Declaration of Practices and Procedures

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Qualifications: I hold a Doctorate of Education Degree (EdD) in Counseling and Guidance from McNeese State University. I am licensed as a Professional Mental Health Counselor (LPC LIC #11) and a Licensed Marriage and Family Therapist (LMFT LIC #11) in the state of Louisiana. I am also a Nationally Certified Counselor and Nationally Certified Clinical Mental Health Counselor. I possess certification as a Reality Therapist from the Institute for Reality Therapy and certification as a Trauma Resolution Therapist. I am also a member of the Louisiana Licensed Professional Counselors Board of Examiners.

In the event you are dissatisfied with my services for any reason, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Licensed Professional Counselors Board of Examiners, 8631 Summa Avenue, Suite A, Baton Rouge, LA 70809.

Specialty Areas: Include but are not limited to children, adolescents, adults, families, and groups. It is a general practice that focuses on custody and visitation issues.

Counseling Relationship: The counseling relationship is unique. The relationship is a professional collaboration rather than a social relationship or friendship. The purpose of the relationship is to provide a safe and trusting environment to encourage personal growth through openness and honesty with the overall objective being the successful resolution of the problems that are deemed the most important.

I consider you a full partner in the counseling relationship. Your honesty and effort is essential to success. As we work together, I expect you to share your ideas and goals so that the experience can benefit you to the fullest. If issues arise for which I do not possess the ability, necessary experience or you think another provider would better serve you, I will help you make a referral. If you are currently receiving services from another mental health professional or are engaged in another counseling relationship, I expect you to inform me of the issue and grant permission to contact that professional to coordinate services for you.

My approach to counseling is integrated in nature, using various theoretical approaches. I usually use a client-centered approach during the beginning part of sessions and move toward a cognitive-behavioral approach to develop solutions to issues presented. This may be modified based upon each client's unique goals, beliefs, and needs. I work with clients in a variety of formats including individually, in groups, as couples, and as families.

Code of Conduct: I am required by law to adhere to the Code of Conduct, which is determined by the Louisiana Professional Counselors Board of Examiners. A copy of the code of conduct and the address is available at your request.

Cllient Name: _____

Privileged Communication and Confidentiality: I am required to abide by the professional practice standards for Licensed Professional Counselors and Louisiana Law. I do not disclose client confidences or information to any third party 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, abuse/neglect of persons 65 or older, or dependent adult abuse/neglect. The law also mandates the report of 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 written authorization from all individuals competent to sign such authorization. For examples, I cannot release any information about either or both spouses I have seen for marital therapy to an attorney without signed authorization from both spouses.

When working with a family or couple, information shared by individuals in session 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 waivers, 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.

Court Related Information: Certain types of litigation (such as child custody suits) may lead to the court-ordered release of information without your consent.

In a court-ordered evaluation, all information that is provided during the evaluation process is privileged to all court/attorney entities involved. In addition, information pertaining to the evaluation will be used to conduct Interviews with other parties associated with the child/persons involved; therefore, the information you provide during the assessment process may be discussed with these individuals. By signing the consent for treatment, you and all parties named understand the above statement and give your authorization for release of your information to all court parties involved, to include all counsel.

Fees, Office Procedures, and Policies for Insurance Reimbursement:

Private pay: The maximum fee for a 45-50 minute individual or family session is $150.00 for the initial session and $120.00 for each subsequent session. Payments should be made directly to New Horizons Counseling Center, LLC.

Insurance: Subject to your policy benefits. Co-payments, co-insurance, and deductibles (should they apply are due at the time of each session.

*Appointments are typically set at the close of each session and a time is set aside specifically for **you**. Except in the case of an emergency, appointments are expected to be cancelled at least 24 hours prior to the appointment time. When the office is closed or no one is available to take your call, you may leave a message on the office voicemail. ****Failure to provide 24 hour notice will result in a $60.00 failed appointment fee.**** Arriving late does not extend the counseling hour. If you are more than 20 minutes late for an appointment and have not called to notify the office, your appointment will be cancelled and you will be charged for the session. All unpaid balances will need to be cleared before further sessions can be scheduled**. **Delinquent accounts may be turned over for collection after 90 days unless prior payment arrangements have been made.***

Cllient Name: _____

Consult your insurance company in advance regarding the extent of your mental health coverage. We will be happy to file insurance for you, but you will be expected to pay the co-payment in advance and pay for any missed sessions or those not covered by insurance.

NOTE: Fees for court appearance or reports written for legal purposes will not be charged to insurance companies and are the responsibility of the client*. These fees must be paid prior to the reports being released*.

Custody Evaluations, Court Ordered Counseling, Assessments, or Evaluations: These services require a $500 deposit from each party prior to making any appointments and are billed as follows: $150 per 1-hour session, $150.00 per hour for reports, and $150.00 per hour for phone consultations between assessed parties and/or their attorneys, which will be pro-rated accordingly. During the assessment/evaluation process, as your initial deposit is exhausted, you will be required to make an additional $500 deposit prior to your next scheduled appointment. Any balance that remains beyond the deposit must be paid in full prior to the release of the reports.

Court Appearance: Appearance fees are billed at the court rate of $250.00 per hour with a 2-hour minimum, with a deposit of $750.00 required before the scheduled court date. If the evaluator does not appear in court and all matters have been completely settled, the deposit will be refunded, minus a $100.00 court preparation fee and any outstanding balance for appointments and requested reports. Depositions are billed at $150.00 per hour, due upon completion of interview.

As a general rule, progress notes are not released without a Judge's order. In lieu of progress notes, a written report and case summary can be provided with signed releases. Report fees are billed at a rate of $150.00 per hour.

After Hours and Emergencies: Should no one be available to take your call, please leave your name, phone number, the time you called, and a brief message on the voicemail. Your call will be returned as soon as possible. If an emergency arises during non-business hours, call **9-1-1** or go to the emergency room at Lake Charles Memorial Hospital (337-494-3000) or a hospital near you.

Physical Health: Physical health is an important factor in the emotional well-being of an individual. I encourage you to have a complete examination if you have not had one within the last year. I would appreciate you sharing with me important medical conditions, your physician's name and all medications that you currently take or have taken. According to June 2011 legislation, certain conditions REQUIRE consultation with your physician. These include: *Schizophrenia/schizoaffective disorder, Bipolar Disorder, Panic disorder, Obsessive-compulsive disorder, Major depressive disorder, Anorexia/bulimia, Intermittent explosive disorder, Autism, Psychosis NOS* (in a child under 17 years old), *Rett's disorder, Tourette's disorder, Dementia.*

Potential Benefits and Risks of Therapy:

1.) Studies suggest that counseling involving only one spouse can lead to dissolution of the marriage instead of improving it.
2.) Changes in relationship patterns that may result from family therapy may produce unpredicted and/or possible adverse responses from other people in the client's social system.
3.) A result of family therapy may be a realization on the part of the client that there are issues that may not have surfaced prior to the onset of the counseling relationship.

Cllient Name: _____

In signing this, I consent to counseling services for myself and/or dependent and agree to the above billing policy. I also acknowledge that I have been given a copy of Brenda Robert's "Declaration of Practices and Procedures" which includes information regarding the counseling relationship, billing, emergency information, and limitations to confidentiality.

Signature _____ ***Date*** _____

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS

I/We, being the parent(s) or legal guardian(s) for _____, a minor child, consent for counseling services to be provided by **Brenda Roberts, EdD, LPC, LMFT, with New Horizons Counseling Center, L.L.C.**

Signature _____ ***Date*** _____

Signature _____ ***Date*** _____

Cllient Name: _____