



# Parker Counseling Services, LLC

*Jacosta Parker, LCSW-BACS, MSW*

[parkercounselingservices@gmail.com](mailto:parkercounselingservices@gmail.com)

(504) 383-5880 (office) 1-504-336-3184 (fax)

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## Declaration of Practices and Procedures

**Qualifications:** I earned a Bachelor of Arts degree in Sociology with a minor in Children, Youth, and Family Advocacy from Nicholls State University in 2010. In 2012, I earned a Master of Social Work degree from Southern University at New Orleans. I am a Licensed Clinical Social Worker #11792 with the Louisiana State Board of Social Work Examiners, 18550 Highland Road, Suite B, Baton Rouge, Louisiana 70809 (phone: 225-756-3470)

**Code of Conduct:** As a Licensed Clinical Social Worker, I am required by state law to adhere to a Code of Conduct for practice that has been adopted by my licensing board. A copy of the NASW Code of Conduct is available to you upon request.

**Therapeutic Relationship:** Therapy is a two-part relationship in which I, the therapist and you, the client, develop an understanding and trusting relationship that allows us to work together to define the reasons for therapy, discover and explore any underlying problems, and define the present situations that led to client and/or caregiver seeking therapy. Together, we will develop goals to help improve client's overall life and work systematically to achieving those goals.

**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, please share those with me so 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, please let me know so we can coordinate services.

**Areas of Expertise:** I focus on adolescents and adults with struggling with Depression, Adjustment Disorder, Trauma, Relationship Issues, and Anxiety. I also have experience working with individuals and families experiencing relational dynamic changes surrounding grief, divorce, and issues parenting/ co-parenting.

**Services offered and Clients Served:** I provide counseling to adolescents and adults through individual and family therapy using an Eclectic Approach. The eclectic approach uses different strategies and techniques from various theories to create the most effective intervention for the client. The theories I typically use are Cognitive Behavioral Therapy (CBT) and Solution Focused Therapy.

**Face-to-Face and Teletherapy:** Services are offered both in-person and virtually. In-person sessions are held at 5817 Citrus Blvd., Suite O, Harahan, LA 70123. During virtual sessions, it is the responsibility of the client to ensure confidentiality by providing a private and secure location for themselves during sessions. A 15-minute grace period is given during both in-person and virtual sessions. If the client doesn't arrive to the session before the 15-minute grace period, the session will be counted as a no-show and the \$100 No Show Fee will be applied. The fee must be paid before the next session can be scheduled. All clients are advised to ensure their insurance covers Telehealth sessions prior to beginning therapy. Any fees not covered by the insurance will be forwarded to the client.

**Emergency Situations:** If an emergency should arise, you can seek immediate medical attention at your local emergency room by calling 911 or calling Jefferson Parish Mobile Crisis Services at (504) 832-5123.



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

**Fees for Services:** The fees for services are \$150.00 per initial session, which last 60 to 90 minutes, and \$125.00 thereafter per 45 to 55-minute session for individual therapy and \$140.00 for 60 minutes of family therapy. Fees are paid directly to me at the beginning of each session by Credit/ Debit Card.

The following insurance plans are also accepted: Medicare, Medicaid, Aetna Commercial, United HealthCare, Optum, Peoples Health, and Blue Cross Blue Shield. You are responsible for paying co-pays at the beginning of each session. I also accept fees based on a sliding fee scale.

Appointments are set at the close of each session. Evening appointments are available Monday through Thursday from 3:30pm—7:30pm. A 24-hour notice of cancellation must be given to avoid a missed appointment fee of \$50 for late cancelations or \$100 for no-show sessions. Failure to keep scheduled appointments will result in termination of services.

**Privileged Communication:** Material revealed in counseling will remain strictly confidential except under the following circumstances in accordance with the state law:

- 1) The client signs a written release of information indicating informed consent of such release,
- 2) The client expresses intent to harm to him/herself or someone else,
- 3) There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (60 or older), or a dependent adult.
- 4) A court order is received directing the disclosure of information.

It is my policy to assert privileged communication on behalf of the client and the right to consult with the client, if possible, except during an emergency, before mandated disclosure. I will explain all mandated disclosures to the client and/or caregiver as possible.

In the event of marriage and family counseling, material obtained from an adult client individually may be shared with client's spouse or other family members only with the client's written permission. Any material obtained from a minor client may be shared with the client's parent or guardian.

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



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## Informed Consent

I have read and received a copy of the Declaration of Practices and Procedures on pages 1 and 2. My signature below indicates my full informed consent to therapy services provided by Jacosta Parker, LCSW-BACS of Parker Counseling Services, LLC.

Client/ Parent or Guardian Signature

Date

*Jacosta Parker, LCSW-BACS*

Jacosta Parker, LCSW-BACS

Date

### Parent/Guardian Consent for Treatment of a Minor:

I, \_\_\_\_\_, give my permission for Jacosta Parker, LCSW to conduct  
(Name of parent or legal guardian)

therapy with my \_\_\_\_\_,  
(relationship) (Name of minor)

Parent or Guardian Signature

Date



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## Client Information

Please provide the following demographic information. The information you provide here is protected under HIPPA and treated as confidential information.

