

**Sherry Kadair, MA, LPC, NCC**  
**Baton Rouge Christian Counseling Center**  
**763 North Blvd, 3<sup>rd</sup> Floor | Baton Rouge 70802**  
**Phone: 225-387-2287 Fax: 225-383-2722**

---

I am very pleased that you have chosen me as your counselor and are allowing me to be a tool in reaching your personal goals. Below is a brief explanation of the things that will be helpful in preparing for your first visit. Please read through and complete all paperwork.

**DIRECTIONS/BUILDING ENTRANCE:**

My office is on the third floor in the administration building of the First Presbyterian Church campus at 763 North Blvd (NOT North Street). There are only 2 entrances to the counseling center. **Park on 8<sup>th</sup> street and enter via the 8<sup>th</sup> street door OR park in the big parking lot on Convention (between 7<sup>th</sup> and 8<sup>th</sup>) and enter via the Chapel door.** At each of these two doors is a buzzer for the Counseling Center. Please do not buzz the church. Once you buzz the counseling center someone will unlock the door. Proceed to the third floor by way of the stairs or elevator. You may want to allow extra time to find the center on your first visit. You will find a map attached to this packet or on our website ([www.brchristiancounseling.com](http://www.brchristiancounseling.com)). For additional assistance call 387-2287.

**PAPERWORK:**

Please review, sign and bring all the attached paperwork to your first appointment. If you do not print out the forms, please allow 20 minutes before your session begins to complete them.

**CONFIRMATION OF APPOINTMENTS:**

When you schedule, you will be asked if you prefer a text or email reminder. However, regardless of whether you receive a reminder, you are responsible for remembering your appointment.

**CANCELLATIONS / NO SHOWS:**

If you need to cancel, you are required to give at least 24 hours notice, preferably 48 hours or more, so that others have an opportunity to schedule. Please cancel via online portal, by leaving a voicemail, or by emailing me. Except in the case of emergencies, no shows or cancelling with less than 24 hours notice will result in a \$100 charge to your credit card on file.

**FEES:**

Please see the attached Policies and Procedures for my fee schedule. **If utilizing insurance, it is your responsibility to confirm the following information prior to using health insurance:** determine that I am on the provider list for your insurance, the number of sessions authorized, your co-payment, and the amount remaining on your deductible. If your deductible is not yet met, I will bill your insurance, however you are responsible for the payment in full per the contracted rate until your deductible is met. Fees/copays are due at the time of service. Payments may be made by cash (exact change only), check or credit card (Visa/MC only). My policy and the policy of BRCCC is to securely store the client's encrypted credit card number for payment purposes. It can then be used for sessions or for fees from any no shows or cancellations with less than 24 hours notice. At time of service, you may use any form of payment you wish.

You have made a brave first start by scheduling. I look forward to meeting with you!

Sherry

# BATON ROUGE CHRISTIAN COUNSELING CENTER

Counselor: Sherry Kadair

DX CODE: \_\_\_\_\_

TO HELP WITH YOUR FIRST SESSION, PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETELY AS YOU CAN.

**PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL**

Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_

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

Address: \_\_\_\_\_ City/St \_\_\_\_\_ Zip: \_\_\_\_\_

Your Phone #'s: (Home) \_\_\_\_\_, (Work) \_\_\_\_\_

(Cell): \_\_\_\_\_

Email Address: \_\_\_\_\_

Your Employment/Job Title: \_\_\_\_\_

Person responsible for your bill, if different than above:

Name/Address: \_\_\_\_\_

If using Insurance, **(you also need to fill out the Insurance Questionnaire)**

Name of Ins. Co.: \_\_\_\_\_

**ANY CHURCH MEMBERSHIP:** \_\_\_\_\_

Briefly describe your **spiritual life:** \_\_\_\_\_

Last year of school completed: \_\_\_\_\_ or **GED** College: 1 2 3 4 Degree: \_\_\_\_\_ Other: \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Remarried \_\_\_\_\_ Widowed \_\_\_\_\_

Total number of prior marriages for you \_\_\_\_\_ for your spouse/partner \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Age of spouse: \_\_\_\_\_ #of yrs. married \_\_\_\_\_

Spouse's employment: \_\_\_\_\_

**WHO REFERRED YOU TO US?** \_\_\_\_\_

Is it ok to call your home & leave message: Yes \_\_\_\_\_ No \_\_\_\_\_; At your work: Yes \_\_\_\_\_ No \_\_\_\_\_

Person to contact in case of an **emergency (name/phone):** \_\_\_\_\_

BRIEFLY describe your reason for seeking counseling: \_\_\_\_\_

\_\_\_\_\_

Do you have children? \_\_\_\_\_ Yes \_\_\_\_\_ No                      If yes:

First Name                      Age    Gender                      Relationship to you                      Live in your home?  
(biological/step/adopted/foster)

---

---

---

---

---

**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 **emotional, 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?

