



**Lori Heroman, LPC**

**7914 Wrenwood Blvd. Suite C**

**Baton Rouge, LA 70809**

**(225) 953-1599**

*Licensed Professional Counselor, Infant Mental Health Specialist*

### **Declaration of Practices and Procedures**

**Qualifications:** I earned a Bachelor of Psychology from Louisiana State University in 1994 and a Master of Arts degree in Mental Health Counseling from Louisiana State University in 1996. I have been a Licensed Professional Counselor in the state of Louisiana since December of 1998. My License number is #2174 and I have a copy for reference if needed. I have worked in several different fields of mental health including inpatient and outpatient hospitalization, school counseling and private practice. I have been in private practice working with children, teens, adults, and their parents since July of 2007.

**Counseling Relationship:** I see counseling as a process in which the client and I the counselor, have come to understand and trust one another. I want to work as a team with my clients to explore and define current problems, develop ways to manage these problems and work to develop goals for an improved life. I hold the counseling relationship in the highest regard and thus confidentiality is of the utmost importance to me. I am an active member of the community in Baton Rouge but want my clients to feel assured that their confidentiality is my main priority. For this reason, if I see a client outside of my office, I will not approach you or identify myself in any way. I do this to protect the confidentiality of my client. Material revealed in counseling will remain strictly confidential except for material shared under the following circumstances, in accordance with the state law:

- 1.) The client signs and 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 a reasonable amount of suspicion of abuse/neglect against a minor child, elderly person (60 or older) or dependent adult
- 4.) A court order if received directing the disclosure of information.

**Privileged Communication:** It is my policy to assert privileged communications on behalf of the client and the right to consult with the client, if possible, except during an emergency before

mandated disclosure. I will endeavor to apprise clients of all mandated disclosures as conceivable.

**Areas of Focus:** As I mentioned previously my areas of expertise are in counseling for children, teens, and adults. I also focus on parenting issues and family concerns.

**Fees and Office Procedure:** The fee for service is 125.00 for one 50-minute session and 175.00 for 1.5-hour session. It is to be paid directly to Lori Heroman via card, check, or cash. Payment for services is due at the end of each session. I do not accept payment from insurance companies but will provide you with an invoice that you can use to file with your insurance company to obtain reimbursement according to your policy. Additionally, these invoices can be use as health deductions when filing your Federal Income Tax. Appointments can be made through me directly or online. I have morning, afternoon, and evening appointments until 6:00 pm on Monday, Wednesday, and Thursday. Appointments, may be scheduled, cancelled, or rescheduled online or directly through me via text, phone, or email. I do require a 48-hour cancellation in order not to be charged fully for the appointment.

**Code of Conduct:** As a Licensed Professional Counselor, I am required by law to adhere to the Code of Conduct for practice that has been adopted by my licensing board, the LPC Louisiana Board of Examiners. A copy of the code of conduct is available upon your request. Should you wish to file a disciplinary complaint regarding my practice as an LPC, you may contact the Louisiana LPC board of Examiners.

**Emergency Situations:** When I am unavailable to answer calls or emails you may leave a message and I will return your call or email as soon as possible. I typically do not return phone calls or emails on the weekends unless indicated by you in the message that it is an emergency, and you need to be called ASAP. If for some reason, I am not able to return the call promptly please do not hesitate to call the COPE TEAM at OLOL Regional Medical Center or go directly to your nearest emergency room.

**Client Responsibilities:** You, the client is 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, please share those with me so that we can make the necessary adjustments. If I determine that another mental health provider would better serve you, I will help you with the referral process. If you are currently receiving services from another mental health professional, please inform me of this and grant me permission to share information with this professional so that we may coordinate care.

**Physical Health:** Physical health can be an important part in the emotional well-being of an individual. If you have not had a physical exam in the last year, it is recommended that you do so. Also please provide me with a list of any medications you are currently taking.

**Use of Recording Materials:** Recording sessions without the therapist's consent is a breach of the therapeutic relationship. Recording individuals requires informed consent from all parties, for this reason I ask that you do not record sessions without consent.

**Court Proceedings:** It is understood that Lori Heroman LPC is in the role of counselor and shall function as a neutral third party to any minor children. It is in a child's best interest to have a neutral person he/she can process any issues regarding parental conflict. It is acknowledged that Ms. Heroman may educate parents about better ways to communicate with each other and their children. It is understood that Ms. Heroman is not a child custody evaluator and does not make recommendations to the court as to custody decisions.

**Potential Counseling Risks:** You, the client should be aware that counseling has potential risks. While working together, additional problems may surface of which you were not initially aware. If this occurs, you should feel free to share those concerns with me.

I have read the Declaration of Practice and Procedures of Lori Heroman LPC, and my signature below indicates my full informed consent to services provided by Lori Heroman LPC.

---

Client Signature

Date

Parent/Guardian Consent for Treatment of a Minor:

I \_\_\_\_\_ give my permission for Lori Heroman LPC to conduct therapy with \_\_\_\_\_.

---

Signature of Parent or Guardian



## **Payment Policies**

*Payment for Services:* Lori Heroman LLC, is a private pay clinic and does not bill or contract with insurance companies directly. As such payment is due in full at the time services are rendered. I will provide a detailed invoice to you for each visit in order that you may seek reimbursement from your insurance company (if applicable) in accordance with your benefit plan. The credit card indicated on the below payment form will be kept confidentially on file to be charged in the event of the individual not having the card available to them to swipe or in the event of a late cancellation or no-show fee. The card will need to be updated when it expires or when use of card changes to another.

If multiple parties are responsible for payment) ie: multiple guardians for the same patient who share the expense of the appointment) please obtain additional copies of this policy and have all necessary parties complete the form, so that we may attempt to charge parties in accordance with payment agreements. In addition, please let me know of how sessions are to be split between parties if applicable.

### **Cardholder Information:**

Name: \_\_\_\_\_

Phone#: \_\_\_\_\_

Card Type: Debit, Credit, Visa, or Mastercard

Card no: \_\_\_\_\_

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

Zip Code: \_\_\_\_\_3

Numbers on the Back \_\_\_\_\_



## **Authorization for Electronic Communications**

As a convenience to me, I hereby request that Lori Heroman LPC communicate with me regarding my treatment (or the treatment of my guardian or child) via electronic communications (email or text messages). I understand this means that Lori Heroman will transmit my protected health information such as information about my appointments, progress, medications, diagnosis, and other individually identifiable information about my treatment to me via electronic communication.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message or otherwise and that such communications may be lost, delayed, intercepted, corrupted, or otherwise altered rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error free and its confidentiality may be vulnerable to access by unauthorized third parties. Lori Heroman LLC shall not have any responsibility or liability with respect to any error, omission, claim, or loss arising from or in connection with the electronic communication of information by Lori Heroman to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Lori Heroman LLC to communicate electronically with me. I understand that I the event that I no longer wish to receive electronic communication from Lori Heroman LLC, I may revoke this authorization by providing written notice to Lori Heroman LLC, 7914 Wrenwood Blvd. Suite C Baton Rouge, LA 70809.

I agree that Lori Heroman, LLC may communicate with me electronically unless and until I revoke this authorization by submitting notice to Lori Heroman LLC in writing. This authorization does not allow for the electronic transmission of my protected health information to third parties, and I understand that I must execute a separate authorization for my protected health information to be disclosed to third parties.

### **Consent:**

I have read and understood this consent in its entirety and agree to abide by these terms. I am also aware that if I have any questions about this document in the future, I am encouraged to bring them up at any time.

---

Signature if seventeen or older or Signature of Guardian

Date: