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 insure 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 $110.00 for the initial session and $90.00 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 retuned checks. **Cancellation: If you are unable to keep an appointment, the office must be notified at least 24 hours in advance or a fee of $35 will be assessed for the first cancellation, then the full $90 fee will be assessed thereafter.** 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: _____

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:

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, 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**

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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

_____ _____

Signature Date