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# SARAH EASTERLY, MA, LPC, CSAT

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

## WELCOME LETTER AND INFORMATION

Thank you for choosing me as your therapist, I am looking forward to meeting you. Below is an explanation of the things you'll need to know to be prepared for our first visit:

**DIRECTIONS:** See the attached map. My office is in on the third floor of the red brick administrative building on the First Presbyterian Church campus at 763 North BOULEVARD (not Street) in downtown Baton Rouge. We are across Convention Street from the downtown Post Office. The church takes up a whole city block, bordered on 4 sides by North Boulevard (grass down the middle), Convention, and 7th and 8th Streets.

In that block, we are in the red brick building closest to the Interstate. Either park at a meter on 8th Street and enter via the 8th Street door OR park in the big free parking lot on Convention and enter via the Chapel door. We can only buzz you in at 2 doors. Buzz the Counseling Center and someone will ask who you are here to see and then unlock the door. The counseling center is located on the 3rd floor. Both an elevator and stairs are available.

You may want to allow extra time to find us for your first session, especially given Baton Rouge's traffic. Printing out these directions and/or bringing the map that is attached will help.

**SCHEDULING:** For your convenience, you can schedule online via [www.therapyappointment.com](http://www.therapyappointment.com). You may have set up your own account or the receptionist can give you a username and password when you call to schedule your first appointment. After your first visit, please access this portal to schedule or cancel and future appointments. To access the portal, visit [www.therapyappointment.com](http://www.therapyappointment.com) and select my name. The first time you can only schedule one appointment, after that as many as you wish. To get a jumpstart, or because of travel, some people elect to schedule 1 ½ or 2 sessions for the first visit, or later visits. This is particularly helpful for couple counseling.

**PAPERWORK:** Please review, sign, and bring all the attached paperwork to your first appointment. Please do not print back to back. If you do not print out the forms, please allow 20 minutes before your session begins to complete them so you won't lose any of your therapy time. If you run late, you lose minutes. If I run late, you will always get all of your time. If you're coming as a couple then I need both of you to fill out all of the forms.

**FEES:** The fee per 50 minute session is \$120. The first evaluative session is \$140. The fee for 1 ½ sessions (75 minutes) is \$180 and a double session of 90-100 minutes is \$240.

**PAYMENT:** It is the BRCCC policy that payment must be made at the time of service. You can pay with check, cash, Visa/Master Card, or Discover -- whichever is best for you.

CREDIT CARD ON FILE: To secure your appointment, we must have your credit card number on file prior to your arrival for the first session. It is safely secured through encryption. You can call our office at (225)387-2287 with a credit card number and we will charge a penny to your account, or you can login to your account on TherapyAppointment.com and do it yourself:

1. Login and click where it says "View or pay online statement"
2. Go to "Do you want to make a payment?"
3. Go to: "Please charge a \_\_\_\_\_ to a new charge card"
4. Fill in the name on the card, street address, and zip code
5. Click "Submit payment to charge card"
6. Verify by clicking "Yes"
7. Put in your credit card number, expiration date and 3-4 digit security CVV code from the back
8. Then click on "Process"

DONE ! Your credit card information is safely stored and encrypted in our system

INSURANCE: I do not file with insurance, but we can give you a receipt with a diagnosis for you to file for reimbursement via "out of network" benefits. You can see if you have mental health benefits by calling your insurance company and asking some questions that we have listed on a form on our website, under FORMS: QUESTIONS FOR INSURANCE COMPANY.

CONFIRMATION OF APPOINTMENT: On the Registration Form in your account online you can elect to have your appointments confirmed through text, email, or automated phone call. *However, whether an appointment is confirmed or not, you are still responsible for remembering your appointments and will be charged if you miss.* Reminders can be sent to up to 2 cell numbers or 2 email addresses – but not to texts AND emails.

CANCELLATIONS: If you ever need to cancel - I need at least 24 hours notice, preferably 48 hours. Cancellation within the remaining 24 hours will result in a charge. I really appreciate your understanding so I can schedule other clients in need of counseling. We have voicemail 24 hours a day, 7 days a week. If you need to cancel within the 24 hours, you can't do that online – you have to call.

WAIT LIST: If you now, or ever, want an earlier appointment and nothing is available – email, message through the online scheduler, or call and ask to be put on my waiting list. We'll call you if something opens up earlier. I sometimes email out notice of last minute cancellations. If you think you'll need more sessions, you may want to not wait until your first appointment to schedule more sessions so that you can get the times you want. The system only lets you schedule your first appointment – if you want more, call.

