

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. After your first visit, you may 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 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 \$112. The first evaluative session is \$132.

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. A 3% service fee will be added when using a credit card. There is no additional fee when using cash, check or debit card.

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 or you can login to your account on TherapyAppointment.com and do it yourself:

INSURANCE: I will file with your insurance and am in network with Blue Cross Blue Shield, United Healthcare/Optum, Aetna, WebTPA, 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:. I do not accept insurance for Couples or Marriage Counseling.

CONFIRMATION OF APPOINTMENT: On the Registration Form in your account online you can elect to have your appointments confirmed through text and/or email. 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.

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 and email 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 or email.

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. I do not accept insurance for couples therapy.

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. Payment is due at the time of the session. Please initial below:

_____ I/We agree to have my/our credit card charged the full fee (\$112 per session) for appointments
missed:
initials

- 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
program, can be used
initials

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

Emotional Concerns

- | | |
|---|--|
| <input type="checkbox"/> feeling anxious or uptight | <input type="checkbox"/> feeling depressed or sad |
| <input type="checkbox"/> excessive worrying | <input type="checkbox"/> being tired or lacking energy |
| <input type="checkbox"/> not being able to relax | <input type="checkbox"/> feeling unmotivated |
| <input type="checkbox"/> feeling panicky | <input type="checkbox"/> loss of interest in many things |
| <input type="checkbox"/> unable to calm yourself down | <input type="checkbox"/> having trouble concentrating |
| <input type="checkbox"/> dwelling on certain thoughts or images | <input type="checkbox"/> having trouble making decisions |
| <input type="checkbox"/> fearing something terrible about to happen | <input type="checkbox"/> feeling the future looks hopeless |
| <input type="checkbox"/> avoiding certain thoughts or feelings | <input type="checkbox"/> feeling worthless or a failure |
| <input type="checkbox"/> having strong fears | <input type="checkbox"/> being unhappy all the time |
| <input type="checkbox"/> worrying about a nervous breakdown | <input type="checkbox"/> dissatisfied with physical appearance |
| <input type="checkbox"/> feeling out of control | <input type="checkbox"/> feeling self critical or blaming yourself |
| <input type="checkbox"/> avoiding being with people | <input type="checkbox"/> having negative thoughts |
| <input type="checkbox"/> fears of being alone or abandoned | <input type="checkbox"/> crying often |
| <input type="checkbox"/> feeling guilty | <input type="checkbox"/> feeling empty |
| <input type="checkbox"/> having nightmares | <input type="checkbox"/> withdrawing inside yourself |
| <input type="checkbox"/> flashbacks | <input type="checkbox"/> thinking too much about death |
| <input type="checkbox"/> troubling or painful memories | <input type="checkbox"/> thoughts of hurting yourself |
| <input type="checkbox"/> missing periods of time - can't remember | <input type="checkbox"/> thoughts of killing yourself |
| <input type="checkbox"/> trouble remembering things | <input type="checkbox"/> frequent mood swings |
| <input type="checkbox"/> feeling numb instead of upset | <input type="checkbox"/> feeling resentful or angry |
| <input type="checkbox"/> feeling detached from all or part of body | <input type="checkbox"/> feeling irritable or frustrated |
| <input type="checkbox"/> feeling unreal, strange or foggy | <input type="checkbox"/> feeling rage |
| | <input type="checkbox"/> feeling like hurting someone |

Behavioral and Physical Concerns

- | | |
|---|---|
| <input type="checkbox"/> not having an appetite | <input type="checkbox"/> trouble finishing things |
| <input type="checkbox"/> eating in binges | <input type="checkbox"/> working too hard |
| <input type="checkbox"/> self induced vomiting for weight control | <input type="checkbox"/> using alcohol too much |
| <input type="checkbox"/> using laxatives for weight control | <input type="checkbox"/> being alcoholic |
| <input type="checkbox"/> eating too much | |
| <input type="checkbox"/> eating too little | <input type="checkbox"/> using drugs |
| <input type="checkbox"/> losing weight - how much? _____ | <input type="checkbox"/> driving under the influence |
| <input type="checkbox"/> gaining weight - how much? _____ | <input type="checkbox"/> blackouts - after drinking |
| <input type="checkbox"/> trouble sleeping | <input type="checkbox"/> excessive internet/phone/tv usage |
| <input type="checkbox"/> trouble falling asleep | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever felt you ought to cut down on your drinking or drug use? |
| <input type="checkbox"/> early morning awakening | <input type="checkbox"/> Yes <input type="checkbox"/> No Have people annoyed you by criticizing your drinking or drug use? |
| <input type="checkbox"/> sleeping too much | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever felt bad or guilty about your drinking or drug use? |
| <input type="checkbox"/> sleeping too little | <input type="checkbox"/> Yes <input type="checkbox"/> 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 |
| <input type="checkbox"/> # of hours I usually sleep: _____ | |
| <input type="checkbox"/> lack of exercise | |
| <input type="checkbox"/> not having leisure activities | |
| <input type="checkbox"/> smoking cigarettes | |
| <input type="checkbox"/> often spending in binges | |
| <input type="checkbox"/> temper outbursts | |
| <input type="checkbox"/> aggressive toward others | |
| <input type="checkbox"/> impulsive reactions | |

Intimate Relationship Concerns

- | | |
|--|---|
| <input type="checkbox"/> feeling misunderstood in relationship | <input type="checkbox"/> lack of respect by partner |
| <input type="checkbox"/> not feeling close to partner | <input type="checkbox"/> partner being secretive |
| <input type="checkbox"/> trouble communicating with partner | <input type="checkbox"/> lack of fairness in relationship |
| <input type="checkbox"/> not trusting partner | <input type="checkbox"/> 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
-

Sexual Concerns

- ___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

When Growing Up to Present Time:

- ___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?

