

Julie Alleman, M.Ed., LPC, LMFT, LAC
Licensed Professional Counselor, Licensed Marriage and Family Therapist, and
Licensed Addiction Counselor
Baton Rouge Christian Counseling Center
763 North Boulevard
Baton Rouge, LA 70802
Phone 225-387-2287 Fax 225-383-2722

Declaration of Practices and Procedures

I am pleased that you have chosen me for your counselor, and appreciate your confidence in contacting me for assistance. This statement is designed to inform you about my background and to insure that you understand our professional relationship. **Please sign and date the last page.**

1. Qualifications: I earned a Master of Education in Community Counseling from Southeastern Louisiana University in 1996. I am a Licensed Professional Counselor , license #3052, and a Licensed Marriage and Family Therapist, license #971, both registered with the Licensed Professional Counselor's Board of Examiners, which is located at 8631 Summa Avenue, Suite A, Baton Rouge, La 70809 (Phone 225-765-2515). I am also a Licensed Addiction Counselor, license #970, with the Department of Health and Hospitals, Office for Addictive Disorders, Addictive Disorders Regulatory Authority, which is located at 8738 Quarters Lake Rd., Baton Rouge, La. 70809 (phone 225-922-7700).

2. Counseling Relationship: It is my desire to promote a warm and trusting atmosphere in which you feel free to examine patterns of relating to others and behaviors, thoughts or moods that are causing you concern. I am multi-theoretical in my counseling approach, including but not limited to Cognitive Behavioral Therapy and EMDR. Goals for therapy are always established through collaboration with you, the client. The ultimate goal of counseling is the successful resolution of the problems that are deemed most important to you through that collaborative process. I often use between-session assignments, which are a vital part of the therapeutic process. Completion of these assignments is necessary for you to obtain the most from the therapeutic experience. You must make your own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to establish custody and visitation. I will help you think through the possibilities and consequences on decisions, but my code of ethics prohibits me from advising you to make a specific decision. Your first session involves information gathering and becoming acquainted. I will obtain historical information from you and review the events that brought you to see me. Feel free to ask me any questions you may have. The nature of your need will be discussed and recommendations made concerning future appointments or outside referrals if I am unable to provide the service appropriate for you.

3. Areas of Expertise: My counseling practice includes individual, marriage, family, couple, and group therapy. The areas of therapeutic intervention in which I specialize in include, but are not limited to, depression, anxiety, trauma, family of origin issues, substance abuse, adult children of alcoholics, and codependency. I work with adults and adolescents ages 13 and up.

4. Session Times and Fees: Counseling sessions are fifty minutes in duration, with the last ten minutes used for rescheduling, payment, and other related business. Fees are due at the time the services are rendered. The Initial Evaluation cost is \$120.00. The fee for each fifty minute individual, marital, or family session is \$100.00. Group counseling fees are \$35.00 for a 90 minute session. Cash, personal checks, and third party payments are acceptable forms of payment. Please make checks payable to Julie Alleman. The final obligation for payment lies with you, the client, not the insurance or managed care companies. Fees are subject to change. There will be a \$20.00 NSF charge on all returned checks.

Cancellation: 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 \$100.00. 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 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.

5. Services Offered and Clients Served: Individual, family, couple, and group counseling are available. I primarily work with adults and adolescents.

6. Code of Conduct/Ethics: As a Licensed Professional Counselor (LPC) and a Licensed Marriage and Family Therapist (LMFT), I am required by law to adhere to the Code of Conduct for LPC's and the Code of Ethics for LMFT's that have been adopted by my licensing board. Copies of these codes/ethics are available to you upon request.

7. Privileged Communication/Confidentiality: I am required to abide by the professional practice standards for Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Louisiana law. I do not disclose client confidences and information to any third party except for materials shared during supervision without a client's 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. When working with 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. For example, I cannot release *any* information about either or both spouses I have seen for marital therapy to an attorney without signed authorizations from both spouses. When working with a family or couple, information shared by individuals in sessions where 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. Your signature at the end of this form also includes permission for audio taping of sessions.

8. 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 Julie Alleman 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.

9. 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.

