

Brandon Husted, M.Ed., LPC, NCC, CTP
Baton Rouge Christian Counseling Center
763 North Blvd, 3rd Floor | Baton Rouge 70802
Office: 225-387-2287 Cell: 225-414-3359

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 at a meter on 8th street and enter via the 8th street door OR park in the big parking lot on Convention (between 7th and 8th) 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). For additional assistance call 225-387-2287.

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.

SCHEDULING:

Upon creating your account on the portal, visit www.therapyappointment.com, you will be able to schedule your first appointment. Additionally, you will be asked for a credit card number and relevant personal information to secure your appointment. After your first visit, please access this portal to schedule or cancel future appointments. **As my schedule tends book several weeks in advance, you may want to schedule more than one appointment when you schedule your first.**

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 charge equal to half the session cost for the first missed appointment and full session cost charge thereafter to your credit card on file.

FEES:

Please see the attached Policies and Procedures for my fee schedule. 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!

Brandon

BATON ROUGE CHRISTIAN COUNSELING CENTER

Counselor: Brandon Husted

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 history of **physical, verbal, or sexual abuse** to you or your family? _____ 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 struggles**: _____ 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?

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	Trauma	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Low Self-Esteem	Concentration
Abuse	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Problems

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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

DECLARATION OF PRACTICE AND PROCEDURES

Brandon Husted—LPC, M.Ed., NCC, CTP
763 North Boulevard
Baton Rouge, LA 70802
Office: 225-414-3359 Cell: 225-414-3359
E-mail: Brandon@brchristiancounseling.com

Counseling Relationship

You are granting me the privilege of walking closely beside you as we explore your story and the journey to your authentic self. Together, in an atmosphere of mutual trust and respect, we will search for meaning, purpose, and solutions that will move you toward connection, balance, and well-being.

Qualifications

I earned a master's degree in Clinical Mental Health Counseling from Malone University in 2020. I am a Licensed Professional Counselor (LPC) # LPC 8423 and hold a license with the Louisiana Board of Examiners located at 11410 Lake Sherwood Avenue North, Suite A, Baton Rouge, LA 70816, (225)295-8444. I am also a Nationally Certified Counselor through the National Board for Certified Counselors (NBCC), am EMDR trained through the EMDR Institute, and am a Certified Trauma Professional. I abide by the code of ethics of the ACA and Louisiana LPC Board of Examiners.

Areas of Focus

My areas of interest are in exploring areas of strength, identifying barriers to emotional, cognitive, and relational health, addiction recovery issues, trauma, depression and anxiety. I find Cognitive Behavioral Therapy, EMDR, and Narrative Therapy helpful approaches to client concerns.

Session Fees and Length of Service

The first session costs \$125.00 and subsequent sessions cost \$105.00. If you are a member of an HMO, PPO, or other managed health care plan, I can tell you if this agency is an authorized provider of services, and we will file the claim for you. Most plans provide for a limited number of visits per year. If you exceed this limit, you may still receive services from me, but must pay for the services out-of-pocket. I request 24-hour notice in the event of a cancellation. Service may be denied for lack of payment, but I will help you find appropriate services that fit your budget, if need be.

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 my licensing board, the Louisiana LPC Board of Examiners. A copy of the Code of Conduct is available to you upon request. Should you wish to file a disciplinary complaint regarding my practice as a Licensed Professional Counselor, you may contact the Louisiana LPC Board of Examiners.

Client and Therapist Expectations

I believe every person can enjoy a meaningful and satisfactory life. In session, we will explore and seek ways to resolve difficult life issues. I will encourage you to identify who you are, what you desire in life, and will offer creative ideas about how to get there. While our relationship is intimate, it is also professional in nature. Our contact will be limited to paid sessions with me. I will only acknowledge you outside of our offices if you greet me first (protecting your confidentiality). I expect you to be on time to each session, to follow through with homework assignments, and be fully present, honest, engaged, and curious at each session. Clients must make their own decisions about important life matters, and according to ACA Code of Ethics I am not allowed to advise you to make specific decisions. I will help you think through possibilities and consequences as you carefully consider your choices.

Confidentiality

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (c) there is a reasonable suspicion of child, elder (60 years or older), or disabled abuse, or (d) I am ordered by a court to disclose information. Any information obtained from a minor client may be shared with his or her parent or legal guardian. In marriage and family counseling, I will strongly promote authenticity. Also, as I am under supervision, I am supervised by a LPC board certified supervisor, Ryan Phillips LPC-S. I may discuss aspects of your case with them in order to ensure I am effectively meeting your needs.

Potential Risks of Therapy

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. Therapy is a process, and you cannot expect immediate results. With time and effort anything is possible.

Physical Health

Often medical health can have an impact on your mental health. If you have not had a physical examination in the last year, it is recommended that you do so. In addition, medications, both prescription and non-prescription, may have significant side effects that may be important to address with me. I expect to receive full disclosure concerning these matters and I may request a release of information to discuss them with your physician.

