KERRI OVERSTREET
COUNSELING AND WELLNESS

Kerri S. Overstreet, MA, LPC, NCC

Baton Rouge Christian Counseling Center

763 North Boulevard Baton Rouge, LA 70802

Phone:225.387.2287 | Fax:225.383.2722 | Email:

kerri@brchristiancounseling.com

Declaration of Practices and Procedures

Qualifications: I earned a Master of Arts Degree in Mental Health Counseling from Southern University A&M College in 2013. I also hold a Bachelor of Arts Degree in English from Southern University A&M College in 2008. I am a Licensed Professional Counselor #5921 that is registered with the LPC Board of Examiners, 11410 Lake Sherwood Drive Avenue North, Suite A, Baton Rouge, LA (225)295-8444. Additionally, I am certified as a National Certified Counselor #846860 through the National Board for Certified Counselors, 3 Terrace Way, Greensboro, NC, 27403

Counseling Relationship: I strive to develop a counseling relationship that is person-centered and interactive to use my skills and professional expertise to facilitate growth and development. Engaging in the counseling relationship is an important step toward making life and particular issues more manageable.

Areas of Focus: My area of focus includes individuals, couples, and families. Areas of concern that may be addressed include but are not limited to: career fulfillment, adult ADD/ADHD anxiety, depression, post-traumatic stress, trauma, adjustment, grief, and loss. My goal is to help my clients create a sense of calm, find clarity in their emotions, and gain control in the direction of their life.

Session Fees Payment can be made by check, cash, or credit card. Payment is due at the time of service. When paying with cash you must have an exact fee or you will be issued a credit toward your next visit. Please write your checks out to Kerri Overstreet, LPC. There will be a $50 NSF charge on all returned checks. The fee per 50-minute session is $115. The first evaluative session is $140.

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

Cancellations The time you schedule your appointments is reserved for you only. In the event you are unable to keep an appointment, a 24-hour advance notice will allow for the scheduling of another person who may benefit from the time. If not cancelled, you are responsible for payment of the unused time, which is the full session fee of $115.00. If you try to call and cannot get an answer it is acceptable to leave a voice message and the time registered. You may also email me at kerri@brchristiancounseling.com to cancel an appointment in 24 hours. Please be courteous and communicate with me or my office staff.

Services Offered My approach to counseling is warm, non-judgmental, and collaborative in nature. I highly value the importance of a strong, trusting relationship and see it as the basis for a successful therapy experience. Through our therapeutic relationship, I can help by providing tools, reflection, support, and unconditional positive regard. I have advanced training in Internal Family Systems Therapy (IFS) Eye Movement Desensitized & Reprocessing(EMDR) and Emotional Focused Therapy(EFT)

Code of Conduct: As a Licensed Professional Counselor, I am required by law to adhere to the Code of Conduct for practice as an LPC that has been adopted by the Louisiana LPC Board of Examiners.

Confidentiality: Material revealed in counseling will remain strictly confidential except for material shared with my supervisor and under the following circumstances, in accordance with state law:

- 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 reasonable suspicion of abuse/neglect against a minor child, elderly person (60 or older) or dependent adult
- A court order is received directing the disclosure of information
  In the event of marriage or family counseling, material obtained from an adult client individually may be shared with the client's spouse or other family member with the client's written permission. Any material obtained from a minor client may be shared with the client's parents or guardian.

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 apprise clients of all mandated disclosures as conceivable. Any material obtained from a minor client may be shared with the client's parent or guardian.

Emergency Situations: If an emergency should arise, you may seek help through hospital emergency room facilities or by calling 911.

Client Responsibilities: You, the client are a full partner in counseling. Your honesty and efforts are essential to your success. As we work together on your personal journey or discovery, I expect you to share any suggestions or concerns so that we can make the necessary adjustments. I also expect you to be a full participant in your session.

- If you have suggestions or concerns about your counseling sessions, 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 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. Also, please consider providing me with a list of any medications that you are currently taking.

Potential Counseling Risk: The client should be aware that counseling poses potential risks. In the course of working together, additional problems may surface of which you were not initially aware. If this occurs, you should feel free to share these concerns with me. I have read the Declaration of Practices and Procedures of *Kerri S. Overstreet, MA., LPC, NCC*. My signature below indicates my full informed consent to the services provided.