<b>PLEASE CIRCLE or CHECK ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU:</b>		
<b>Nervousness</b>	<b>Depression</b>	<b>Fear</b>
<b>Shyness</b>	<b>Sexual Problems</b>	<b>Suicidal Thoughts</b>
<b>Separation</b>	<b>Divorce</b>	<b>Finances</b>
<b>Drug Use</b>	<b>Alcohol Use</b>	<b>Friends</b>
<b>Anger</b>	<b>Self-Control</b>	<b>Unhappiness</b>
<b>Sleep</b>	<b>Stress</b>	<b>Work</b>
<b>Relaxation</b>	<b>Headaches</b>	<b>Tiredness</b>
<b>Legal Matters</b>	<b>Memory</b>	<b>Ambition</b>
<b>Energy</b>	<b>Insomnia</b>	<b>Making Decisions</b>
<b>Loneliness</b>	<b>Inferiority Feelings</b>	<b>Concentration</b>
<b>Education</b>	<b>Career Choices</b>	<b>Health Problems</b>
<b>Temper</b>	<b>Nightmares</b>	<b>Marriage</b>
<b>Children</b>	<b>Appetite</b>	<b>Stomach Problems</b>

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

## **NOTICE OF PRIVACY PRACTICES CONSENT FORM**

Effective April 14, 2003 a federal regulation, commonly known as the “HIPAA Privacy Rule”, requires that we must provide all of our clients with a detailed notice, in writing, of our privacy practices. We have this lengthy “*Notice of Privacy Practices*” available in our waiting room and it is also on our web site: [www.brchristiancounseling.com](http://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 SHERRY KADAIR, LPC, LLC to restrict how my health information is used or disclosed. SHERRY KADAIR, LPC, LLC does not have to agree to my request for the restriction, but if SHERRY KADAIR, LPC, LLC does agree, SHERRY KADAIR, LPC, LLC 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 SHERRY KADAIR, LPC, LLC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Sherry Kadair, LPC, NCC**  
Baton Rouge Christian Counseling Center  
Office Address: 763 North Blvd. Baton Rouge, LA 70802  
Office Number: 225-387-2287

**Qualifications:** I earned an MA degree in Counseling from Denver Seminary, a CACREP accredited program. I am licensed as a Licensed Professional Counselor (Lic # 4036) with the Licensed Professional Counselors Board of Examiners, 11410 Lake Sherwood Ave North, Ste A, Baton Rouge, Louisiana 70816. Telephone (225) 295-8444.

**Counseling Relationship:** I see counseling as a process in which you and I explore and define present problem situations, develop goals and work during sessions and through outside homework assignments toward realizing those goals.

**Areas of Expertise:** I have a general practice but focus on trauma. I hold a certification as a National Certified Counselor (NCC Lic#63282). I am also trained in EMDR therapy.

**Fee Scales:** The fee for a 60 min session is \$125. The first appointment fee is \$150. I am on many insurance panels. For those without insurance, some sliding scale appointments are available. Payment is due at the time of service. Clients are seen by appointment only. Clients will be charged for appointments that are broken or canceled without 24-hour notice.

**Fee for Missed Appointments / Late Cancellations:** There will be a \$50 charge for the first missed appointment and/or appointment cancelled without 24 hours notice. Subsequently the fee will be \$100 per occurrence. It is my policy, and the center's policy, to securely store the client's credit card number for payment purposes. It will be used for the initial session, subsequent sessions (if desired) and to bill Missed Appointment/Late Cancellation fees.

**Services Offered and Clients Served:** I counsel men and women ages 18 and above. I use an eclectic approach tailored to meet an individual's needs and goals.

**Code of Conduct:** As a Licensed Professional Counselor, I am required by state law to adhere to the Code of Conduct for practice that has been adopted by my licensing board. A copy of this Code of Conduct is available upon request.

**Privileged Communications:** Materials revealed in counseling will remain strictly confidential except when:

- The client signs a written release of information indicating informed consent of such release.
- The client expresses intent to harm him/herself or someone else.
- There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (65 or older), or a dependent adult.
- A court order is received directing the disclosure of information. (It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures as conceivable.)

- In the event of marriage or family counseling, material obtained from an adult client individually may only be shared with the client's spouse or other family members with the client's permission.
- Any material obtained from a minor client may be shared with that client's parents or guardian.

**Emergency Situations:** If an emergency situation should arise, you may seek help through hospital emergency room facilities or by calling 911. You can also call the national suicide hotline at 988. If you need to contact me, leave a voicemail at 225-387-2287. I will endeavor to return your call within 24 hours.

