

ADULT INTAKE FORM

HOME INFORMATION

List all persons living in the home

Name	Age	Relationship	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any immediate family members not living with you due to some type of separation:

YOUR FAMILY

Relative	Name(s)	Living?	Age or age at death	Occupation	Describe Relationship
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

ADULT INTAKE FORM

HISTORY

Have you ever sought counseling before? ___ Y ___ N

If yes, name of professional: _____

Duration of counseling: _____

Who referred you to Karen L. Steen, MA, LPC-S?

___ Self/Former Client

___ Managed Care

___ Family/Friend

___ Employee Assistance Program

___ School

___ Insurance Carrier

___ Courts/Judicial System

___ Other _____

EDUCATION

Where did you attend public school? _____

Did you attend college/professional school? ___ Y ___ N If yes, when, where & what degree earned? _____

Any plans to further your education? ___ Y ___ N

If yes, when and what? _____

COMPLAINT DESCRIPTION

Please list the main reason for seeking counseling at this time:

What would you like to get out of counseling at this time?

Is there anything else you would like me to know?

ADULT INTAKE FORM

COMPLAINT CHECKLIST

Please check any of the following symptoms you are currently experiencing.

Abuse – emotional	Abuse – neglect	Abuse – physical	Abuse – sexual
Aggression	Anger	Anxiety	Arguing
Attention problems	Career concerns	Childhood issues	Children – care of
Children/Parenting	Choices I have made	Codependence	Compulsive spending
Concentration problems	Confusion	Crying	Crying – unable to
Deaths	Debt	Decision making	Delusions – false ideas
Dependence	Depression	Distractibility	Divorce
Drug abuse – over the counter	Drug abuse – prescription	Drug abuse – street drugs	Drug abuse – alcohol
Eating – poor appetite	Eating – making myself vomit	Eating – overeating	Eating – undereating
Emptiness	Failure	Fatigue	Fears
Financial troubles	Friendship problems	Gambling	Goals not being met
Grieving	Guilt	Headaches/pain	Health/Medical concerns
Hearing Things or Seeing Things	Hostility	Impulsive spending	Impulsiveness
Indecision	Inferiority feelings	Inhibitions	Interpersonal conflicts
Irresponsibility	Irritability	Judgment problems	Laziness
Legal matters	Loneliness	Loss of control	Low energy
Marital coldness	Marital conflict	Marital distance	Marital infidelity/affairs
Memory problems	Menopause	Menstrual problems	Mood swings
Motivation	Obsessions	Oversensitivity	Panic or anxiety attacks
Perfectionism	Pessimism/Negativism	Phobias	Poor self care

ADULT INTAKE FORM

SYMPTOM CHECKLIST

Please check any of the following symptoms you are currently experiencing.

Procrastination	Relationship problems	Relaxation	Remarriage
Risk taking	Sadness	School problems	Self abuse – burning
Self abuse – cutting	Self abuse – other	Self abuse – scratching	Self centeredness
Self control	Self esteem	Self neglect	Separation
Sexual conflicts	Sexual desire differences	Sexual dysfunctions	Sexual – other issues
Shyness	Sleep – insomnia	Sleep – nightmares	Sleep – too little
Sleep – too much	Stepparenting	Stress	Stress management
Suicidal thoughts	Suspiciousness	Temper problems	Thought disorganization
Threats of violence	Tobacco use	Violence	Violence – victim of crime
Work problems	Weight and diet issues	Withdrawal – isolating	Employment problems
Employment – lack of	Employment – overdoing	Employment – termination	Other concerns or issues

Court/Report Policy

This policy needs to be signed by each client receiving services in order to provide for any potential future needs from this office involving the described services below

I, _____, understand that fees for Karen Steen, MA, LPC-S, to appear in court are as follows:

Appearance fees are billed at the court rate of **\$250.00** an hour with a 2 hour minimum with a deposit of **\$750.00** required before the scheduled court date. If the counselor 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. If you, the Client, chooses to not release your file or records to the court, you will be responsible for all attorney fees, court fees, and filing fees associated with your decision to not release your information. Brighter Days Counseling Services, LLC or Karen Steen, MA, LPC-S will not be responsible for any legal fees accrued by the client.

