight control

____using laxatives for weight control

____eating too much

____eating too little

____losing weight - how much?_____

____gaining weight - how much?____

____trouble sleeping

____trouble falling asleep

____early morning awakening

____sleeping too much

____sleeping too little

____# of hours I usually sleep: _____

____lack of exercise

____not having leisure activities

____smoking cigarettes

____often spending in binges

____temper outbursts

____aggressive toward others

____impulsive reactions

____trouble finishing things

____working too hard

____using alcohol too much

____being alcoholic

____using drugs

____driving under the influence

____blackouts - after drinking

____excessive internet/phone/tv usage

___Yes ___No Have you ever felt you ought to cut down

on your drinking or drug use?

___Yes ___No Have people annoyed you by criticizing

your drinking or drug use?

___Yes ___No Have you ever felt bad or guilty about

your drinking or drug use?

___Yes ___No Have you ever had a drink or used drugs

first thing in the morning to steady your nerves or to get

rid of a hangover

Intimate Relationship Concerns

____feeling misunderstood in relationship

____not feeling close to partner

____trouble communicating with partner

____not trusting partner

____lack of respect by partner

____partner being secretive

____lack of fairness in relationship

____problems with dividing household tasks

____disagreeing about children

____lack of affection

____unsatisfactory sexual relationship

____lack of time together

____lack of shared interests

____lack of positive interaction

____lack of time with other couples

____jealousy in relationship

____frequent arguments

____trouble resolving conflict

____partner being demanding and controlling

____partner putting you down

____violent arguments

____emotional abuse in relationship

____physical abuse in relationship

____sexual abuse in relationship

____partner having alcohol or drug problem

____self or partner having an affair

____feeling uncommitted to relationship

____wanting to separate

____discussing separating or divorce

____problems with in-laws

____problems with ex-partner

____problems with step parents

____children having special problems

_____

<u>Sexual Concerns</u>

____worrying about getting pregnant

____having miscarriage(s)

____choice of birth control

____having an abortion

____not able to become pregnant

____not enjoying sexual affection

____too tired to have sex

____too anxious to have sex

____feeling a lack of sexual desire

____wanting to have sex more often

____feeling neglected sexually

____feeling used sexually

____feeling unable to have orgasm

____being unable to sustain an erection

____feeling negatively about sex

____porn usage

____I think I may be a sex addict

____I think my partner may be a sex addict

<u>When Growing Up to Present Time:</u>

____being physically abused - by whom?

____being emotionally abused - by whom?

____being sexually abused - by whom?

____having an alcoholic parent - which?

____having a drug abusing parent - which?

____having a depressed parent - which?

____having a parent with emotional problems

____having parents separate or divorce

____close family member dying - who?

____felt neglected or unloved - by whom

____having an unhappy childhood

____having serious medical problems - what?

____having drug or alcohol problem

____frequent moves

____having learning problems - what?

____having emotional problems

____having attempted suicide - when?

_____
_____
_____

<u>Stresses During the Past Several Years:</u>

____death of family member or friend - who?

____birth or adoption of child

____self or family member hospitalized - who?

____moved

____being harassed or assaulted

____frequent family or couple arguments

____separation/divorce

____an important relationship ending - who?

____losing or changing job

____financial trouble

____legal problems

____natural disaster

____serious or chronic illness - what:_____

____other

Declaration of Practices and Procedures

Stacy House, LPC-S

Baton Rouge Christian Counseling

763 North Blvd., Baton Rouge, LA 70802

(225)-387-2287

Qualifications: I earned a MA degree in counselor education from Southeastern Louisiana University in 2009. I am licensed as a LPC-S #4621 with the LPC Board of Examiners which is located at 11410 Lake Sherwood Ave. North Suite A, Baton Rouge, LA 70816 (phone 225-295-8444).

Counseling Relationship: I see counseling as a process in which the client and the counselor work together to explore and define present problem situations. We then develop goals and work in a systematic fashion to realize these goals.

Area of Expertise: My interests include but are not limited to working with individuals, couples, and families dealing with mental health issues, especially those surrounding the family unit and child abuse and or neglect. I have additional training in child parent psychotherapy. I am registered as a LPC-S in Louisiana.

Fees and Office Procedures: Therapeutic services are offered to client's with mild to moderate mental health needs.. Fees are $120 for initial session and $102 for each subsequent session. Initial appointments can be made by contacting our office at (225)387-2287 or creating an account on our website at brchristiancounseling.com. Follow up appointments can be made on our website at brchristiancounsleing.com or by calling the office at 225-387-2287. My policy, and the policy of BRCCC, is to securely store the client's credit card number for payment purposes. It is used for the initial session, for subsequent sessions, for any "no shows", and for appointments not cancelled with at least 24 hours of notice. 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 $102. If the office is not open and you need to cancel, you can leave a message in our voicemail 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

Services Offered and Clients Served: I approach counseling from a family systems and client centered approach. I am open to work with any client with whom I believe I can form an effective counseling relationship. I am open to working with individuals, couples, and families.