COMING AS A COUPLE: I generally meet with a couple together first, then one session with each person individually, then back together as a couple from then on. If this isn't possible, I can be flexible. And for future sessions if one can't come it's OK to come alone.

If you have any questions, please email me or give me a call.

Please know that I'm looking forward to meeting you!

SARAH EASTERLY, MA, LPC, CSAT

763 North Blvd, Baton Rouge, LA 70802

(225) 387-2287 • (225) 383-2722 fax

[www.brchristiancounseling.com](http://www.brchristiancounseling.com)

sarah@brchristiancounseling.com

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## DECLARATION OF PRACTICES AND PROCEDURES

Qualifications: I earned a Master of Arts degree in Marriage and Family Counseling from New Orleans Baptist Theological Seminary in 2013. I am licensed as a LPC# 5661 with the Licensed Professional Counselors Board of Examiners, 11410 Lake Sherwood Ave N, Suite A, Baton Rouge, LA 70816, (225) 295-8444.

Counseling Relationship: I see counseling as a process in which you the client, and I, the counselor, having come to understand and trust one another, work as a team to explore and define present problem situations, develop future goals for an improved life and work in a systematic fashion toward realizing those goals. 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.

Areas of Focus: I focus on clients with individual, marriage, and family issues. I conduct individual, couple, family and group formats for counseling sessions.

Fees and Office Procedures: The Initial Evaluation cost is \$140. The fee for each fifty-minute individual, marital, or family session is \$120. Fees are subject to change. Payment for services is due at the time services are rendered. Cash, personal checks, debit/credit cards are acceptable forms of payment. Please make checks payable to Sarah Easterly. There will be a \$50 NSF charge on all returned checks. Payment is not accepted from insurance companies. 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. 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 \$120. 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.

Services Offered and Clients Served: I approach counseling from an emotionally-focused theoretical framework. This experiential and person-centered perspective holds that emotions are connected to our most essential needs. As the client, emotions, and problems are explored, rapport is built, and priorities emerge. Utilized concurrent with this framework, I incorporate the cognitive-behavioral perspective in that patterns of thoughts and actions are explored in order to better understand the clients' problems and to develop solutions. I work with clients in a variety of formats, including individually, as couples, and as families. I also conduct group therapy. I see clients of all ages and backgrounds with the exception that I do not work individually with children under five years of age.

Code of Conduct: As a Counselor, I am required by law to adhere to the Code of Conduct for practice that has been adopted by my licensing Board. A copy of the Code of Conduct is available to you upon request.

Confidentiality: Material revealed in counseling will remain strictly confidential except for under the following circumstances, in accordance with State law:

1. The client signs a written release of information indicating informed consent of such release.
2. The client expresses intent to harm him/herself or someone else.
3. There is reasonable suspicion of abuse/neglect against a minor child, elderly person (60 or older), or dependent adult.
4. A court order is received directing the disclosure of information.

In the event of marriage or family counseling, material obtained from an adult client individually may be shared with the client's spouse or other family member with the client's written permission. Any material obtained from a minor client may be shared with the client's parent or guardian.

Privileged Communication: 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.

Emergency Situations: If an emergency situation should arise, seek help through calling Our Lady of the Lake's COPE Team at (225) 765-8900 or (800) 864-9003 and proceed to Our Lady of the Lake Regional Medical Center. If you are out of town, dial 911 for your nearest emergency room.

Client Responsibilities: You are expected to follow billing, scheduling and office procedures. You, the client, are a full partner in counseling. Your honesty and effort are essential to success. As we work together, if you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary adjustments. If you or I determine that you would be better served by another mental health provider, I will help you with the referral process. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate our services to you.

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. Also, please provide me with a list of any medications that you are currently taking.

Potential Counseling Risk: 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.

Telemental Health: When appropriate, I provide Teletherapy, an alternative form of counseling provided at a distance through confidential technology. I have completed 9 hours of live telehealth care training in addition to my professional qualifications as a clinician. This training covered the law and ethics and clinical skills specifically related to telehealth care. I continue to receive at least three hours of continuing education in the area of telemental health every two years. It is imperative that you sign my Telemental Counseling Consent Form before entering into telemental counseling; it is attached to my Declaration of Practices.

I HAVE READ THE DECLARATION OF PRACTICES AND PROCEDURES of Sarah Easterly, MA, LPC, CSAT and my signature below indicates my full informed consent to services provided by Sarah Easterly, MA, LPC, CSAT.