_____

Client Signature Date

_____

Kerri S. Overstreet, MA., LPC, NCC Date

KERRI OVERSTREET
COUNSELING AND WELLNESS

PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Name: _____

Date: _____ Birth Date: _____ Age: _____

Address/City/St.

_____

Email Address:

_____

Cell Phone _____Work Phone_____ Home Phone_____

Your Employment/Job Title:

_____

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: _____ #ofyrs.Married_____

Spouse's employment:

_____

Who referred you to us or how did you find Me?

_____

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):_____

Do you have children? ____Yes ____No If yes: First Name Age Sex Relationship to you Live in your home? (biological/step/adopted/foster)

_____

_____

_____

_____

Birth Order: ____ of _____# of children Has anyone in your family 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, 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 currently? _____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: 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?

_____

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?

_____

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?_____

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?

_____

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?

_____

6. Were your parents ever separated or divorced?

_____

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?

_____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

_____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

_____

10. Did a household member go to prison?

_____

Please State Your Goals for Therapy:

1. _____

2. _____

3. _____

Please circle any of the following challenges that you are experiencing.

Parent Consulting for Academic Magnet and College Prep Programs	Parent Consulting for Academic Learning Disabilities	Career Decision Making	Making Decisions	Adult Adhd
Accomplished & unfulfilled	Gun Violence Survivor	Women Issues	Men Issues	Life's Purpose
Anxiety	ADD/ADHD	Guilt	Communication	PTSD
Anger Management	Finances	Job Stress	First Responder	Domestic Violence
Unforgiveness	Self-Esteem	Depression	Peer Relationships	Male/female Infertility
Coping Skills	Fear of Failure	Trauma	Food Addiction	Life Adjustment
Perfectionist	Toxic Relationships	Stressed Bride	Difficult Childhood	Sexual Abuse
Underachieving	Health Problems	Inferiority	Emotional Abuse	Misunderstood
Frustrated	Crying Often	Sleep Issues	Loneliness	Ambition
Suicidal Thoughts	Marriage			

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POLICY FOR CANCELLATIONS, NO SHOWS AND CREDIT CARD AUTHROZATION

I,

_____

Print Name

agree to have my/our MasterCard or Visa charged the FEE of $115

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.
4) Balances refused by insurance

_____

Signature Date

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

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.

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ [OTHER]

Card Number	Security Code	
Cardholder Name	Zip Code	EXP Date
Signature Amount: $115 for any missed appointments or any balance due past 30 days		

I understand that any card on file, whether listed above or encrypted in our software program, can be used.

_____

Signature Date

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INFORMED CONSENT FOR TELETHERAPY (VIDEO) COUNSELING-**Required Signature**

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

✓ There are potential benefits and risks for videoconferencing 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.
• 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, counseling services cannot be delivered across state lines. I must know where you are when I am performing telehealth 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 in-person sessions.

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 and Teletherapy. At the beginning of each session, I agree to disclose my current location and allow my therapist to assess safety, security, and comfort in my environment. The virtual teletherapy sessions will be conducted through Zoom, a HIPAA compliant teletherapy platform, and provides a Business 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 Is 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 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 picture 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: _____
Kerri S. Overstreet, MA, LPC, NCC

SOCIAL MEDIA POLICY

KERRI OVERSTREET
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Please read this policy to understand how I conduct myself on the internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the internet.If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, Pinterest) I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

Following: My primary concern is your privacy. I do not follow current or former clients on social media. My reasoning is that viewing online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Messaging: Please do not use messaging/commenting on social networking sites to contact me. These sites are not secure, and I may not read these messages in a timely fashion. Do not use wall postings, @ replies or other means of engaging with me online if we have already established a client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone. Direct email at kerri@brchristiancounseling.com is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

Location-Based Services: If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location.

Email: I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my internet services providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Conclusion: Thank you for taking the time to review my social media policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the internet, do bring them to my attention so that we can discuss them.