**Client Responsibilities:** You, the client, are a full partner in counseling. Your honesty and effort are essential to your success.

- If you have suggestions or concerns about your counseling, I invite you to share these with me so that we can make the necessary adjustments.
- If you or I come to believe that you would be better served by another mental health provider, I am happy to help you with the referral process.
- If you are currently receiving services from another mental health professional, I need you to inform me of this in order to coordinate your treatment. I may ask you to grant me permission to obtain information from or share information with that professional.

**Physical Health:** Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. It is also important to provide me with a list of the medicines you are currently taking.

**Potential Counseling Risk:** Please be aware that counseling poses potential risks. In the course of working together additional issues may surface, may become more acute, or may affect your relationships in ways you had not fully anticipated. If this occurs, please feel free to share any new concerns with me.

If you have any questions or would like additional information, please feel free to ask. I look forward to working together with you.

**I have read and understand the above information.**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Counselor Signature \_\_\_\_\_ Date \_\_\_\_\_

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

## Credit Card Authorization Form

Confirmation of appointments is provided as a courtesy. Keeping the appointment is the responsibility of the client. Please use the online system to schedule and cancel appointments. If it is less than 8 hours before an appointment, the online system is unavailable and you will need to call to cancel.

There will be a \$50 charge for the first missed appointment and/or appointment cancelled without 24 hours notice. Subsequently the fee will be \$100 per occurrence.

It is my policy, and the center's policy, to securely store the client's credit card number for payment purposes. It will be used for the initial session, subsequent sessions (if desired) and to bill Missed Appointment/Late Cancellation fees. A \$0.01 fee will be charged if you have no copy to store the card. Payment is due at the time of the session.

I, \_\_\_\_\_, agree to have my/our MasterCard or Visa charged the **FEE OF \$50 for first appointment missed and the FULL FEE of \$100 for all successive appointments**. Insurance does not cover missed appointments.

- 1) for any session not cancelled with **at least** 24 hour notice, and/or
- 2) for any appointment I/we neglect to appear ("no show"), and/or
- 3) for any balance owed 30 days past due.

---

Signature

---

Date

**HEALTH INSURANCE INFORMATION**

We **do not** verify coverage or call to get the information concerning your coverage for you. You must **call** the phone number(s) on your health insurance card to get the following information **PRIOR** to your first session. **Without ALL questions on this form answered by your Insurance Company you will be responsible for the full session fee.**

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Effective date: \_\_\_\_\_

Insured's ID number \_\_\_\_\_ Group Numbers: \_\_\_\_\_

**Call the number on your insurance card and ask the following questions:**

To what address do we mail Mental Health Claims? \_\_\_\_\_

Do I have **mental health** out-patient benefits? Yes \_\_\_\_\_ No \_\_\_\_\_ (if no stop here)

Is (give counselors name) on my provider list? Yes \_\_\_\_\_ No \_\_\_\_\_

If not, do I have any **"out of network"** benefits? Yes \_\_\_\_\_ No \_\_\_\_\_  
(Write what those benefits are on the back of this form)

Do I have a deductible? Yes \_\_\_\_\_ No \_\_\_\_\_

If applicable, how much of that deductible have I met? N/A \_\_\_\_\_ or \$ \_\_\_\_\_

What is my co-payment for **mental health**? \$ \_\_\_\_\_ per session

(If applicable) do I have marital counseling benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

Is prior authorization needed for counseling? Yes \_\_\_\_\_ No \_\_\_\_\_

Authorization number? \_\_\_\_\_ how many sessions are authorized? \_\_\_\_\_

**SIGN BOTH PLACES BELOW**

I authorize the release of any medical or other information necessary to process claims.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

I authorize payment of medical benefits to the counselor who provided the service.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_



## Sherry Kadair, LPC

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

### **INFORMED CONSENT FOR TELETHERAPY (VIDEO) COUNSELING**

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

- There are potential benefits and risks for video-conferencing that differ from 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.
- We need a back-up plan (e.g., phone number where you can be reached) in case we have technical difficulties. If we get disconnected, I will continue to try to reach you. If we both initiate, we will miss each other.

**Back-up phone number:** ( \_\_\_\_\_ ) \_\_\_\_\_

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

**Emergency Contact Name:** \_\_\_\_\_

**Emergency Contact Number:** ( \_\_\_\_\_ ) \_\_\_\_\_

**Closest ER:** \_\_\_\_\_

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

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

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

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

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

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

Client's Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Counselor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Sherry Kadair, LPC**

## **BRCCC Parking and Entering Directions**

You may park in the free parking lot of First Presbyterian located behind the church off Convention Street between 7<sup>th</sup> and 8<sup>th</sup>. It is located directly across from the Post Office.