Client Signature

\_\_\_\_\_ Date \_\_\_\_\_

Client Signature

\_\_\_\_\_ Date \_\_\_\_\_

Counselor

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Consent for Treatment of a Minor:

I \_\_\_\_\_, give my permission for Sarah Easterly, MA, LPC, CSAT to

conduct therapy with my \_\_\_\_\_.

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## NO SECRETS POLICY FOR

## COUPLES AND FAMILIES

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. Thus, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During my work with a couple/family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions are a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We acknowledge by our individual signatures below, that each of us has read this policy, understand it, have had an opportunity to discuss its contents with Sarah Easterly, MA, LPC, CSAT and we enter couple/family therapy in agreement with this policy.

Signature\_\_\_\_\_

Date:\_\_\_\_\_

Signature\_\_\_\_\_

Date:\_\_\_\_\_

Signature\_\_\_\_\_

Date:\_\_\_\_\_

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## POLICY FOR CANCELLATIONS, NO SHOWS, AND CREDIT CARD AUTHORIZATION

It is my policy, and the BRCCC's policy, to securely store the client's credit card number for payment purposes. Credit card numbers will be securely locked and kept confidentially along with other client data. 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 to store the card and credited back to you at the first session. Payment is due at the time of the session. Please initial below:

\_\_\_\_\_ I/We agree to have my/our credit card charged for \$.01 and kept on file for payments and  
Initial(s) agree to a charge of full fee (\$120 per therapy hour) for appointments missed:

- 1) For any session not cancelled with at least 24 hour notice
- 2) For any appointment I/we neglect to appear ("no show")
- 3) For any balance owed 30 days past due. My card will be charged for the amount of the remaining balance due.

\_\_\_\_\_ I understand that any card on file, whether listed below or encrypted in our software  
- program, can be used

<input type="checkbox"/> MASTERCARD EXPRESS	<input type="checkbox"/> VISA	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> AMERICAN
CARD NUMBER:	SECURITY CODE:	ZIP CODE:	
CARDHOLDER NAME:	EXP DATE:		
SIGNATURE:			

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## COMMUNICATION ADDENDUM TO THE INFORMED CONSENT

Because cell phone or regular e-mail technologies cannot be fully assured, it is your right to determine whether communication by non-secure technologies may be permitted, whether initiated by you or your clinician. You should also know that any correspondence I receive from you and any responses that I send to you becomes a part of your legal record.

Initial all you permit (if couple, both initial):

\_\_\_\_\_ Voice & Text communication to and from client's cell phone  
Initial(s)

\_\_\_\_\_ Voice & Text communication to and from clinician's cell phone  
Initial(s)

\_\_\_\_\_ Messages left on client's cell or home land lines  
Initial(s)

\_\_\_\_\_ Communication to and from client's e-mail  
Initial(s)

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## SOCIAL MEDIA POLICY

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

**FRIENDING:** I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

**FOLLOWING:** I share articles, posts and may publish blogs on my social media sites. I have no expectation that you as a client will follow my accounts. However, if you use an easily recognizable name and I happen to notice that you've followed me, we may briefly discuss it and its potential impact on our working relationship.

My primary concern is your privacy. You are welcome to use your own discretion in choosing whether to follow me. Note that I will not follow you back. I do not follow current or former clients on social media. My reasoning is that viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

**MESSAGING:** Please do not use messaging/commenting on Social Networking sites to contact me. These sites are not secure, and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone. Direct email at [sarah@brchristiancounseling.com](mailto:sarah@brchristiancounseling.com) is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

**SEARCH ENGINES:** It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

**LOCATION-BASED SERVICES:** If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally “checking in,” from my office or if you have a passive LBS app enabled on your phone.

**EMAIL:** I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

**CONCLUSION:** Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

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# BATON ROUGE CHRISTIAN COUNSELING CENTER

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

## 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](http://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.

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Signature

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Date

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Signature

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Date

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Signature

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Date

# BATON ROUGE CHRISTIAN COUNSELING CENTER

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

DX CODE: \_\_\_\_\_

To help with your first session, please provide the following information as completely as you can.

**PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL**

Name: \_\_\_\_\_ (if a couple, please each fill out forms)

Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Counselor \_\_\_\_\_

Address: \_\_\_\_\_ City/St \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Your Employment/Job Title: \_\_\_\_\_

Person responsible for your bill, if different than above:

Name/Address: \_\_\_\_\_

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 or how did you find us? \_\_\_\_\_

Is it ok to call your home/cell & leave message: Yes \_\_\_ No \_\_\_ At your work: Yes \_\_\_ No \_\_\_

Person to contact in case of an emergency (name/phone): \_\_\_\_\_

Please State Your Goals for Therapy:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Do you have children? \_\_\_Yes \_\_\_No If yes:

First Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Relationship to you \_\_\_\_\_ Live in your home?  
(biological/step/adopted/foster)

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Father's Name \_\_\_\_\_ Age: \_\_\_\_\_ or \_\_\_ Deceased

Mother's Name \_\_\_\_\_ Age: \_\_\_\_\_ or \_\_\_ Deceased

Number of Brothers: \_\_\_\_\_ Number of Sisters: \_\_\_\_\_ Birth Order: \_\_\_\_\_ of \_\_\_\_\_ # of children

Has anyone in your family ever had counseling before? If so, for what? \_\_\_\_\_

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Any history of drug/alcohol abuse for self, father, mother, siblings? \_\_\_Yes \_\_\_No

If yes, please describe: \_\_\_\_\_

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Any history of physical or sexual abuse to you or your brothers/sisters? \_\_\_Yes \_\_\_No

If yes, please describe: \_\_\_\_\_

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Do you use alcohol or nonprescription drugs? \_\_\_Yes \_\_\_No

If yes, describe frequency and type: \_\_\_\_\_

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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:

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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) \_\_\_\_\_

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

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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? \_\_\_\_\_

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Additional Comments:

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While you were growing up, during your first 18 years of life:

- |     |    |  |
|-----|----|--|
| Yes | No | 1. Did a parent or other adult in the household often ... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?  |
| Yes | No | 2. Did a parent or other adult in the household often ... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?   |
| Yes | No | 3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Try to or have oral, anal, or vaginal sex with you?   |
| Yes | No | 4. Did you often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?   |
| Yes | No | 5. Did you often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?   |
| Yes | No | 6. Were your parents ever separated or divorced?   |
| Yes | No | 7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife? |
| Yes | No | 8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?   |
| Yes | No | 9. Was a household member depressed or mentally ill or did a household member attempt suicide?   |
| Yes | No | 10. Did a household member go to prison?   |

Put a number next to any item which you experience. 1=mildly, 2=moderately, 3=severely

### **Emotional Concerns**

- |   |  |
|---|--|
| <input type="checkbox"/> feeling anxious or uptight                 | <input type="checkbox"/> being tired or lacking energy             |
| <input type="checkbox"/> excessive worrying                         | <input type="checkbox"/> feeling unmotivated                       |
| <input type="checkbox"/> not being able to relax                    | <input type="checkbox"/> loss of interest in many things           |
| <input type="checkbox"/> feeling panicky                            | <input type="checkbox"/> having trouble concentrating              |
| <input type="checkbox"/> unable to calm yourself down               | <input type="checkbox"/> having trouble making decisions           |
| <input type="checkbox"/> dwelling on certain thoughts or images     | <input type="checkbox"/> feeling the future looks hopeless         |
| <input type="checkbox"/> fearing something terrible about to happen | <input type="checkbox"/> feeling worthless or a failure            |
| <input type="checkbox"/> avoiding certain thoughts or feelings      | <input type="checkbox"/> being unhappy all the time                |
| <input type="checkbox"/> having strong fears                        | <input type="checkbox"/> dissatisfied with physical appearance     |
| <input type="checkbox"/> worrying about a nervous breakdown         | <input type="checkbox"/> feeling self critical or blaming yourself |
| <input type="checkbox"/> feeling out of control                     | <input type="checkbox"/> having negative thoughts                  |
| <input type="checkbox"/> avoiding being with people                 | <input type="checkbox"/> crying often                              |
| <input type="checkbox"/> fears of being alone or abandoned          | <input type="checkbox"/> feeling empty                             |
| <input type="checkbox"/> feeling guilty                             | <input type="checkbox"/> withdrawing inside yourself               |
| <input type="checkbox"/> having nightmares                          | <input type="checkbox"/> thinking too much about death             |
| <input type="checkbox"/> flashbacks                                 | <input type="checkbox"/> thoughts of hurting yourself              |
| <input type="checkbox"/> troubling or painful memories              | <input type="checkbox"/> thoughts of killing yourself              |
| <input type="checkbox"/> missing periods of time - can't remember   | <input type="checkbox"/> frequent mood swings                      |
| <input type="checkbox"/> trouble remembering things                 | <input type="checkbox"/> feeling resentful or angry                |
| <input type="checkbox"/> feeling numb instead of upset              | <input type="checkbox"/> feeling irritable or frustrated           |
| <input type="checkbox"/> feeling detached from all or part of body  | <input type="checkbox"/> feeling rage                              |
| <input type="checkbox"/> feeling unreal, strange or foggy           | <input type="checkbox"/> feeling like hurting someone              |
| <input type="checkbox"/> feeling depressed or sad                   |  |

