

Declaration of Practices and Procedures

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Qualifications:

I earned a M.Ed. Degree from Southeastern Louisiana University in 1999. I am licensed as a LPC #2518 with the Louisiana Licensed Professional Counselors Board of Examiners, 8631 Summa Avenue, Suite A Baton Rouge, La 70809. Telephone (225) 765-2515. I am also licensed as a LMFT #964.

Counseling Relationship:

I view counseling as a joint effort between the client and the counselor in which the client and the counselor work together to explore present issues, develop goals for an improved quality of life, and work toward achieving those goals.

Areas of Expertise:

I am experienced in working with problems of depression, anxiety, grief/loss, relationship problems, family and marriage conflicts, conduct and oppositional defiant behaviors, and boundaries.

Fee Scales:

I understand that **I must provide documentation of income** if using private pay so that fees may be assessed by a sliding fee scale. If I fail to provide such documentation, my fee will be set at \$100.00/individual session. These fees are due at the end of each visit and may be paid in the form of cash, money order, or personal check or pay pal. For individuals who have insurance, services will be reimbursed through their insurance company.

Services Offered and Clients Served:

I assist clients in understanding how thoughts and feelings influence behaviors. I approach counseling from a cognitive behavioral perspective. Patterns of thoughts, emotions, and behaviors that interfere with present functioning are examined. Various other perspectives and strategies are used based on the client's individual issues and needs which include the use of experiential and family systems. I work with clients in a variety of formats, including individually, as couples and as families, and groups. I see clients starting at age 5 and older and from all backgrounds. Techniques that I often use are role-playing, role-reversal, modeling, and homework assignments.

Code of Conduct:

I am required by state laws to adhere to a Code of Conduct for my practice which is determined by the Louisiana Board of Examiners of Professional Counselors. Copies are available upon request.

Privileged Communication:

Clients have the right to expect confidentiality except for information shared with my supervisor and under the following circumstances in accordance with the state law:

- 1.) The client signs consent to release information form that gives permission to receive, release, or share information.
- 2.) The client expresses intent to harm him/herself or someone else.
- 3.) There is a reasonable suspicion of abuse/neglect against a minor child or elderly person (65 or older), or a dependent adult. A subpoena or other court order is received requesting the disclosure of information. It is my policy to assert privileged communication on behalf of the client and right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to inform clients of all mandated disclosures. In the event of marriage and family counseling, information about one family member will not be disclosed with another family member without that individual's consent. Any material obtained from a minor client may be shared with the client's parent or guardian.

Emergency Situations:

I understand that the therapist is **not providing emergency services** and I have been informed that, in the event of an emergency, that I may contact any of the following:

--911

--Hospital emergency rooms

Client responsibilities:

Clients are expected to follow office procedures for keeping appointments. I understand that **I must give 24 hour notice in canceling appointments except in an emergency**, and that I will be charged half of my counseling fee for failure to attend a scheduled session. **If two consecutive sessions are missed or three sessions in a three month period without giving prior notice**, my case will be placed on a waiting list for counseling to allow other individuals and/or families to acquire services I/we are not utilizing.

It is the responsibility of each client to provide the counselor with adequate feedback during the counseling relationship. Clients are responsible for following through with homework and agreed upon goals. In addition, the client is responsible for informing the counselor of his/her progress toward meeting these goals. Should the need arise to receive counseling services from another mental health professional, please inform me so that I can request a release form from you to share information with this professional in order to maintain a collaborative professional relationship.

Physical Health:

Please schedule an appointment with your doctor for yearly physical examination as this can keep you abreast of your physical health, which can be an important factor in your emotional well being. As a routine part of the initial session, you will be asked the name of your physician, and to list any medications that you are currently taking.

Potential Counseling Risk:

There are sometimes psychological risks involved in counseling. The primary risks involve increased awareness which brings to the surface problems clients are not currently aware of. Counseling tends to help clients release emotions in an environment that may otherwise be hard to experience. As clients go through the counseling process, many issues will arise. An adjustment period may be needed by family members and friends in order for them to adapt to new behaviors that will lead to the client’s growth and development.

While I expect benefits from this treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed. In addition, I understand that **regular attendance and compliance with treatment (such as completing homework assignments) will produce maximum benefits**. I also understand that I am/we are free to discontinue treatment at any time, and **agree before doing so to have a termination session with the therapist providing services**.

I am/am not (circle one) aware of any reason why I/we should not proceed with therapy and I/we/he/she agree to participate fully and voluntarily. I have been informed of all aspects of treatment fully, have had my questions answered, and understand the treatment planned and the policies and procedures. Therefore, I consent to treatment, agree to comply, and authorize _____ as the clinician designated to provide treatment to me/us/my child

Client signature _____ Date _____

Counselor signature _____ Date _____

If the client is a minor, the parent or guardian must also sign.

I _____ (parent’s signature) give permission for my child(ren) to receive counseling at Northshore Center For Wellness _____ (print parent’s name).