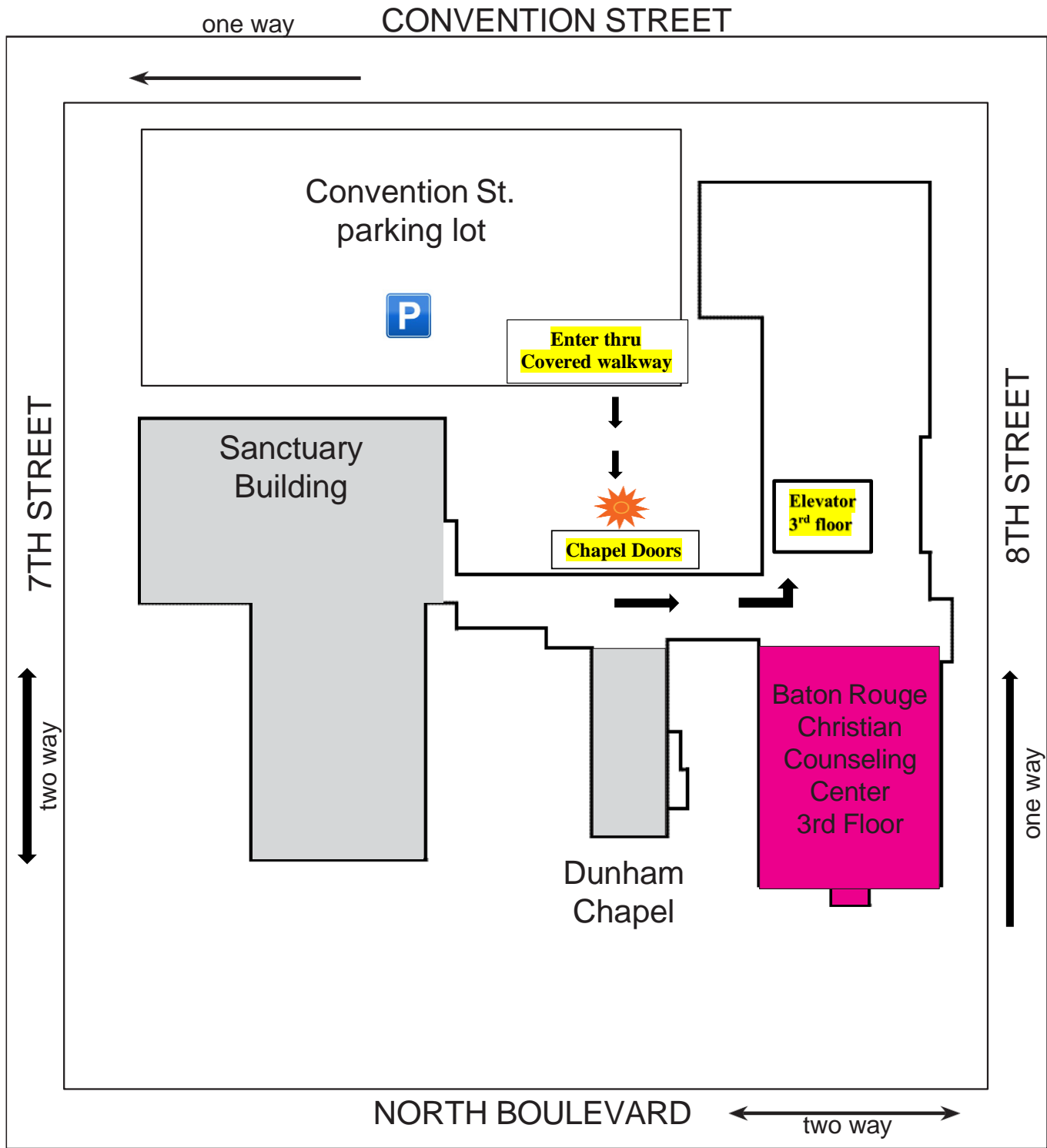
From that lot, look for the black iron gate and follow the sidewalk to the Dunham Chapel doors. There is a plaque on the wall by the doors.

You then press the box which says, "Counseling Center" and we will answer and unlock the doors for you.

Once you enter, take a left toward the elevator and ride it to the 3<sup>rd</sup> floor.

Exit the elevator and go toward the end of the hall to the open door on your right that reads "Check In."

IF you MUST use stairs to reach the 3<sup>rd</sup> floor, you will need to park on 8<sup>th</sup> street. Be advised that the city charges for parking and you will be limited to using the stairs both up and back down.



 Enter at the Convention Street Dunham Chapel entrance.

 Parking available in the Convention St. lot (free).