Emergency Situations

For normal issues or concerns, I can be reached at (225)-414-3359 during the hours of 7:00am-4:00pm Monday-Friday. If you have an emergency, you can contact Lake After Hours Hotline at (877) 765- 5253 or the Suicide and Crisis Lifeline at 988. You may also seek help through hospital emergency room facilities or by calling 911.

Acceptance of Terms

I have read the Declaration of Practices and Procedures of Brandon Husted, M.Ed., LPC, and my signature below indicates my full informed consent to services provided by Brandon Husted, M.Ed., LPC. I am willing to engage in therapy fully in order to maximize the potential results.

Client Signature: _____ Date: _____

Brandon Husted, LPC: _____ Date: _____

PARENT CONSENT FOR TREATMENT OF A MINOR:

I, _____, give my permission for Brandon Husted, LPC, to conduct

therapy with my _____, _____.
(relationship) (name of client)

Signature of parent/legal guardian: _____ Date: _____

Teletherapy Declaration of Policies and Procedures

Please read the following information carefully pertaining to your teletherapy sessions as an addendum to your orientation documents.

CLIENT RESPONSIBILITIES:

- Provide clinician with an emergency contact who will be able to go to your location and provide assistance to you in an emergency (i.e., transport to hospital).
- Dress appropriately during sessions.
- Do not bring weapons of any kind to sessions.
- Avoid mind altering substances prior to sessions.
- Do not record session without first obtaining clinician's approval.
- Be in an area that is safe and provides privacy.
- Do not have others in the room unless you discuss with clinician prior to session.
- Do not conduct other activities while in session, such as driving.
- Be located in the state of Louisiana.
- Have an accurate phone number and email address on file with clinician.
- Bring a charger to the session, if using a chargeable device.

MODE AND PARAMETER OF TELETHERAPY SERVICES, INTERRUPTION TO SESSION

Ring Central Meetings is used to provide teletherapy service, which is HIPAA compliant. Texting will only be used if client initiates or agrees to receiving text messages from business and/or me. The most effective ways to contact me are my direct line (225)-414-3359 or my email Brandon@brchristiancounseling.com. While email is not always secure, we use Office 365, which is designed for privacy and security and is HIPAA compliant. If our teletherapy technology fails and you are disconnected from the session, please end and restart the session. If you are unable to restart within a few minutes, the phone is the best back-up plan. I will call the number I have on file for you. If we are unable to connect by phone, I will send you an email using the address I have on file.

POTENTIAL COUNSELING RISKS

Teletherapy technology provides risk that communication can be forwarded, intercepted, circulated, stored, or changed and security of devices could be compromised. It is the client's responsibility to ensure his/her connection is private and secure.

POSSIBLE LIMITATIONS OF TELETHERAPY

Teletherapy has benefits and limitations and should not be viewed as a substitute for in-person counseling sessions. Limitations may include:

- Misunderstanding due to the lack of visual/audio cues
- Disruptions in service and quality of connection
- Being an inappropriate means of therapy if client is experiencing a crisis.

OFFICE PROCEDURES AND FEES

Appointments are scheduled and reminders are sent for individual sessions. For individual clients, a credit card is required to be kept on file and will be charged after the session or if a no-show fee is assessed. You may be asked to verify your identity by providing picture

identification. This protects your identity. Our receptionist handles private payments for all clients.

CONFIDENTIALITY OF RECORDS

Your records are kept for 5 years and stored on a secure website. Your counselor has access to your records and our administrative team has access to information needed for scheduling and billing. Any paper records are kept in locked offices. Your online records are stored in Therapy Appointments, which is a HIPAA compliant sites. In the event that I am no longer able to work with you (death, retirement, etc.), you can request your records by signing a release form. If you are a current client, I will give you several referral sources.

EMERGENCY SITUATIONS

If you have an emergency, you can contact Lake After Hours Hotline at (877) 765- 5253 or the Suicide and Crisis Lifeline at 988. You may also seek help through hospital emergency room facilities or by calling 911.

I have read and understand Brandon Husted's Teletherapy Declaration of Policies and Procedures. My signature below indicates my full informed consent for the use of teletherapy in my mental health care.

Client signature: _____ Date:

Clinician Signature: _____ Date:

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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 24 hours before an appointment, if the online system is unavailable and you will need to call to cancel.

Except in the case of emergencies, no shows or cancelling with less than 24 hours' notice will result in a charge equal to half the session cost for the first missed appointment and full session cost charge thereafter to your credit card on file.