Services involving mental health assessments of any kind require a **\$500.00** deposit prior to making any appointments and are billed as follows: **\$150.00** 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 prorated accordingly. Any balance that remains beyond the deposit must be paid in full prior to the release of the reports. An extensive assessment report involving your individual therapy that does not require the assessment of other parties is also billed at the rate of **\$150.00** per hour paid in full prior to the release of the report.

All of the above services cannot be billed through your insurance carrier, therefore are your full responsibility.

If you do not understand any of the information contained in this policy or have any questions concerning this policy, please do not hesitate to bring your concerns to your counselor.

CLIENT

DATE

COUNSELOR

DATE

ADULT INTAKE FORM

INSURANCE INFORMATION

Please provide a copy of both sides of your insurance card and driver's license for verification of benefits and identity. You can bring these with you on the day of your appointment if you would like it to be verified at that time. For your convenience, you can also scan these and email to karensteenlpc@brighter-days.net or take a picture and text it to 337-515-5654 if you would like it to be verified prior to your appointment.

RESPONSIBLE PARTY

Name: _____ Birth Date: _____
Address: _____
Drivers License #: _____ SS# _____ Phone: _____

INSURANCE INFORMATION

Who is the insured? _____ SS # _____
Birth Date: _____ Relationship to Client: _____
Cell Phone: _____ Work Phone: _____
Employer of Insured: _____
Insurance Company Name: _____
Insurance Phone # for Mental Health _____ Member ID#: _____
Group ID#: _____

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that Brighter Days Counseling Services, LLC will diligently attempt to get accurate information regarding my mental health insurance benefits. I will not hold Brighter Days Counseling Services, LLC liable for insurance nonpayment due to misquoted benefits. I will not hold Brighter Days Counseling Services, LLC responsible to know and understand my benefits plan. Brighter Days Counseling Services, LLC will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request benefits be paid to Brighter Days Counseling Services, LLC.

Signature of Client and/or Responsible Party: _____
Date: _____

MEDICAL INFORMATION

In order to provide you with quality care, your counselor needs to know as much about you as possible. This includes obtaining information regarding your health.

SECTION I: Medical Checklist

Please review and check any of the following you are experiencing or have experienced in the past.

- | | | |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma/Allergy | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Respiratory Illness |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sleeping Disorder |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cardio-Vascular |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Other Impairment | <input type="checkbox"/> Sexually Transmitted Disease | |

If other has been indicated, please describe: _____

SECTION II: Medications

List the medications you are currently taking:

Medication	Dosage	Start Date

Date of your last physical examination: _____ Doctor: _____

Client Name: _____

Signature of Client/Caregiver

Date

Request/Authorization for Releasing/Obtaining Information

Client Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Parent/Guardian Name (if minor) _____

I, _____, hereby authorize Brighter Days Counseling Services, LLC and Karen L. Steen, MA, LPC-S (748 Bayou Pines East, Suite B, Lake Charles, LA 70601) to exchange information with _____

(name of individual or organization). This information will be shared for the following purpose(s):

Assist with treatment planning for the continuity of care

Document a need for services

Other: _____

Individual or Organization Information

Name: _____ Contact Person: _____

Address: _____ Phone: _____

_____ Fax: _____

I understand that I may revoke this consent at any time. I further understand that this consent may not be renewed without my written consent. This consent will expire in one year from the signature date.

Client Signature or Parent/Guardian/
Representative

Printed Name

Date

Eve Bernstein Carlson, PhD

Frank W Putnam, MD

Directions

this questionnaire consists of 28 questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

(never)

(always)

Date _____ Age _____ Gender M__ F__

1. Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realized that they did not hear part or all of what was said. Circle the number to show the percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. Some people have the experience of finding themselves dressed in close that they don't remember putting on. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

5. Some people have the experience of finding new things among the belongings that they do not remember buying. Circle the number to show the percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

6. Some people sometimes find that they are approached by people that they do not know or who call them by another name or insist that they have met them before. Circle the number to show the percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

8. Some people are told that they sometimes do not recognize friends or family members. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

9. Some people find that they have no memory for something or the events in their lives (for example, a wedding or graduation). Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