---

### **Behavioral and Physical Concerns**

- |   |   |
|---|---|
| <input type="checkbox"/> not having an appetite                   | <input type="checkbox"/> aggressive toward others   |
| <input type="checkbox"/> eating in binges                         | <input type="checkbox"/> impulsive reactions  |
| <input type="checkbox"/> self induced vomiting for weight control | <input type="checkbox"/> trouble finishing things   |
| <input type="checkbox"/> using laxatives for weight control       | <input type="checkbox"/> working too hard   |
| <input type="checkbox"/> eating too much                          | <input type="checkbox"/> using alcohol too much   |
| <input type="checkbox"/> eating too little                        | <input type="checkbox"/> being alcoholic  |
| <input type="checkbox"/> losing weight - how much? _____          | <input type="checkbox"/> using drugs  |
| <input type="checkbox"/> gaining weight - how much? _____         | <input type="checkbox"/> driving under the influence  |
| <input type="checkbox"/> trouble sleeping                         | <input type="checkbox"/> blackouts - after drinking   |
| <input type="checkbox"/> trouble falling asleep                   | <input type="checkbox"/> excessive internet/phone/tv usage  |
| <input type="checkbox"/> early morning awakening                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever felt you ought to cut down |
| <input type="checkbox"/> sleeping too much                        | <input type="checkbox"/> on your drinking or drug use?  |
| <input type="checkbox"/> sleeping too little                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Have people annoyed you by criticizing   |
| <input type="checkbox"/> # of hours I usually sleep: _____        | <input type="checkbox"/> your drinking or drug use?   |
| <input type="checkbox"/> lack of exercise                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever felt bad or guilty about   |
| <input type="checkbox"/> not having leisure activities            | <input type="checkbox"/> your drinking or drug use?   |
| <input type="checkbox"/> smoking cigarettes                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a drink or used drugs  |
| <input type="checkbox"/> often spending in binges                 | <input type="checkbox"/> first thing in the morning to steady your nerves or to get               |
| <input type="checkbox"/> temper outbursts                         | <input type="checkbox"/> rid of a hangover  |

### **Intimate Relationship Concerns**

- |   |  |
|---|--|
| <input type="checkbox"/> feeling misunderstood in relationship  | <input type="checkbox"/> trouble resolving conflict              |
| <input type="checkbox"/> not feeling close to partner           | <input type="checkbox"/> partner being demanding and controlling |
| <input type="checkbox"/> trouble communicating with partner     | <input type="checkbox"/> partner putting you down                |
| <input type="checkbox"/> not trusting partner                   | <input type="checkbox"/> violent arguments                       |
| <input type="checkbox"/> lack of respect by partner             | <input type="checkbox"/> emotional abuse in relationship         |
| <input type="checkbox"/> partner being secretive                | <input type="checkbox"/> physical abuse in relationship          |
| <input type="checkbox"/> lack of fairness in relationship       | <input type="checkbox"/> sexual abuse in relationship            |
| <input type="checkbox"/> problems with dividing household tasks | <input type="checkbox"/> partner having alcohol or drug problem  |
| <input type="checkbox"/> disagreeing about children             | <input type="checkbox"/> self or partner having an affair        |
| <input type="checkbox"/> lack of affection                      | <input type="checkbox"/> feeling uncommitted to relationship     |
| <input type="checkbox"/> unsatisfactory sexual relationship     | <input type="checkbox"/> wanting to separate                     |
| <input type="checkbox"/> lack of time together                  | <input type="checkbox"/> discussing separating or divorce        |
| <input type="checkbox"/> lack of shared interests               | <input type="checkbox"/> problems with in-laws                   |
| <input type="checkbox"/> lack of positive interaction           | <input type="checkbox"/> problems with ex-partner                |
| <input type="checkbox"/> lack of time with other couples        | <input type="checkbox"/> problems with step parents              |
| <input type="checkbox"/> jealousy in relationship               | <input type="checkbox"/> children having special problems        |
| <input type="checkbox"/> frequent arguments                     |  |
- 

