

Joel Gilbert, MSW, LCSW

Baton Rouge Christian Counseling Center

763 North Boulevard, Baton Rouge, Louisiana 70802 | Phone: 225-387-2287 Fax: 225-383-2722

Declaration of Practices and Procedures

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

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

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

- 2. Qualifications:** I received my Master of Social Work degree from Louisiana State University in 2009. I earned a Bachelor of Science in Psychology from Louisiana State University in 2007. I am a Licensed Clinical Social Worker, license number: 10585.
- 3. Areas of Expertise:** My areas of specialization include the treatment of depression and anxiety, grief and loss, couples counseling, relational issues, communication issues, anger management, parenting, and sex education. I work with both individuals and couples. I also work with clients who present with mood and/or personality disorders.
- 4. Session Fees:** Fees are \$155.00 for the initial session and \$135.00 per each 50- minute session thereafter. Payment can be made by check, cash, Visa, or MasterCard and is due at the time of service. Fees are payable to Joel Gilbert, LCSW. (NOTE: When paying with cash you must have exact fee, or you will be issued a credit toward your next visit.)
- 5. Explanation of the types of services and client population:** Individual, child, adolescent, marriage, and family counseling are available. Counseling with children is available within the context of family therapy. Group counseling is offered as needed.
- 6. Code of Ethics:** I am required by state law to adhere to the Louisiana Code of Conduct for Louisiana Licensed Clinical Social Workers. Copies of this code are available upon request.

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

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

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

9. Fees are subject to change. There will be a \$20 NSF charge on returned checks.

Cancellation: If you are unable to keep an appointment, the office must be notified at least 24 hours in advance or the full fee of \$135 will be assessed . If the office is not open and you need to cancel, you can leave a message in our voice mail at (225) 387-2287 and the time of your call will be registered. We aim to confirm appointments, but do not always have ample staff to do so. Responsibility for remembering appointments rests with the client.

10. Emergency Situations: In case of emergency, call 911, The Crisis Intervention Center (The Phone) at (225) 924-3900, a psychiatric hospital, and/or go to the nearest emergency room, if warranted.

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

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

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

13. My policy, and the policy of BRCCC, is to securely store the client's credit card number for payment purposes. It is used for the initial session, for subsequent sessions, for any "no shows", and for appointments not cancelled with at least 24 hours of notice.

Client Signature _____ Date _____

Joel Gilbert, MSW, LCSW _____ Date _____

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

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

_____, (Relationship)

_____ (Name of Minor)

BATON ROUGE CHRISTIAN COUNSELING CENTER

...a ministry of First Presbyterian Church

Counselor: Joel Gilbert

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 No.: (Home) _____, (Work) _____

(Cell): _____

Email Address: _____

Your Employment/Job Title: _____

Person responsible for your bill, if different than above:

Name/Address: _____

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

Name of Ins. Co.: _____

ANY CHURCH MEMBERSHIP: _____

Briefly describe your **spiritual life:** _____

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

Single _____ Married _____ Separated _____ Divorced _____ Remarried _____ Widowed _____

Total number of prior marriages for you _____ for your spouse/partner _____

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

Spouse's employment: _____

WHO REFERRED YOU TO US? _____

Is it ok to call your home and leave a message: Yes ___ No ___; At your work: Yes _____ No _____

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

BRIEFLY describe your reason for seeking counseling: _____

Do you have children? _____ Yes _____ No

If yes:

<u>First Name</u>	<u>Age</u>	<u>Sex</u>	<u>Relationship to you</u> (biological/step/adopted/foster)	<u>Live in your home?</u>
-------------------	------------	------------	--	---------------------------

Your Parents: (Father) Age: _____ or _____ Deceased (Mother) Age: _____ or _____ Deceased

Number of **Brothers:** _____ Number of **Sisters:** _____

Has anyone in your family ever had **counseling** before? If so, for what? _____

Any history of **drug/alcohol abuse** for self, father, mother, siblings? _____ Yes _____ No