Stresses During the Past Several Years:

- ___ 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 \$132 for initial session and \$112 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 brchristiancounseling.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 \$112. 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.

Litigation Limitation: Given that certain types of litigation (such as child custody suits) may lead to the court ordered release of information without your consent, it is expressly agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.) neither you or any attorney, or anyone else acting on your behalf, will call Stacy House to testify in a deposition or in court or any other proceeding, nor will a disclosure of any information contained in the chart, including but not limited to the psychotherapy notes, as defined and protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) be requested.

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 VSEE 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

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.
- 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.

HOUSE Teletherapy Consent Form

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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 Opicture 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.

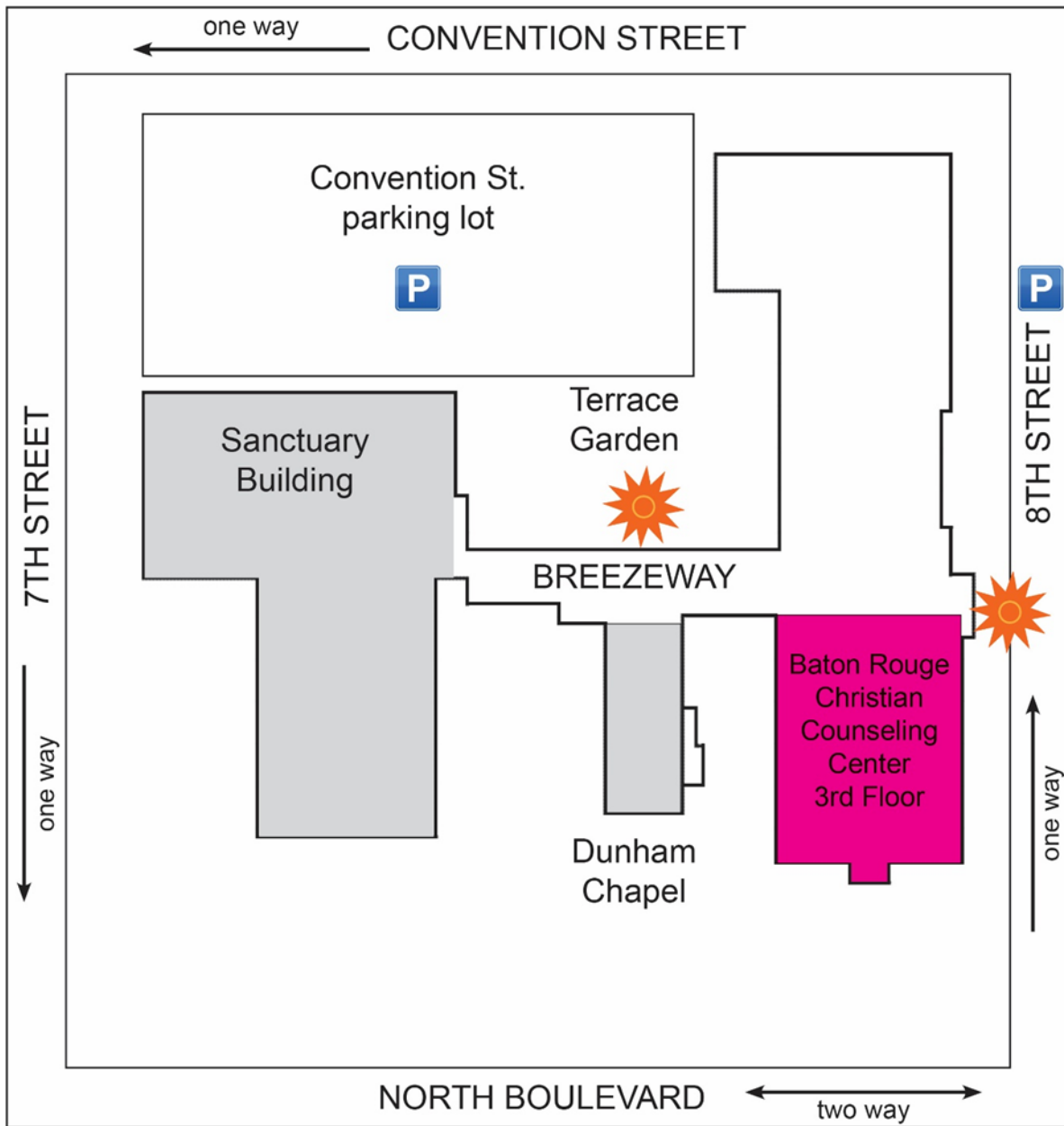
Risk: There is confidentiality risk involved for both parties in utilizing digital technology Communication. I understand the risk involved in digital communication and I hereby authorize my therapist to communicate with me utilizing digital technology on the internet.

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

Client's Signature(s): _____ Date: _____

Print Name: _____

Counselor's Signature: _____ Date: _____



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

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