### **Sexual Concerns**

- |  |   |
|--|---|
| <input type="checkbox"/> worrying about getting pregnant | <input type="checkbox"/> wanting to have sex more often         |
| <input type="checkbox"/> having miscarriage(s)           | <input type="checkbox"/> feeling neglected sexually             |
| <input type="checkbox"/> choice of birth control         | <input type="checkbox"/> feeling used sexually                  |
| <input type="checkbox"/> having an abortion              | <input type="checkbox"/> feeling unable to have orgasm          |
| <input type="checkbox"/> not able to become pregnant     | <input type="checkbox"/> being unable to sustain an erection    |
| <input type="checkbox"/> not enjoying sexual affection   | <input type="checkbox"/> feeling negatively about sex           |
| <input type="checkbox"/> too tired to have sex           | <input type="checkbox"/> porn usage                             |
| <input type="checkbox"/> too anxious to have sex         | <input type="checkbox"/> I think I may be a sex addict          |
| <input type="checkbox"/> feeling a lack of sexual desire | <input type="checkbox"/> I think my partner may be a sex addict |
- 

### **When Growing Up to Present Time:**

- |  |  |
|--|--|
| <input type="checkbox"/> being physically abused - by whom?      | <input type="checkbox"/> felt neglected or unloved - by whom     |
| <input type="checkbox"/> being emotionally abused - by whom?     | <input type="checkbox"/> having an unhappy childhood             |
| <input type="checkbox"/> being sexually abused - by whom?        | <input type="checkbox"/> having serious medical problems - what? |
| <input type="checkbox"/> having an alcoholic parent - which?     | <input type="checkbox"/> having drug or alcohol problem          |
| <input type="checkbox"/> having a drug abusing parent - which?   | <input type="checkbox"/> frequent moves                          |
| <input type="checkbox"/> having a depressed parent - which?      | <input type="checkbox"/> having learning problems - what?        |
| <input type="checkbox"/> having a parent with emotional problems | <input type="checkbox"/> having emotional problems               |
| <input type="checkbox"/> having parents separate or divorce      | <input type="checkbox"/> having attempted suicide - when?        |
| <input type="checkbox"/> close family member dying - who?        |  |
- 

### **Stresses During the Past Several Years:**

- |  |  |
|--|--|
| <input type="checkbox"/> death of family member or friend - who?   | <input type="checkbox"/> an important relationship ending - who? |
| <input type="checkbox"/> birth or adoption of child                | <input type="checkbox"/> losing or changing job                  |
| <input type="checkbox"/> self or family member hospitalized - who? | <input type="checkbox"/> financial trouble                       |
| <input type="checkbox"/> moved                                     | <input type="checkbox"/> legal problems                          |
| <input type="checkbox"/> being harassed or assaulted               | <input type="checkbox"/> natural disaster                        |
| <input type="checkbox"/> frequent family or couple arguments       | <input type="checkbox"/> serious or chronic illness -what:_____  |
| <input type="checkbox"/> separation/divorce                        | <input type="checkbox"/> other                                   |

## **INFORMED CONSENT FOR IN-PERSON THERAPY DURING THE COVID-19 CRISIS**

### **Decision to Meet Face-to-Face**

If we mutually decide to meet in person (Face-to-Face, hereinafter - F2F) for some or all future counseling sessions, precautions must be in place to mitigate the COVID-19 pandemic. This document contains information about those precautions and guidelines to safely meet F2F. Your signature(s) below indicates that you understand and agree to undertake these actions concerning all F2F appointments. Please read this carefully and let me know if you have any questions.

If we mutually decide to meet in person (F2F) and there is a subsequent resurgence of the pandemic, or subsequent changes in local, state, or federal guidelines, or if other health concerns arise, I may require that we meet via teletherapy. If you decide at any time that you would prefer teletherapy, I will respect that decision, provided it is clinically appropriate.

Also be mindful that if your therapist files for reimbursement for any teletherapy services, such reimbursement is determined by insurance companies and applicable law. You are responsible for payment whether services are provided via teletherapy sessions or F2F, and whether insurance companies reimburse or not.

### **Risks of Opting for In-Person F2F Services**

Although there are potential benefits for in-person F2F counseling, there are also risks. You understand that by attending F2F sessions, you would be assuming the risk of exposure to the coronavirus, or other public health risks, and that this risk may increase if you travel by public transportation, cab, or ridesharing service.

In consideration of the services of Baton Rouge Christian Counseling Center (hereinafter BRCCC) and my therapist, I hereby agree to release, indemnify, defend and discharge both BRCCC and my therapist, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:

I have been offered by BRCCC and my therapist to conduct the therapy session remotely via Zoom or other online means, however, I desire a face to face therapy session. I am aware of the risk of infection with COVID 19 and I understand that such risk simply cannot be eliminated without completely avoiding a face to face therapy session.