If yes, please describe: _____

Any history of **physical** or **sexual abuse** to you or your brothers / sisters? _____ Yes _____ No

If yes, please describe: _____

Do you use **alcohol** or **nonprescription drugs**? _____ Yes _____ No

If yes, describe frequency and type:

Have you ever experienced any **sexual difficulties**: _____ Yes _____ No

If yes, please describe:

Have you ever had **counseling** before? _____ Yes _____ No

If yes, describe and list counselor, rough number of sessions, any psychiatric hospitalizations:

Describe any **major changes** that have occurred to you or your family in the last few years?
(moves, changes in number of family members, marital status, situation, or income)

List any **major health problems** for which you have received treatment for in the last 24 months:

Primary Care Physician: _____

Phone: _____

Are you taking any **prescription drugs** at this time? _____ Yes _____ No

If yes, what type, for what purpose, and who prescribed?

PLEASE CIRCLE or CHECK ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU:

Nervousness	Depression	Fear
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Problems

Baton Rouge Christian Counseling Center

Phone (225) 387-2287 | Fax (225) 383-2722 | 763 North Boulevard, Baton Rouge, LA 70802

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 agree to my request for the restriction, but if BRCCC does agree, BRCCC is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent in writing, at any time. My revocation/withdrawal will be effective except to the extent that BRCCC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

Signature

Date

Signature

Date

Signature

Date



JOEL GILBERT, LCSW

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

INFORMED CONSENT FOR TELETHERAPY (VIDEO) COUNSELING

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

- There are potential benefits and risks for video-conferencing that differ from in-person sessions (secure internet connection).
- Confidentiality still applies and no one will record the session without the permission of the other person.
- You will need a webcam or a smartphone/tablet for the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be in a quiet, private space that is free of distractions during the session.
- The same 24-hour cancellation rules apply to video counseling.
- We need a back-up plan (e.g., phone number where you can be reached) in case we have technical difficulties. If we get disconnected, I will continue to try to reach you. If we both initiate, we will miss each other.
 - Back-up phone number: _____
- We need a safety plan that includes at least one emergency contact and the closest ER to your location in the event of a crisis situation.
 - Emergency Contact Name: _____ ◦ 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 Spruce, a HIPAA compliant teletherapy platform, and my Patient Health Information (PHI) will be protected within the limitations of Spruce and the environment in which the services are utilized.

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

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

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

Client's Signature: _____ Date: _____

Print Name: _____

Counselor's Signature: _____ Date: _____ Print

Name: Joel Gilbert, LCSW

Policy for Cancellations & "No Shows"

Joel Gilbert, MSW, LCSW

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

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

my/our MasterCard or Visa charged the **FULL FEE of \$135 for all appointments:**

- 1) If you are unable to keep an appointment, the office must be notified at least 24 hours in advance or the full fee of \$135 will be assessed.
- 2) for any appointment I/we neglect to appear ("no show")
- 3) for any balance owed 30 days past due.

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.

| PLEASE FILL IN THE INFORMATION BELOW |                                                                                                                         |                                                                                                                   |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| CARD TYPE                            |  <input type="checkbox"/> MASTERCARD |  <input type="checkbox"/> VISA |
|                                      |  <input type="checkbox"/>          |                                                                                                                   |
| CARD NUMBER:                         | SECURITY CODE:                                                                                                          | ZIP CODE:                                                                                                         |
| CARDHOLDER NAME:                     | EXP DATE:                                                                                                               |                                                                                                                   |
| SIGNATURE:                           | AMOUNT: Maximum \$135.00 for missed appointments or ANY balance due past 30 days                                        |                                                                                                                   |

