**Declaration of Practices and Procedures**

Carol A. Harvey, M.A., PLPC

New Orleans Growth Center

3712 MacArthur Blvd. Suite 209

New Orleans, LA 70114

504-508-4531

**Qualifications**: I earned a Masters of Arts degree in Marriage and Family Therapy from University of Holy Cross. I am Provisional Licensed Professional Counselor (PLPC) #PLC6938 and a Provisional Licensed Marriage and Family Therapist (PLMFT) #PLM1322 and hold provisional licenses with the Louisiana LPC Board of Examiners located at 8631 Summa Avenue, Baton Rouge, LA 70809 (225-765-2515). The Louisiana LPC Board of Examiners has approved Dr. Matt Morris PhD., LMFT-S, LPC-S, 4123 Woodland Dr. New Orleans, LA. 70131 (504-398-2234) as my LPC Board-Approved Supervisor. Dr. Morris is licensed with the Louisiana LPC Board as a Licensed Professional Counselor (LPC) and a Licensed Marriage and Family Therapist (LMFT), and is approved to supervise PLPCs/PLMFTs obtaining supervised experience hours needed to be fully licensed as a LPC and/or a LMFT in the State of Louisiana.

**Counseling Relationship**: I see counseling as a process in which you the client, and I, the PLPC/PLMFT 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.

**Areas of Focus**: I focus on clients with individual, marriage, and family issues, as well as, emotional and substance abuse issues. In addition to being provisionally licensed as a PLPC and PLMFT in Louisiana, I hold a national certification as a National Certified Counselor (NCC#819605).

**Fees and Office Procedures**: The fee for services is $60.00 per session and paid directly to New Orleans Growth Center. Payment for services is due at the close of each session. Payment is not accepted from insurance companies. As a PLPC/ PLMFT, I may not accept payment for services directly.

**Appointments/Missed Appointments**: Appointments are typically set at the end of each session. Appointments may be scheduled, rescheduled or cancelled by emailing me *or* by calling me. You may also leave a voicemail or text me, if that is easiest. I realize situations come up and prevent us from keeping our scheduled plans. If you must cancel or reschedule, please do so at least 24 hours before our scheduled session or a cancellation fee will be assessed in the amount of half the typical session ($30.00). If you fail to show up for our scheduled session, a “no-show” fee of $60.00 will be assessed and payment will be due at the next scheduled session. The fee may be waived, *only*, in the event of serious or contagious illness or emergency situation.

**Services Offered and Clients Served**: I approach counseling from a person-centered and solution focused perspective. I look for patterns of behavior to identify times in the client’s life when things were working well for them. We will examine, together, what differences or obstacles are evident now that may be interfering with living a fulfilling life. The client will develop goals for themselves and together, we work toward achieving those goals. I work with clients in a variety of formats, including individually, as couples and as families. I see clients of all ages and backgrounds with the exception of children under the age of six, unless they are part of a family session including all members.

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

**Confidentiality**: Material revealed in counseling will remain strictly confidential except for material shared with my Board-Approved Supervisor and 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 only be shared with the client’s spouse or other family members 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**: In the event of a mental health emergency, you may leave a message on my cell phone and I will return your call as soon as possible. In an emergency situation when an immediate response is necessary, you may call Orleans Parish Mobile Crisis at 504-826-2675 or the Jefferson Parish Mobile Crisis Unit at 504-832-5123. You may also seek help through hospital emergency facilities or by calling 911.

**Client Responsibilities**: 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 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**: The client should be aware that counseling poses potential risks. In the course of working together, additional problems may surface of which you were not initially aware or relationship patterns may change, thus affecting your social system. Additionally, studies suggest that marital counseling involving only one spouse can lead to the dissolution of the marriage instead of improvement. If any of these conditions occur, you should feel free to share these concerns with me.

I have read the Declaration of Practices and Procedures of Carol A. Harvey, M.A., PLPC, PLMFT and my signature below indicates my full informed consent to services provided by Carol A. Harvey, M.A., PLPC, PLMFT. I am aware that Ms. Harvey may share information with Dr. Matt Morris, PhD., LPC-S, LMFT-S and other PLPCs for the sole purpose of supervision toward licensure. Information shared in supervision may not be used for any other purposes. I am also aware that my sessions with Carol A. Harvey, M.A., PLPC, PLMFT may be audio or videotaped, *with permission*, for the purpose of supervision.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Carol A. Harvey, M.A., PLPC, PLMFT Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Matt Morris PhD., LPC-S, LMFT-S Date

Parent/Guardian Consent for Treatment of a Minor:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my permission for Carol A. Harvey, M.A., PLPC to

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

(Relationship) (Name of minor)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian Date