Declaration of Practices and Procedures

Anne Breaux, M.A., LPC

Hope Healing Joy Counseling

1003 Hugh Wallis Rd S. Building E

Lafayette LA, 70508

Qualifications: I earned a Masters of Science degree in Clinical Mental Health Counseling at Southeastern Louisiana University in 2022. I am a Licensed Professional Counselor (LPC) LPC #9031 provisionally licensed with the Louisiana LPC Board of Examiners, 11410 Lake Sherwood Ave North Suite A Baton Rouge, LA 70816, (225) 295-8444.

Counseling Relationship: I see counseling as a process in which you, the client, and I, the LPC 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 aged 12 years and older experiencing different presenting issues such as but not limited to trauma, and anxiety. I have experience working with children and adolescents that have been through trauma and abuse. I also have experience working with children in grades Pre-K to 6th grade with various presenting issues such as anxiety, anger management, emotional regulation, impulse control, etc.

Services Offered and Clients Served: I approach counseling from a person-centered perspective using unconditional positive regard to build a healthy therapeutic relationship to help clients grow. I work individually with my clients and talk with parents as needed. I see clients from age 12 years old and up.

Code of Conduct: As a LPC in the state of Louisiana, I am required by law to adhere to the Code of Conduct for practice as a LPC that has been adopted by my licensing board, the Louisiana LPC Board of Examiners. I am also required to follow the NBCC code of ethics. 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 LPC, you may contact the Louisiana LPC Board of Examiners.

Fee Scales: As a LPC I may not accept payment for services directly. My fee is $150 initial session and $135 subsequent, I also provide a sliding scale to work with my clients financial needs. I provide groups as well, if you choose to do a group the rate is $45 per group.

Appointment: Please be on time for your appointment as other clients may be scheduled after your appointment. If you are late for your session it will end at your scheduled time. An appointment is considered cancelled if you are more than 15 minutes late.

No Show/Cancellation Policy: Anne Breaux M.A., LPC requires 24 hour notice of cancellation of your session. The client will be responsible for **$50** cancellations until the client reaches 3 or more missed appointments in a calendar year. At this point the client will be held responsible for the entire session fee of **$135.**. You may be asked to put a card on file and will be notified when the card is charged for appointments missed. *Client relationship may be terminated until debt is paid and credit card on file for future absences.*

Confidentiality: Material revealed in counseling will remain strictly confidential except for material shared 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 a reasonable suspicion of abuse/neglect against a minor child, elderly person (60 years of age or older), or a dependent adult.

4) A court order is received directing the disclosure of information.

In the event of family counseling, material obtained from an adult client individually may 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 disclosure as conceivable.

Emergency Situations: When I am unavailable to answer calls after normal hours, you may leave a message at (337) 534-8140 and I will return your call as soon as possible. In an emergency situation when an immediate response is necessary, you may call your local hospital or 911.

Client Responsibilities: You, the client, are a full partner in counseling. Your honesty and effort is 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 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, 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 and to list any medications you are now 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 the client was not initially aware. If this occurs, the client should feel free to share these new concerns with me.

I have read the Declaration of Practices and Procedures of Anne Breaux, M.A., LPC and my signature below indicates my full informed consent to services provided by

_____

Client Signature Date

_____

Anne Breaux, M.A., LPC Date

Parental or Guardian Authorization

I,_____ , give permission for Anne Breaux, M.A., PLPC to

(Name of Parent or Legal Guardian)

conduct counseling with my _____, _____

(relationship) (Name of Minor)

Signature of Parent or Legal Guardian:_____ Date:

_____

Informed Consent for Tele-health Service

Telebehavioral health is the delivery of behavioral health services using electronic communications that enable Hope Healing Joy clinicians to connect with individuals using live interactive video and audio communications. The interactive technologies use software protocols to protect the confidentiality of client information transmitted via any electronic channel and has safeguards to protect data and aid in protecting intentional or unintentional corruption. I understand that I have rights with respect to telehealth:

1. The laws that protect confidentiality of my personal information that I have already signed in clinicians Declaration of Practice also apply to tele-health. A copy of this can be found under your clinician's name on our website, Hopehealingjoy.com.
2. I understand that I have the right to withhold or withdraw my consent to use tele-health in the course of my care at any time, without affecting my right to treatment.
3. I understand that there are risks and consequences of tele-health, including but not limited to, the possibility despite reasonable efforts not the part of the counselor, that the transmission of my personal information could be disrupted or distorted due to technical failures, the transmission of my personal information could be unintentionally lost or accessed by unauthorized persons. HHJ uses secure, encrypted HIPPA compliant audio/video transmission software to deliver tele-health via doxy.me. You can visit Doxy.me for more information. However if technology fails, utilization of Psychology Today Therapist Finder HIPPA compliant video platform may be used.
4. If services are disrupted, clinician will call the cell phone number I have provided. By signing this I am granting access to being called by clinician. In addition, if there is a reason to believe an emergency situation has arose clinician will call my emergency contact and/or the emergency department nearest you. If I wish to change my emergency contact or live outside the Lafayette area, please provide the number to the area that serves me, i.e. police department or sheriff department's phone number.
5. Clinicians follow the State of Louisiana Counseling Board Regulations for tele-health and have received education LA LPC Board requires hours for tele-health.
6. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency, I should call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
7. It is my responsibility to maintain privacy on the client end of communication. I will take precautions to ensure my communications are directed only to my clinician.

Client Consent: I have read and understand the information provided above regarding tele-behavioral health. If desired I have discussed it with my counselor, and all my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of tele-behavioral health services and have had my questions regarding the procedure explained.
I hereby give my informed consent to participate in the use of tele-behavioral health services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood and agree to terms of this document.

_____

Client's Signature Date

_____

Anne Breaux, M.A., LPC Signature Date