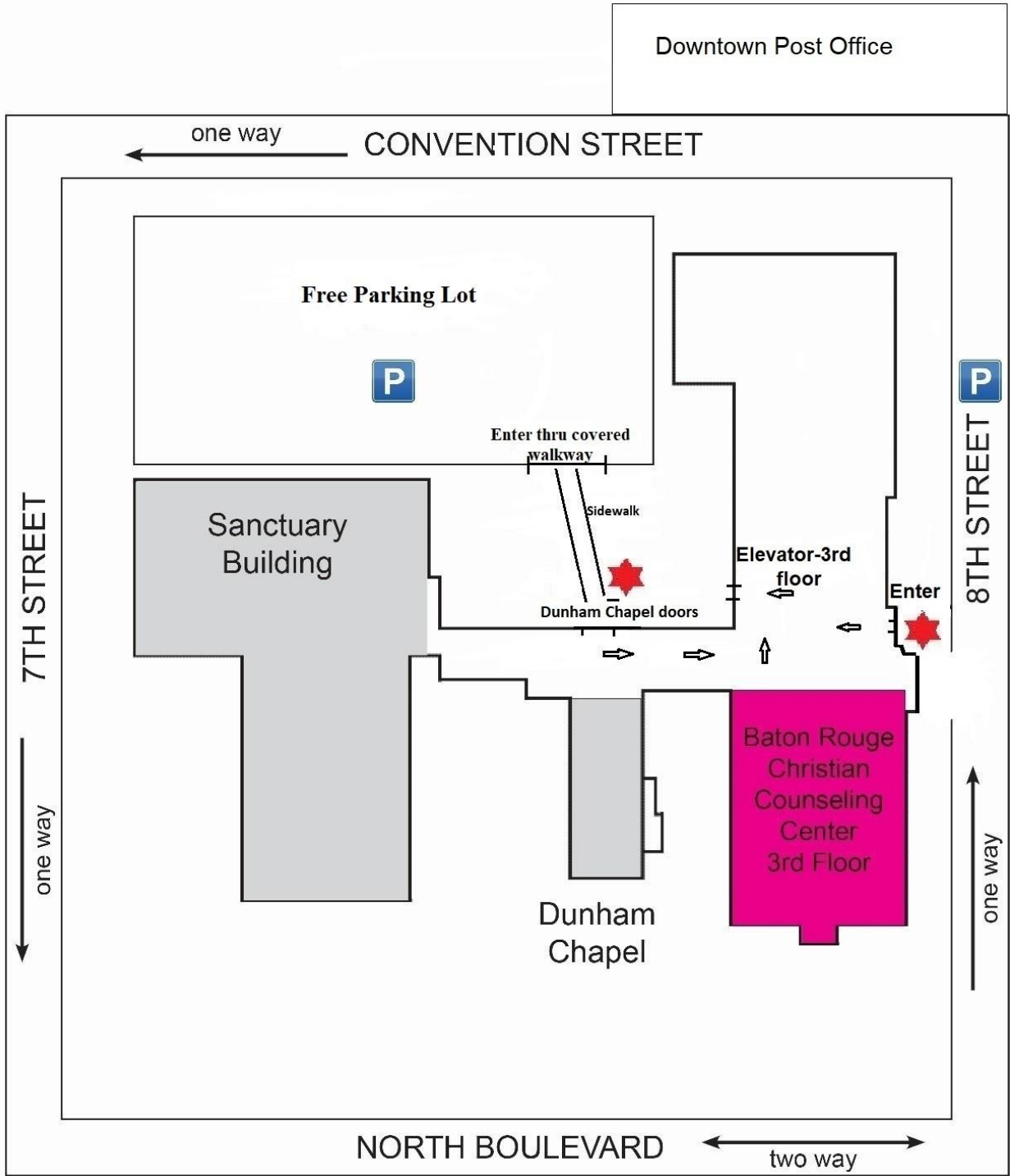
It is my policy, and the center's policy, to securely store the client's credit card number for payment purposes. It will be used for the initial session, subsequent sessions (if desired) and to bill Missed Appointment/Late Cancellation fees. Payment is due at the time of the session.

I, _____, agree to have my/our MasterCard or Visa charged the **FEE OF half the session cost for first appointment missed and the FULL SESSION FEE for all successive missed 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



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

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

Client Understanding & Consent: AI-Based Transcription of Therapy Sessions

Purpose:

To support high-quality care, your therapist may use an AI transcription tool during sessions. This tool listens only for the purpose of generating accurate therapy notes. This allows your clinician to be more engaged, responsive, and focused on you-while ensuring documentation meets professional and legal standards.

What This Means for You:

- The AI does not interpret, store, or analyze the content beyond transcribing it into text.
- The AI-generated transcript is used only by your therapist to create accurate clinical documentation.
- The transcript is not stored or accessed by third parties beyond what is required for secure, HIPAA-compliant processing.
- Your therapist remains solely responsible for the session content, notes, and clinical decisions.
- This use of AI increases efficiency and allows for more attention during the session itself.

Your Privacy Rights:

- This transcription process complies with HIPAA and applicable privacy laws.
- You have the right to ask questions about how the technology works and how your data is handled.
- You may withdraw your consent to this process at any time without penalty or disruption of your care.

Consent Statement:

I have read and understood the information above regarding the use of AI technology to transcribe therapy sessions. I understand that this tool is used only to assist the therapist in documenting our sessions and does not replace human judgment or decision-making. I consent to the use of AI transcription during my sessions.

Client Name: _____ Date: _____

Client Signature: _____

Therapist Name: _____ Date: _____

Therapist Signature: _____