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

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

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

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

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

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

4. **Session Fees:** Fees are $122.00 for the initial session and $104.00 per each 50- minute session thereafter. Payment can be made by check, cash, Visa, or MasterCard and is due at the time of service. Fees are payable to Joel Gilbert, LCSW. (NOTE: When paying with cash you must have exact fee, or you will be issued a credit toward your next visit.)

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

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

7. **Privileged Communication/Confidentiality**: I am required to abide by the professional practice standards and Louisiana law. I do not disclose client confidences and information to any third party except for materials shared during supervision without clients written consent or waiver except when mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations. State law mandates that I report to the appropriate authorities suspected cases of child abuse/neglect, elder abuse/neglect, or disabled abuse/neglect and instances of danger to self or others when reasonably necessary to protect the client or other parties from a clear and imminent threat of serious physical harm. Certain types of litigation may lead to the court-ordered release of information without your consent.

   When working with individuals, couples, families, or groups I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. When working with a family or couple, information shared by individuals in sessions, when other family members are not present, must be held in confidence (except for the mandated exceptions already noted) unless all individuals involved sign written waivers at the outset of therapy. Clients may refuse to sign such a waiver but should be advised that maintaining confidentiality for individual sessions during couple or family therapy could impede or even prevent a positive outcome to therapy.

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

9. **Fees are subject to change.** There will be a $20 NSF charge on retuned checks. <u>**Cancellation**</u>**: If you are unable to keep an appointment, the office must be notified at least 24 hours in advance or a fee of $50 will be assessed for the first cancellation, then the full $104 fee will be assessed thereafter.** If the office is not open and you need to cancel, you can leave a message in our voice mail at (225) 387-2287 and the time of your call will be registered. We aim to confirm appointments, but do not always have ample staff to do so. Responsibility for remembering appointments rests with the client.

10. **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.

11. **Telephone Consultations**: are available on a fee basis; when deemed appropriate and agreed upon by counselor.

12. **Client Responsibilities:** The client is expected to follow billing, scheduling, and office procedures. It is expected that he or she will terminate any previous counseling relation or get permission from the prior therapist. It is suggested that the client have a complete physical examination if he/she has not had one within the past year. Also, the client agrees to list on the intake form any medication he/she is taking. I have read and understand the above information and have received a copy of it. I hereby sign in agreement and authorize

the provider to release any information necessary to obtain assignment of health care benefits for the above services and to release information to my primary care physician, as needed.

13. **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.

Client Signature___________________________________Date_____________

Joel Gilbert, MSW, LCSW___________________________Date _____________

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

give permission for Joel Gilbert, LCSW to conduct therapy with my

_____________________,(Relationship)

______________________(Name of Minor)

BATON ROUGE CHRISTIAN COUNSELING CENTER

...a ministry of First Presbyterian Church

DX CODE: ________

Counselor: ______________________________

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 No.: (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 Questions Form**)
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 and leave a 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 Sex 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, please 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**

Baton Rouge Christian Counseling Center

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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

JOEL GILBERT, LCSW

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 in-person sessions (secure internet connection).
- 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:____ o Emergency Contact Number: ______________________________________ o 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 Spruce, a HIPAA compliant teletherapy platform, and my Patient Health Information (PHI) will be protected within the limitations of Spruce 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.

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: ____ Date: __________________

Print Name: ____

Counselor's Signature: ____ Date: ___________________ Print Name: Joel Gilbert, LCSW

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

Policy for Cancellations & "No Shows"

Joel Gilbert, MSW, LCSW
Baton Rouge Christian Counseling Center
763 North Boulevard, Baton Rouge, LA 70802
(225) 387-2287 *(24-hour voice mail)*

I, ____, agree to have
Print Name(s)

my/our MasterCard or Visa charged the **FEE OF $50 for first appointment and the FULL FEE of $104 for all successive 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")
3) for any balance owed 30 days past due.

____ __________
Signature Date

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BRCCC's policy is that payment is due at the time of the session.

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Keeping the appointment is the responsibility of the client.

All new or returning clients will need to have a credit card number on file before scheduling their first or a new appointment.

Credit cards numbers will be securely locked and kept confidentially along with other client data. 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.