## **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.

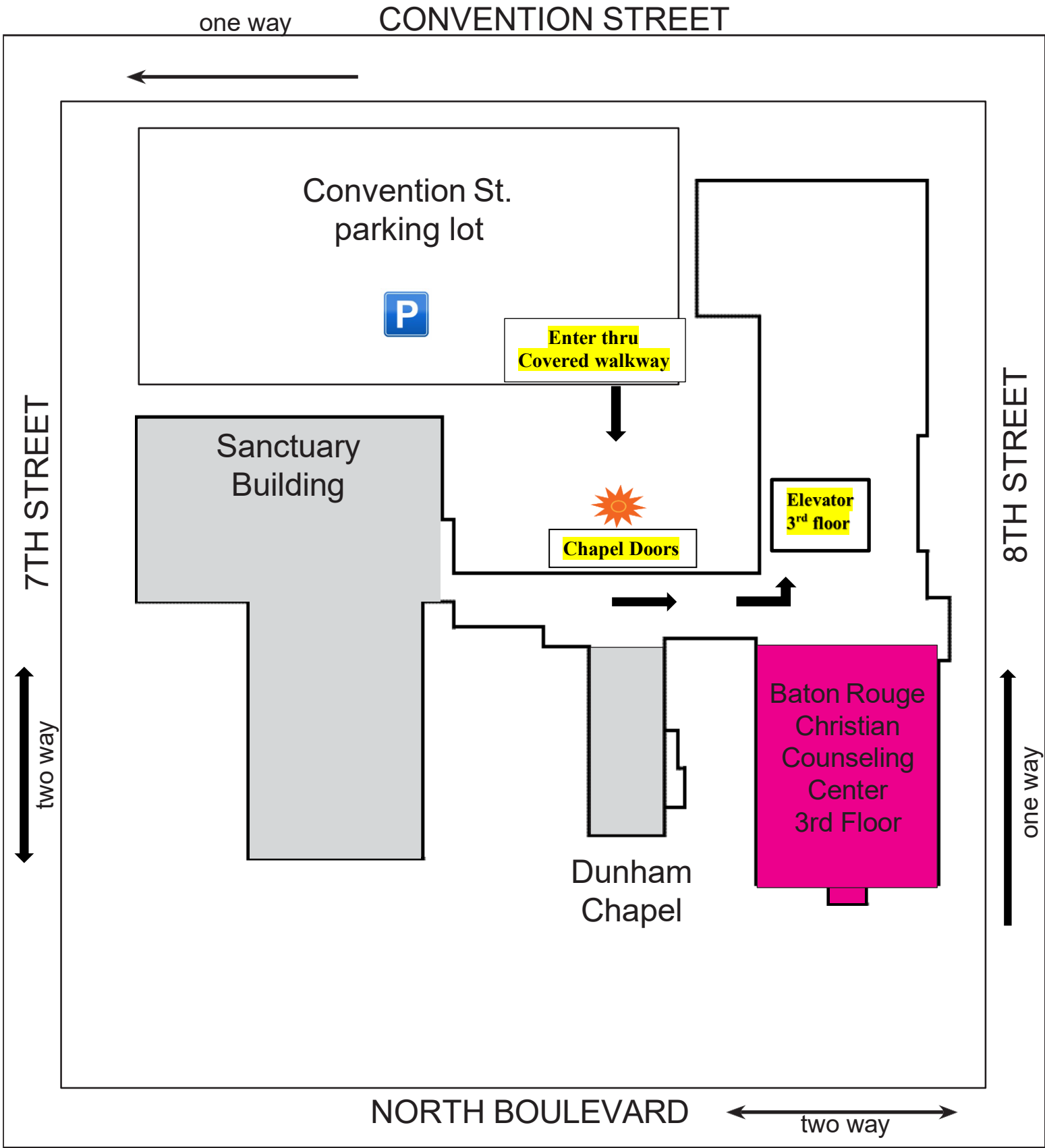
From that lot, look for the black iron gate and follow the sidewalk to the Dunham Chapel doors. There is a plaque on the wall by the doors.

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).