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Client Name: \_\_\_\_\_ Gender:  Male  Female Race: \_\_\_\_\_

Name of parent/ guardian if minor: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status:  Never Married  Domestic Partnership  Married  Separated  Divorced  
 Widowed

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_

May we leave a message?  Yes  No

Cell/ Other Phone: (\_\_\_\_) \_\_\_\_\_

May we leave a message?  Yes  No

**\*\* Text communication is used during scheduling. \*\***

E-mail: \_\_\_\_\_

May we email you?  Yes  No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

### Emergency Contact Information:

\_\_\_\_\_  
(Name) (Number) (Relationship)

\_\_\_\_\_  
(Name) (Number) (Relationship)



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## Medical History

**Please provide the following information for client's Primary Care Provider (PCP)**

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

PCP Phone Number: \_\_\_\_\_ PCP Fax Number: \_\_\_\_\_

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**Check all symptoms experienced by client and/or family members:**

- Bipolar/ Mood swings     Depression/ Sadness     Insomnia     Panic attacks     Guilt
- Obsessions/compulsions     Hopelessness     Racing thoughts     Personality changes
- Anxiety     Fatigue     Withdrawn/decrease socialization     Decrease interest
- Irritability/easily angered     Aggression     Behavioral problems     Impulsivity
- Grief/loss     Uncontrollable fear/phobia     Nightmares     Trauma/ PTSD
- Worthlessness     Eating disorder     Chronic pain     General overwhelming stress
- Homicidal Thoughts     Suicidal Thoughts     Active plan to hurt myself
- Hallucinations     Difficulty with work/school/family     Rapid weight loss/weight gain
- Memory impairment     Difficulty motivating myself to do basic responsibilities
- Mania (decrease sleep accompanied by high energy or agitation, impulsivity, increase in drive to do activity)

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**How did you hear about these services?** \_\_\_\_\_

**In general, what are your reasons for seeking therapy?**

**Are you seeking Virtual (telehealth) or in-person therapy?**     Virtual     In-person

\*\* In-person sessions are held at 5817 Citrus Blvd., Suite O, Harahan, LA 70123



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## Insurance Information

**\*\* If you have private insurance in addition to Medicaid, you must provide the information and insurance card for both insurances. Failure to do so can result in additional fees being acquired.**

**Insurance:** \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Member #: \_\_\_\_\_ Policy/ Group #: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Member #: \_\_\_\_\_ Policy/ Group #: \_\_\_\_\_

**If services aren't covered by the insurance company OR you do not have insurance, please provide information for the responsible party—the person who will be responsible for paying the per-session fee for services.**

Estimated Income:  Monthly  Annual \_\_\_\_\_

Responsible Party's Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_



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## Financial Policy Agreement:

I believe that everyone benefits when there is a clear and definite understanding of the financial policy prior to treatment.

- PATIENTS WITHOUT INSURANCE:** All patients without insurance are required to pay in full for the service rendered at the time of the appointment.
- PATIENTS WITH INSURANCE:** If my office is contracted with your insurance company, I will file your insurance claims if you provide me with the proper information along with a copy of your current insurance card. Copays are due at the beginning of sessions via Square Invoice. The session will not occur if the copay isn't paid prior to the start of the session.
- LATE CANCELLATION POLICY:** *There is a charge for late cancellations of appointments when less than 24-hour notice from the session start time is given by the client.* **Late cancellations will result in a \$50 late cancellation fee.** This fee must be paid prior to being allowed to schedule another session. Sessions cannot be scheduled with outstanding fees.
- NO-SHOW POLICY:** *There is a charge for not attending a session without prior notice.* **No-show sessions will occur a fee of \$100.** This fee must be paid prior to scheduling another session. No client will be able to schedule a session with any unpaid fees.
- I cannot bill insurance companies for these appointments. Reminder emails and texts to clients are offered as a courtesy to avoid no-show and late cancellations. Please respond appropriately when courtesy reminders are sent.
- It is the responsibility of the client to reschedule their session. Reminders to reschedule will not be sent and future reoccurring appointments will be removed from the calendar unless communication is and any acquired fees are received.
- DELIQUENT ACCOUNTS:** In the event I am forced to pursue the balance of your account through a collection process, you will be responsible for all costs and fees associated with this process.
- Payments for services rendered may be made by credit/ debit card through Square. Invoices are created and sent to the client when payment is being rendered.

**I have read and agree with the terms of this agreement and authorize payment of insurance benefits to Jacosta Parker, LCSW for services rendered.**

SIGNATURE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_



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## Credit Card Consent Policy Form

I, \_\_\_\_\_, authorize Jacosta Parker of Parker Counseling Services, LLC. to keep my signature on file and charge my credit/debit card account as indicated below:

A charge to the credit/debit card will ONLY be made under the following circumstances:

1. Missed Appointments (no call/ no show)
2. Cancellations made less than 24 hours from time of scheduled appointment

Charges are as follows: (unless otherwise discussed)

1. Cancellation less than 24 hours..... \$50
2. Missed appointments ..... \$100
3. Any amount associated with the delinquent account according to invoices received from Square.

I, the undersigned understand that this form will be valid for the duration of my enrollment with Jacosta Parker, LCSW of Parker Counseling Services, LLC. UNLESS I provide written notice to cancel.

Card type (please check):  Visa  Master Card  Discover  American Express

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Name on card: \_\_\_\_\_

Cardholder Billing Address: \_\_\_\_\_  
Street City State Zip Code

Credit/Debit Card Number \_\_\_\_\_ Exp Date \_\_\_\_\_ CVC \_\_\_\_\_

Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_

**This card will only be charged for the fees listed above. All charges made to this card will be accompanied by an invoice from Square explaining the charge.**

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date