Parker Counseling Services, LLC

Jacosta Parker, LCSW-BACS, MSW

parkercounselingservices@gmail.com

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

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 this 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 $25.00 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 Cash or Credit/ Debit Card.

The following insurance plans are accepted: Aetna, United Healthcare, Optum, Peoples Health, Blue Cross Blue Shield, and certain medicaid plans. Co-pays are due at the beginning of each session. Sliding fee scale options are available based on income.

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 $25. 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. May we text you for scheduling □Yes □No

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: _____

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)

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.

1. **PATIENTS WITHOUT INSURANCE:** All patients without insurance are required to pay in full for the service rendered at the time of the appointment.
2. **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.
3. **CANCELLATION POLICY:** *There is a charge for failed appointments/late cancellations of appointments when less than 24-hour notice is given by the patient.* You will be charged **$25** for the service which would have been rendered. I cannot bill insurance companies for these appointments. Reminder calls and/or texts to clients are offered as a courtesy.
4. **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.
5. Payments for services rendered may be made by cash or credit/ debit card.

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. Cancelation less than 24 hours…….. $25
2. Missed appointments …….. $25

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_____

If you wish not to give credit card information, you understand that at the next scheduled appointment, you will be responsible for paying the cancelation/no show fee of $25 at the beginning of session by cash, check or credit.

_____ _____

Signature of responsible party **Date**