11. Some people have the experience of looking in the mirror and not recognizing themselves. Circle the number to show the percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

13. Some people have the experience of feeling that their body does not seem to belong to them. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they are reliving the event. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle the number to show what percentage of time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

18. Some people find that they become so involved in a fantasy or daydream that it feels as if it really happened to them. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

19. Some people find that they are sometimes able to ignore pain. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

20. Some people find that they sometimes sit staring off into space thinking of nothing, and are not aware of the passing of time. Circle the number to show what percentage of time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

21. Some people sometimes find that when they are alone they talk out to themselves. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were 2 different people. Circle the number to show what percentage of the time this happened to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

24. Some people sometimes find that they cannot remember whether they have done something or just talk about doing it (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Circle the number to show what percent of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

25. Some people find evidence that they have done things that they do not remember doing. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle the number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away and unclear. Circle the number to show what percent of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Notice of HIPAA Practices

Please take a moment to review the following notice carefully as it describes my duty to protect your Personal Health Information. Protecting the privacy and security of my client's Personal Health Information is important to me. This notice describes how I may use your information or disclose it, what your privacy rights are and how you may gain access to your own Personal Health Information.

PRIVACY PRACTICES

Designated Security and Privacy Officer for Brighter Days Counseling Services, LLC

Karen L. Steen, MA, LPC-S is the designated Security Officer and Privacy Officer and all privacy and security questions, concerns or requests should be directed to me as I will be responsible for handling them.

How Karen Steen Uses and/or Discloses Your Personal Health Information

Abuse, Neglect or Domestic Violence – As a mandated reporter in the State of Louisiana, if I believe you or your child/children may be victims of abuse, neglect or domestic violence I may disclose health information about you or your child/children to the appropriate agency which requires me to disclose this information.

Serious Threat to Safety or Health – I may use or disclose information about you or your child/children if I believe that there is a serious and immediate threat and that it is needed in order to protect the safety of you, your child/children, a person, or the public.

Judicial Proceedings – I may use or disclose you or your child/children's health information in any judicial proceeding if I receive a court ordered subpoena that requires me to disclose it.

Privacy and Security Policies

All reasonable measures have been taken to ensure confidentiality of any and all electronic information sent and received (i.e. emails, texts). It is important for you to be aware of the risks taken when information is shared in this format. Some possible risks of sharing personal or confidential information in this way:

- Accidental delivery of an email or text to an incorrectly typed address or phone number
- Email accounts may be "hacked" giving a 3rd party access to sensitive

Notice of HIPAA Practices

Information such as the content of the message, email addresses, etc.

- Email providers (Gmail, Yahoo, etc) keep a copy of each email on their servers, where it might be accessible to their employees or other company individuals

Karen Steen takes precautions to help minimize the chance of a compromise in your Personal Health Information

- Cell phones and lap top contains password protection
- When electronic devices such as cell phone or laptop is retired, it is first "wiped" of all information before it is either recycled or destroyed
- If there is a breach of your Personal Health Information, I will personally contact you to inform you of the extent of the breach and the plan to contain the situation
- I will not sell any of your Personal Health Information for marketing purposes
- I follow all Ethical Codes which help in securing your information. You may obtain a copy of the Codes on the Louisiana LPC Board's Official Website.
- All HIPAA documentation will be kept on file for a minimum of 6 years

Storage of Client Files

Your client file containing your Personal Health Information as well as any and all information concerning treatment are stored in a locked file cabinet for 5 years after the date of the last session. If something should happen to me, the LPC Board has a designated counselor on record who is responsible for taking possession of my files. They will store them under the same guidelines to protect your confidentiality. When a file is ready to be destroyed, it is shredded.