Code of Conduct: I am required by law to adhere to the code of conduct for my practice which is determined by the Louisiana LPC Board of Examiners. A copy of this code is available on request.

Confidentiality: Information that is expressed in the counseling relationship is confidential except for materials shared with my supervisor and in certain circumstances in accordance with state laws:

1. The client provides a written request for release of information indicating informed consent.

2. The client expresses intent to hurt him or herself or anyone else.
3. There is reasonable suspicion of neglect of a minor, elderly adult (60 or older), or dependent Adult.
4. A court order is received directing the disclosure of information.

In any of these situations I will do my best to alert the client that their information is being disclosed as quickly as possible. In the case of minor children information may be shared with the parent. In couple and family counseling information will only be shared when the client consents.

Privileged Communication: 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 inform clients of all mandated disclosures when possible.

Emergency Situations: If an emergency occurs, please dial 911 or go to the nearest emergency room.

Client Responsibilities: Clients are expected to arrive on time for appointments. Clients should actively participate in the counseling session to achieve any successful outcome. If the client feels as if he or she is not benefiting from sessions he or she should inform the counselor. The client should keep the counselor informed of his or her perceived progress. If you are currently receiving any mental health services from another provider I expect you to disclose this to me and allow me to work together with that professional to better accommodate your needs. If you would be better served by another mental health provider, I will help you with the referral process.

Physical Health: It is important that I am aware of any medications legal and illegal you are currently taking. If you have not had a complete physical in the last year I strongly recommend that you have one now as any medical problems can exacerbate problems you are currently dealing with.

Potential Counseling Risk: As a result of Counseling a client may realize that there are additional issues which had not surfaced prior to the counseling relationship. It is also important to realize that as the client changes the relationships he or she has will be affected. This is especially apparent in marriage and couple counseling.

Digital Communication and Technology Agreement: As per the certification requirement of the LPC Board, I have taken the continuing education necessary to utilize telemental health services in my practice. At the beginning of each session, we will assess for safety, security, and comfort in your environment. Online sessions will be conducted through my Zoom business account. The client should be aware that they have the right to refuse digital communications with the therapist.

Teletherapy: Synchronous (real-time video and audio transmission) sessions may be provided to client's where appropriate. Client's must be in safe and private environments while participating in video-based sessions. Other individuals who have not consented to counseling or signed a release of information may not observe sessions. Teletherapy or in-person sessions cannot be recorded, redistributed, posted, uploaded, etc. All clients who participate in Teletherapy Sessions must sign an Informed Consent Agreement. For client's convenience, paperwork may be emailed through an encrypted email service. However, counseling services will not be provided through asynchronous (e-mail, text, chat, blogs, etc.) methods. Communication via video, e-mails, texts and telephones can compromise the privacy and confidentiality of conversations. Please notify me if you decide to avoid or limit in any way the use of video, telephone, or any other form of electronic communication. As part of my practice I may call you or email you between your appointments to confirm / remind you of upcoming appointments or to assist you with any technical problems that may occur.

I have read the declaration of practices and procedures of Stacy House, LPC-S and my signature below indicates my full informed consent to services provided by Stacy House, LPC-S.

Client Signature_____ Date_____

Stacy House, LPC-S_____ Date_____

Parental authorization section for minor clients.

I, _____, give permission for Stacy House, LPC-S, to conduct counseling with my (relationship)_____

(Name of minor) _____

STACY HOUSE, LPC-S

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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 in-person 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.
- Session fees are handled in an identical fashion as for teletherapy as in-person 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:_____

- **Consultation**: I may deem it appropriate to consult with or coordinate your care with other professionals, but only with your written agreement.
- **Louisiana License**: I can only counsel in the state I am licensed, Louisiana. Except in an emergency,
  i.e. COVID-19, counseling services cannot be delivered across state lines. I must know where you are when I am performing counseling services.
- **Ethics Code**: I follow the same Louisiana Code of Conduct and adhere to its ethics as outlined in my Declaration of Practices as an LPC.
- 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:

Limits of Liability: 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 Zoom, a HIPAA compliant teletherapy platform, and provides a Busin4ss Associate Agreement and my Patient Health Information (PHI) will be protected within the limitations of Zoom and the environment in which the services are utilized. Your PHI is stored via our EHR system, Therapy Appointment, which is an electronic healthcare system. It is designed specifically for healthcare and provides a Business Associate Agreement for HIPAA compliance. Therapy Appointment uses encryption which is point to point and federally approved. Any paper with your personal information s kept in a locked cabinet behind at least one locked door.

