BATON ROUGE CHRISTIAN COUNSELING CENTER

DX CODE: _____

Counselor: __Sherry Kadair_____

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 Questionaire**)
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 (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**

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. 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

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

Declaration of Policies and Procedures

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, 8631 Summa Avenue, Baton Rouge, Louisiana 70809 Telephone (225)765-2515.

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 adult clients. I hold a national certification as a National Certified Counselor (NCC Lic#63282).

Fee Scales: The fee for a 60 min session is $100. The first appointment fee is $135. 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 (see attached form).

Services Offered and Clients Served: I counsel men, women and children ages 16 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 dependant 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. If you need to contact me, leave a voice mail at the number above. I will 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/Guardian Signature _____ Date _____

Counselor 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 8 hours before an appointment, the online system is unavailable and you will need to call to cancel.

There will be a $35 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 copay 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 $35 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

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims.

SIGNED: _____**DATE:** _____

INSURED'S OR AUTHORIZED PERON'S SIGNATURE: I authorize payment of medical benefits to the counselor who provided the service.

SIGNED: _____**DATE:** _____