_____ _____

Signature Date

_____ _____

Kerri S. Overstreet, MA, LPC, NCC Date

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NOTICE OF PRIVACY PRACTICES CONSENT FORM

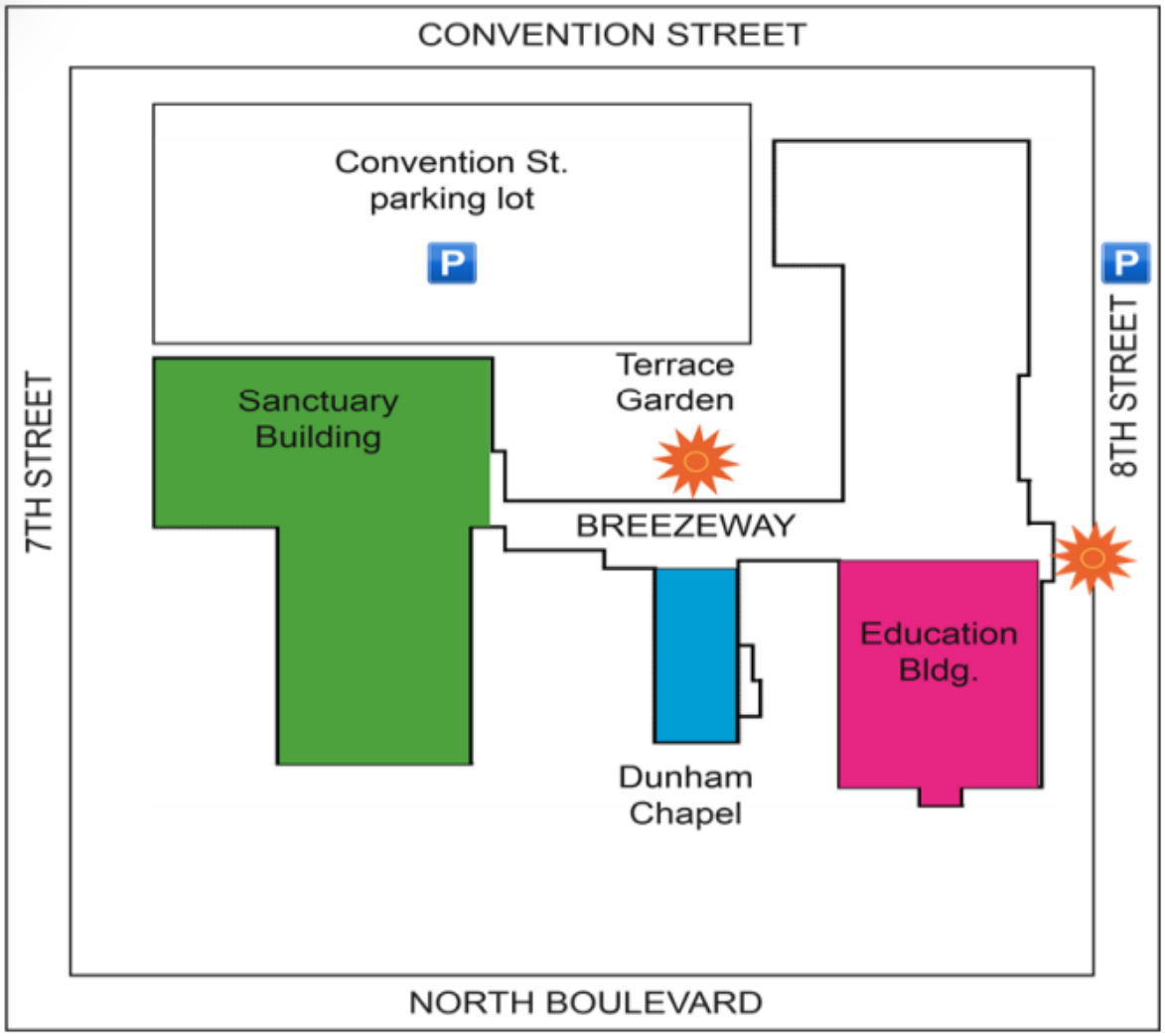
Effective April 14, 2003 a federal regulation, commonly known as the HIPPA Privacy Rule" requires that we must provide all of our clients with a detailed notice, in writing, of our privacy practices. We have this lengthy "Notice of Privacy Practices" available in our waiting room and it is also on our 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



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).