Records: In the event that your clinician is no longer available due to untimely death or incapacity, the Senior Receptionist, Lisa Smith, along with one of the remaining counselors at BRCCC – Baton Rouge Christian Counseling Center will be glad to assist you in providing appropriate referrals for further treatment and access to your records. They will also be responsible for destroying records after the legal time frame of storage.

Verify Identity: Anyone receiving teletherapy via videoconferencing is required to verify their identity by showing his/her 0picture ID during the first session. If Teletherapy is being conducted over the phone, a passphrase or number will be chosen which will be used for all future sessions. This process is in place to protect you from another person posing as you.

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.

Risk: 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: _____

Stacy House, LPC-S

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

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.

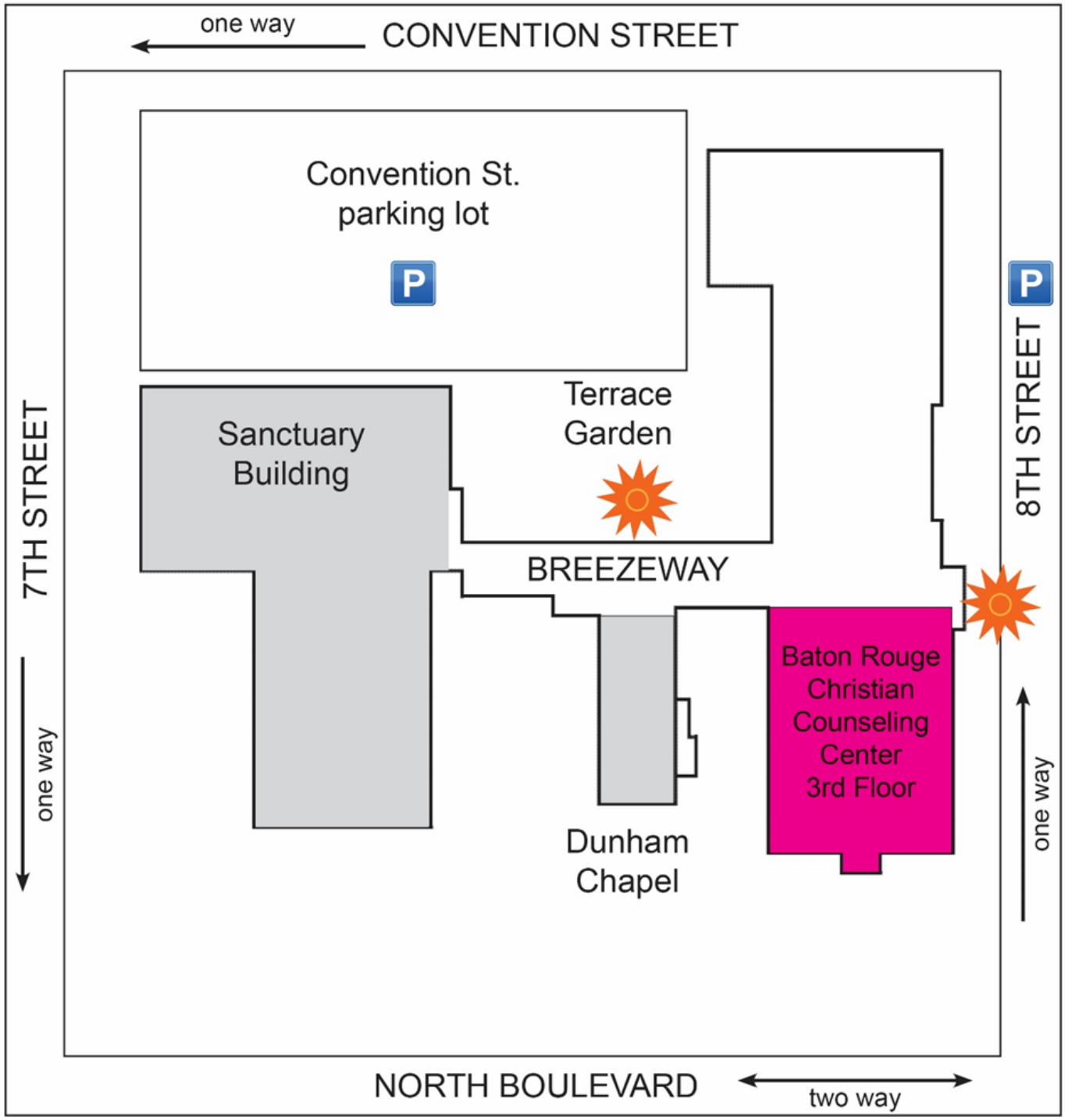
_____	_____
Client	Date
_____	_____
Client (if couple, both sign)	Date
_____	_____
Therapist	Date

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



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

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