I expressly agree and promise to accept and assume the risk of infection with COVID 19 existing in a F2F therapy session. My participation in a F2F therapy session at BRCCC and with my therapist is purely voluntary, and I elect to participate in spite of the risks.

### **Your Responsibility to Minimize Your Exposure**

To obtain counseling in person (F2F), and signing this document, you will take the following precautions which will help keep all of us (you, me, our families, my staff, and other clients) safer from exposure, sickness and possible death. Failure to adhere to these safeguards, may result in our starting or returning to a teletherapy arrangement.

- If you reasonably believe that you have recently been exposed to, are infected with, or have symptoms of the coronavirus, you will cancel your F2F appointment or proceed using teletherapy.
- You will wait in your car or outside until no earlier than 5 minutes before your appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will wear a mask in all areas of the office (I, and my staff will too). Clients agree to:
  - bring their own face mask that covers their nose and mouth,
  - wear the face mask upon entering the building,
  - continue to wear the face mask until entering the counseling session, (face masks are not required during the counseling session, unless your therapist deems them necessary), and
  - wear a face mask after the session while exiting the building.
- You will adhere to the safe distancing precautions we have set up in the waiting areas and offices.
- You will keep a distance of 6 feet from all other persons and there will be no physical contact (i.e. no shaking hands) with me, other clients, or with my staff.
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- You will not bring guests and/or non-client children to BRCCC.
- You will take steps between F2F appointments to minimize your exposure to COVID-19.
- If you have a job, other responsibilities, or activities that put you in close contact with others infected with COVID, you will notify me immediately.

- If a resident of your home tests positive for the coronavirus infection, you will notify me immediately. Continuing treatments will be conducted via teletherapy until quarantine is over.
- To minimize contact with support staff, you will do all scheduling of appointments either online through the Therapy Appointment software, or over the phone with support staff.
- To minimize the exchange and handling of payment(s), you will have your credit card information on file with BRCCC at least one day prior to the counseling session.

I reserve the right to change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, you will be notified about any necessary changes.

**My Commitment to Minimize Exposure**

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

**If You or I are Sick**

You understand that I am committed to keeping you, me, my staff, all clients, and all of our families safe from the spread of this virus. If you show up for an appointment and I, or my office staff believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by teletherapy as appropriate.

If I, or my staff, test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

**Your Confidentiality in the Case of Infection**

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I am required to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for your visits. By signing this form, you are agreeing that I may do so without an additional signed release.

**Informed Consent**

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature(s) below shows that you agree to and will abide with these terms and conditions. By signing this document, I acknowledge that I waive my right to maintain a lawsuit against BRCCC and my therapist on the basis of any claim that I released herein. I also agree to pay BRCCC and my therapist attorneys’ fees and costs in enforcing this agreement.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client (if couple, both sign)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist

\_\_\_\_\_  
Date

*Written incorporating sample-informed-consent-form-1 from APA-1  
Dee Adams, PhD, LPC, LMFT; LCC  
Director BRCCC  
May 18, 2020*

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# SARAH EASTERLY, MA, LPC, CSAT

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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.
- 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.
- Session fees are handled in an identical fashion for teletherapy as in-person counseling.
- We need a back-up plan (eg, 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.
- **Consultation:** I may deem it appropriate to consult with or coordinate your care with other professionals, but only with your written agreement.
- **Louisiana License:** I can only counsel in the state I am licensed, Louisiana. Except in an emergency, i.e. COVID-19, counseling services cannot be delivered across state lines. I must know where you are when I am performing counseling services.
- **Ethics Code:** I follow the same Louisiana Code of Conduct and adhere to its ethics as outlined in my Declaration of Practices as an LPC.

**PLEASE READ AND SIGN AND RETURN THE TELEMENTAL HEALTH AGREEMENT AS FOLLOWS:**

**Limits of Liability:** 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 Doxy, a HIPAA compliant teletherapy platform, and provides a Business Associate Agreement and my Patient Health Information (PHI) will be protected within the limitations of Doxy and the environment in which the services are utilized. Your PHI is stored via our EHR system, Therapy Appointment, which is an electronic healthcare system. It is designed specifically for healthcare and provides a Business Associate Agreement for HIPAA compliance. Therapy Appointment uses encryption which is point to point and federally approved. Any paper with your personal information s kept in a locked cabinet behind at least one locked door.

**Records:** In the event that your clinician is no longer available due to untimely death or incapacity, the Senior Receptionist, Lisa Smith, along with one of the remaining counselors at BRCCC – Baton Rouge Christian Counseling Center will be glad to assist you in providing appropriate referrals for further treatment and access to your records. They will also be responsible for destroying records after the legal time frame of storage.

**Verify Identity:** Anyone receiving teletherapy via videoconferencing is required to verify their identity by showing his/her picture ID during the first session. If Teletherapy is being conducted over the phone, a passphrase or number will be chosen which will be used for all future sessions. This process is in place to protect you from another person posing as you.

**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.

**Risk:** 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.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

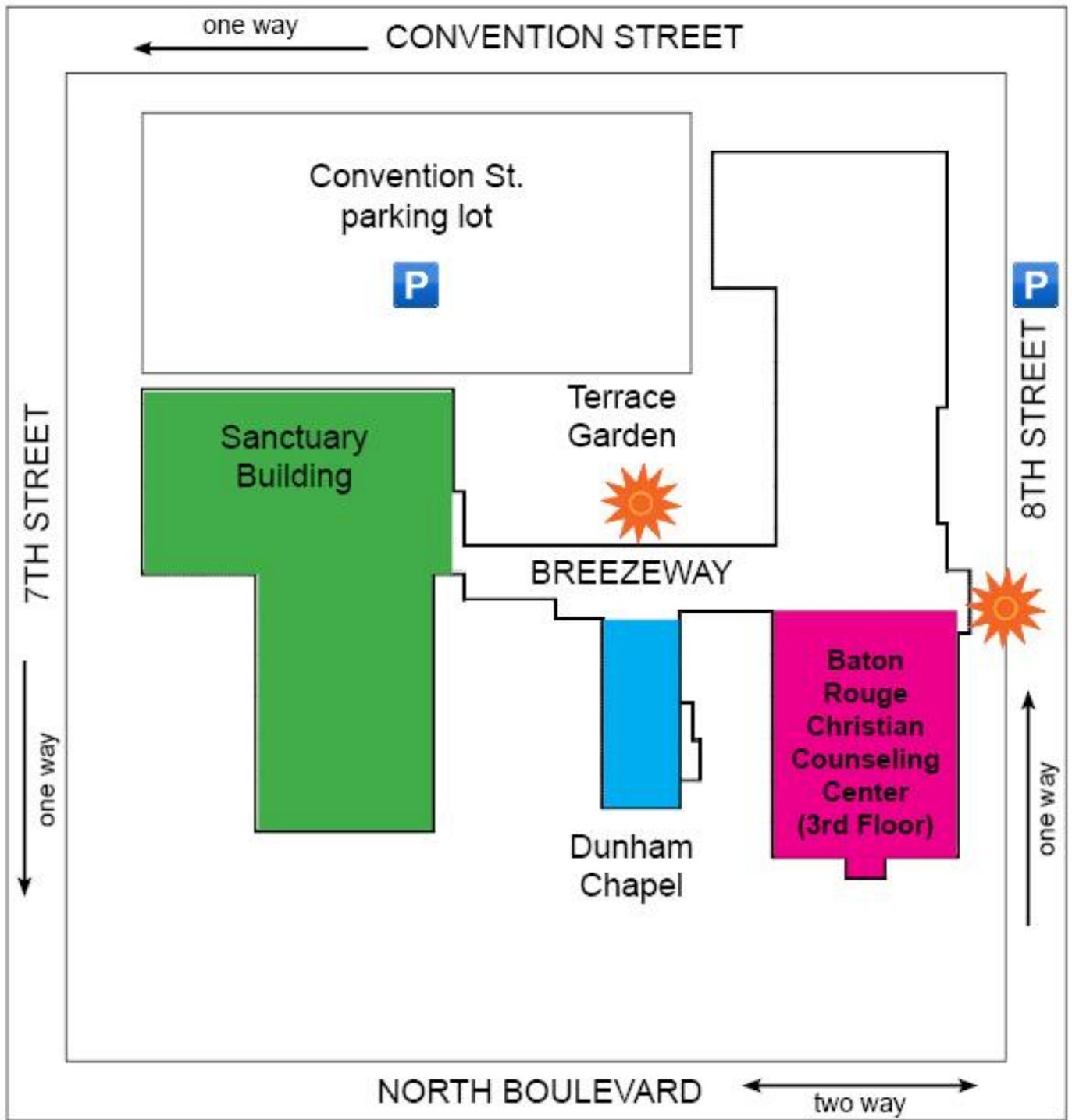
Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name(s): \_\_\_\_\_

Counselor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Sarah Easterly, MA, LPC**

Easterly Teletherapy Form Pg



 Enter at either the 8th Street entrance or the Convention Street Chapel Breezeway entrance.

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

Relationship to Minor Child

Name of Minor Child