10. Client Responsibilities: You are expected to follow billing, scheduling and office procedures. If you have been seeing another mental health professional it is expected that you get permission from them or terminate the counseling relationship. If permission is allowed I would ask that you grant me authorization to share information with this professional so that we may coordinate our services to you. If you have suggestions or concerns about the counseling services that you are receiving please share these with me so that the necessary adjustments or referrals can be made. In addition, you are expected to follow through on any homework assignments in order for the therapeutic experience to be beneficial. Throughout the exploration process, issues may arise that are not

within my realm of expertise. It may be necessary to refer you to a therapist with the training and expertise appropriate for you. This will be discussed with you should these issues arise.

11. Physical Health: Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical within the last year, it is recommended that you do so. Also, you agree to list any medications that you are taking on the intake form and who your primary care physician is.

12. Telephone Consultations: Telephone consultations are rarely recommended, but are available as scheduled on a fee basis.

13. Potential Counseling Risks: As a result of mental health counseling, you may realize that you have additional issues which may not have surfaced prior to the onset of the counseling relationship. If this occurs, please feel free to share these new concerns with me. Also, there is a possible risk in couple or family counseling. If one partner changes, an additional strain may be placed on the relationship(s) if the other(s) involved refuse to grow. Marital or family conflicts may intensify as feelings are expressed.

I have read, or have had read to me, and understand the above information. I hereby sign in agreement and authorize this provider to release information to my primary care physician as needed. I also hereby sign in agreement and authorize this provider to release any information necessary to obtain assignment/payment of health care benefits from third party insurers, such as health insurance companies, HMO or PPO plans, or EAP programs, for the above services.

Client's Signature

Date

Julie Alleman, M.Ed., LPC, LMFT, LAC

Date

If the client is a minor, parental authorization is needed:

I _____ give permission for Julie Alleman, M.Ed., LPC, LMFT, LAC to conduct therapy with my (relationship) _____ (name of minor)_____

BATON ROUGE CHRISTIAN COUNSELING CENTER

...a ministry of First Presbyterian Church

Counselor: _____

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 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 & 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 Sex Relationship to you
(biological/step/adopted/foster) Live in your home?

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, 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

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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 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

Last Name, First Name: _____

BRCCC Appointment Confirmation Consent Form

In accordance with BRCCC's policy, there is a charge for missed appointments that are not cancelled with 24 hour's notice.
(whether appointments are confirmed or not)

I, _____, do NOT want my appointments confirmed.

I, _____, hereby give permission to have my counseling appointments confirmed.

Our preferable choice!

_____ E-mail: _____ @ _____
(INITIAL)

_____ Telephone number(s): (____) _____ HOME
(INITIAL)
(____) _____ CELL
(____) _____ WORK

If someone else -ANYONE else, presently or in the future, answers at ANY of these phone numbers listed above

OR

If voicemail / answering service/answering machine picks up:

_____ It **IS** permissible to leave a message, OR
_____ It is **NOT** permissible to leave a message

*Note-BRCCC may show up on your caller ID.

Signature of Client

Date

Signature of Spouse (if applicable)

Date

NOTE: DUE TO FLUCTIATIONS IN STAFF, WE ARE NOT ALWAYS ABLE TO CONFIRM APPOINTMENTS.

Remembering appointments is the responsibility of the client.

Policy for Cancellations & "No Shows"

Julie Alleman, M.Ed., LPC, LMFT, LAC

Baton Rouge Christian Counseling Center
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(225) 387-2287 (24 hour voice mail)

I, _____, agree to have my/our
Print Name(s)

MasterCard or Visa charged the **FEE OF \$35 for first appointment and the FULL FEE of \$100 for all successive 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")
- 3) for any balance owed 30 days past due.

Signature

Date

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

Confirmation of appointments is provided as a courtesy, when there is ample staff to do so.  
**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.

| <b>PLEASE FILL IN THE INFORMATION BELOW</b> |                                                                                                                                |                                                                                                                          |                                                                                                                                |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| <b>CARD TYPE</b>                            |  <input type="checkbox"/> <b>MASTERCARD</b> |  <input type="checkbox"/> <b>VISA</b> |  <input type="checkbox"/> <b>DISCOVER</b> |
| <b>CARD NUMBER:</b>                         | <b>SECURITY CODE:</b>                                                                                                          |                                                                                                                          | <b>ZIP CODE:</b>                                                                                                               |
| <b>CARDHOLDER NAME:</b>                     | <b>EXP DATE:</b>                                                                                                               |                                                                                                                          |                                                                                                                                |
| <b>SIGNATURE:</b>                           | <b>AMOUNT: Maximum \$100.00 for missed appointments or ANY balance due past 30 days</b>                                        |                                                                                                                          |                                                                                                                                |