CLIENT PRIVACY

Private Health Information may be used and/or disclosed in the following situations:

- Information that is necessary in order to file insurance claims and complete billing and collection procedures
- When required for workman's compensation
- When required by any state or federal law, such as in cases of abuse or neglect
- When required by any specialized government or military functions
- When required in cases of an individual who is confined to a correctional

Notice of HIPAA Practices

institution or under any type of law enforcement supervision

- When used for any clerical purposes and necessary file audits by managed care companies

As a client, you have the following rights with regard to your Personal Health Information:

- The right to review or receive a copy of your records by signing and providing a written request. Under rare circumstances, a request may be denied. In such cases, you may choose to receive a summary of progress instead which will include information about symptoms and treatment plans. Requests for records will receive a response or will be completed within 15 days
- The right to request information on any party that has requested information pertaining to your Private Health Information from me
- The right to receive confidential information about your Private Health Information
- The right to revoke this consent in writing. However, please be aware that it will not affect any information already disclosed
- The right to request a copy of this notice at any time

As a mental health professional, I have the responsibility to:

- Make each client aware of the Privacy Notice and any changes made to it
- Make necessary changes to the Privacy Notice as required by law

The protection and security of your Personal Health Information is very important to me. If you have questions or comments about this Privacy Notice, please let me know. If you as the client feel your privacy has been violated, you have the right to contact the U.S. Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/. Any and all complaints filed against me will be recorded on this company's Complaints Form and provided to any and all of Karen's clients with the intake paperwork.

By signing below, I acknowledge that I have read and understand this document.

Client Signature

Date

Karen L. Steen, MA, LPC-S

Date

DECLARATION OF PRACTICE AND PROCEDURES

KAREN L. STEEN, MA, LPC-S
4131 Canal St, Suite B
Lake Charles, LA 70605
Phone: (337) 515-5654
Fax: (337) 564-3932
karensteenlpc@brighter-days.net

QUALIFICATIONS: I hold a Master of Arts in Clinical/Counseling Psychology from McNeese State University. I am licensed as a Licensed Professional Counselor (#3088) with the LPC Board of Examiners, which is located at 11410 Lake Sherwood Avenue North, Suite A, Baton Rouge, LA 70816, phone: (225) 295-8444 & fax: (225) 295-8448. I am an LPC-S, certified to supervise Provisional Licensed Professional Counselors working towards their licensure in the State of Louisiana.

AREAS OF EXPERTISE: I have training and experience working with individuals, adults, adolescents, children, families, couples and groups on a variety of issues such as depression, anxiety, interpersonal relationships and other mental health concerns. I have training in the field of Infant Mental Health and have done dyadic work with mothers and infants and have provided mental health consultation to childcare centers in the five parish area. I have training in and work with clients using Eye Movement Desensitization Reprocessing (EMDR) therapy which is aimed at giving relief to individuals suffering symptoms related to trauma. I am currently working towards certification for this specialized therapy. I also have training in and practice Antheics Therapy involving inner figure work with individuals to relieve their suffering from a variety of mental health issues.

THERAPEUTIC RELATIONSHIP: I view the counseling relationship as one built on trust, where teamwork is a must. We will work to develop and implement goals to improve your quality of life. While it is not possible or realistic to guarantee certain results, together you and I can work to achieve positive results for you.

I see a variety of people and use a variety of formats including individual, dyadic, couples, families and group settings. I choose techniques that fit each client's beliefs and needs individually and techniques that will be the most beneficial to them. While I typically prefer to use EMDR, Antheics Therapy or the cognitive- behavioral approach, I often integrate other theoretical approaches into the sessions.

CODE OF CONDUCT: It is important for you to realize that we are entering a professional relationship and that you are experiencing me in my professional role. I am best able to serve you if our relationship stays strictly professional and if our sessions focus only on your concerns. Additionally, while I can assist in understanding the consequences of making certain decisions, my professional code of conduct prohibits me to advise you how to make decisions. I am required by state law to adhere to the Code of Conduct for practice that has been adopted by the Louisiana Licensed Professional Counselors' Board of Examiners. A copy of the code of Conduct is available upon request.

PRIVILEGED COMMUNICATION: I am required to abide by the professional practice standards for Licensed Professional Counselors and Louisiana law. Information shared during sessions will be kept confidential, with certain exceptions, such as a client's written consent authorizing the sharing of information or when I am mandated or permitted by law to disclose information.

State law mandates that I report to the appropriate authorities suspected cases of child abuse/neglect, elder abuse/neglect (60 or older), or abuse/neglect of a disabled person, and instances in which you are believed to be a danger to yourself or someone else. Certain types of litigation may result in a court-order to release information without your consent.