PLEASE FILL IN THE INFORMATION BELOW		
CARD TYPE MasterCard ☐ MASTERCARD VISA ☐ VISA DISCOVER NETWORK ☐ DISCOVER		
CARD NUMBER:	SECURITY CODE:	ZIP CODE:
CARDHOLDER NAME:	EXP DATE:	
SIGNATURE:	AMOUNT: **Maximum $104.00 for missed appointments or ANY balance due past 30 days**	
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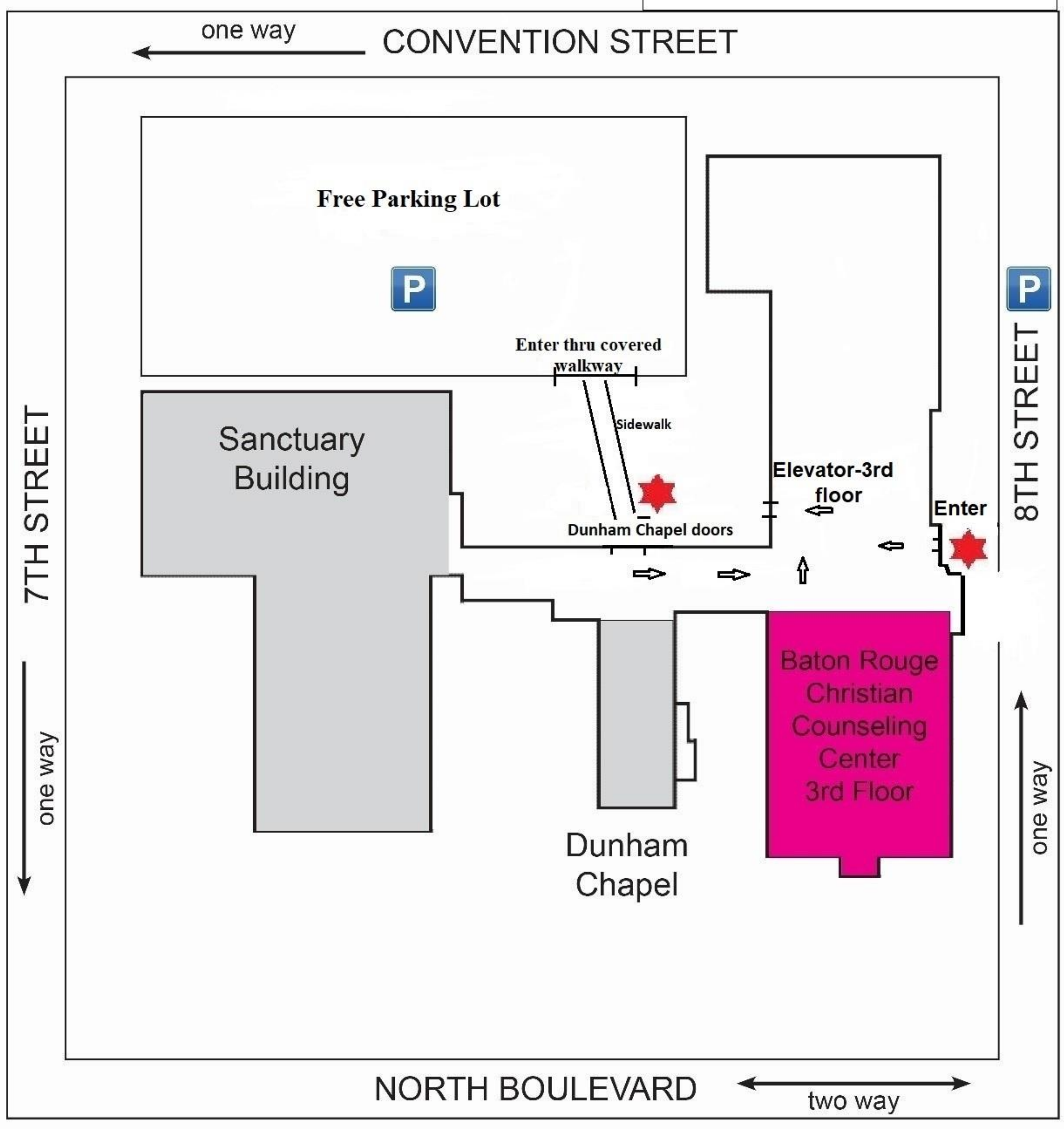

Enter at either the 8th Street entrance or the Convention Street Chapel. Buzz appropriate box.

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