In family counseling situations, information obtained from an individual adult client may be shared with the client's family members only with the written consent of the client, with the exception of marriage counseling situations. Material which is discussed with a minor client may be shared with the client's parent or legal guardian.

In marriage counseling situations, I do not withhold information from one spouse/partner which is provided to me by another spouse/partner. This includes any and all information provided to me through individual counseling sessions with a spouse/partner or through any type of electronic communication such as email, phone calls, texts, etc. Should you desire such confidentiality, I can assist you with a referral to a therapist who can provide marriage counseling where such information is shared only with your written consent or I can assist you with a referral to a therapist who can provide you with individual counseling that can occur in conjunction with the marriage counseling I provide to you and your spouse/partner.

FEE SCALES: The cash/self pay fee for an initial 45-50 minute individual or family session is \$120.00. The cash/self pay fee for additional 45-50 minute sessions is \$75.00. If insurance is being used, client is responsible for any copay or deductible required by their insurance company. Fees can either be paid at the end of the session with cash, check, debit or credit card, or client can choose to receive email invoices to be paid upon receipt. As a courtesy, I will submit claims to insurance companies for you. Any portion not paid by your insurance company will be your responsibility. Except in the event of an emergency, any cancellation or rescheduling of appointments made with less than 24 hours notice will result in your being charged the full session fee. Arriving late does not extend the counseling hour. All sessions will end at the scheduled time regardless of the time at which you arrive for the appointment. This is a courtesy to other clients who may be scheduled after your appointment.

CLIENT RESPONSIBILITIES: As a client, your honesty and participation are necessary if progress and success are the desired results. During this process, should questions or concerns arise regarding the services received, I would hope that you would share those with me so that we can address those issues. If you should feel you would be better served by another mental health provider, I will assist you with a referral. If you are currently seeing another mental health professional, I ask that you inform me of this and grant me permission to share information with them so that we may coordinate our efforts to better serve you.

In the counseling relationship, clients are primarily responsible for following appointment scheduling procedures, making a committed effort in the counseling process, and terminating one counseling relationship before beginning another.

POTENTIAL COUNSELING RISK: The client should be aware of the possibility that counseling could result in having underlying issues brought to the surface which you may not have been aware of prior to the onset of the counseling relationship.

PHYSICAL HEALTH: Physical health can be an important factor in an individual's emotional well being. If you have not had a physical examination within the past year, it is recommended that you do so and that you provide me with a list of any medications which you are currently taking, in an effort to help me better serve you.

AFTER HOURS AND EMERGENCY SITUATIONS: If a crisis or emergency should arise, you may seek assistance through hospital emergency room facilities or by calling 911.

Client Signature

Date

Karen L. Steen, MA, LPC-S

Date

I, (parent or guardian) _____, give permission
for Karen L. Steen, MA, LPC-S to conduct counseling with my (relationship)

_____ (name of minor) _____ .

TELETHERAPY ADDENDUM TO DECLARATION STATEMENT

This Addendum includes important information on doing psychotherapy using Tele-mental Health, also known as “Teletherapy” sessions. This Addendum shall not take the place of therapist’s Declaration Statement. This Addendum supplements the separately signed Declaration Statement. Upon signature of this document by both client and therapist, it will represent an agreement between us. Your signature indicates your agreement with the terms and conditions of both the Declaration Statement and this Teletherapy Addendum to the Declaration Statement.

BENEFITS AND RISKS OF TELETHERAPY

Benefits: Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. Benefits of teletherapy include the ability to conduct a session even if the client moves locations, takes a vacation, has transportation issues, struggles with childcare issues, works at a job where it is difficult to take off for long periods of time, in the event of inclement weather, or any other reason making it challenging or impossible for a client to meet in person. While there are benefits of teletherapy, there are some risks as well. Some of those risks are outlined in the following sections.

Confidentiality: I have a legal and ethical responsibility to use due diligence and make my best effort to protect all communications that are a part of our teletherapy. However, due to the everchanging nature of technology, I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications as I could on my end with an in-person session. I will use methods such as performing sessions on secure, HIPPA compliant teletherapy platforms, using HIPPA compliant software for scheduling and billing, trying to use updated encryption methods for emails, using firewalls, and using back-up systems to help keep your information private. However, there is always a risk that our electronic communications may be compromised or accessed by others.

On your end, you can take measures to try to ensure the security of our sessions as well. I strongly urge you to set a password on any device you use for teletherapy and to not share that password with anyone else. Because teletherapy sessions take place outside of the therapist’s private office, there is potential for other people to overhear sessions if you are not in a private place during the session. It is important for you to find a private place where you will not be interrupted or overheard on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Please be aware that the extent of confidentiality and the exceptions to confidentiality that I outline in my Declaration Statement **ALL** apply to all teletherapy sessions as well. After signing both the Declaration Statement and this Teletherapy Addendum, you are responsible for familiarizing yourself with the confidentiality and limits to confidentiality in both documents.

Geographical Limitations: Counselors providing teletherapy services to clients across state lines or international borders must not only comply with the regulations of the licensing board in the state in which they are licensed and reside in, but also in the location where the client lives. The counselor must either be licensed in the state where the client lives or must be in contact with that area’s licensing board to be sure they are in compliance with the rules there. Because of these requirements, I will only provide teletherapy services to clients who reside in the State of Louisiana.

Issues related to technology: Technological issues might arise and negatively impact teletherapy in the sense that the online platform being used may stop working or may get “glitchy” during a session. Additionally, other people might be able to get access to our private conversation or your stored data if they have access to your device which is why it is important to password protect your devices. Email and text communications should only be used for administrative purposes such as scheduling appointments or billing concerns. Personal or private information should be discussed during our teletherapy session, not in an email or text, to protect your privacy.

Emergencies: Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in teletherapy services. I will ask you to identify an emergency contact person who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

I define a crisis situation as being one where an individual’s life (whether that be the client or someone else) is in danger. If you are suicidal or homicidal, please contact me by phone. If I am unable to answer my phone, go to your nearest emergency room or call 911. DO NOT wait for me to return your call in an emergency situation. While non-life threatening situations may be stressful or upsetting, I do not define a situation as a crisis unless it is life threatening. An appointment should be scheduled to discuss non-life threatening issues in a session.

If the session is interrupted for any reason, such as the technological connection fails, **and you are having an emergency**, do not call me back; instead, call 911, or go to your nearest emergency room. Contact me after you have called or obtained emergency services so that we can ensure your safety.

Efficacy: Research shows that teletherapy can be just as effective (if not more) as in-person psychotherapy for some clients. Teletherapy may not be a comfortable or effective fit for every client or therapist which is why I offer both or a combination of both, except under certain extenuating circumstances like with the COVID 19 lockdown or with natural disasters.

Electronic Communications: You will have to have certain computer or cell phone devices as well as internet or internet capability to use teletherapy services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or services should you choose to take part in teletherapy sessions.

Scheduling: You are expected to show up for teletherapy appointments as you would an in-person session. As with office sessions, if there is a need to cancel or reschedule your session, you are asked to give me 24 hours notice so that other clients on the cancellation list may be contacted. I understand that some situations do not allow for such a notice, but to the extent 24 hours notice can be given and is not, I reserve the right to charge a \$60 fee which insurance (if you are using insurance) will not cover. You will be responsible for paying the \$60 fee before another session can be scheduled.

Appropriateness of Teletherapy: I will let you know if I decide that teletherapy is no longer the most appropriate form of treatment for you. Should that situation arise, we will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services for you.

Technological Issues: If the session is interrupted and you are **not having an emergency**, feel free to disconnect from the session, if the platform doesn't automatically disconnect, and I will re-contact you via the teletherapy platform on which we agreed to conduct therapy. If I am unable to secure a connection with you upon reconnecting, I will contact you via the phone number stored in your file.

Fees: The same fee rates will apply for teletherapy as apply for in-person psychotherapy. At this time most insurance companies are encouraging and covering teletherapy sessions. However, it is not a guarantee that your particular insurance or other managed care provider will cover them. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in teletherapy sessions in order to determine whether these sessions will be covered.

Records: Teletherapy sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies and complying with HIPPA regulations.

Informed Consent: This agreement is intended as a supplement or addendum to the general Declaration Statement that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions as well as the terms and conditions of this teletherapy addendum.

_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature (if client is a minor)	Date
_____	_____
Counselor Signature	Date