Rooted in Grace La Fayette
Amanda Wilke, CMA, Min., Christian Counselor
LaFayette, Georgia 30728 | Phone: 706-954-4324

Declaration of Practices and Procedures

I am pleased that you have chosen me as your Christian counselor. The purpose of this statement is to inform you of my background and to ensure that you understand our professional relationship.

Counseling Relationship: To promote a positive therapeutic environment, it is my desire to provide a safe and open atmosphere in which you feel free to examine your thoughts, emotions, and patterns of behavior which are of concern to you. It is my desire to establish a non-clinical Christian counseling relationship based on mutual respect, trust, and honesty. My approach to counseling is Biblical and from real life. After a thorough assessment, goals are established through collaboration with the client. The goal of counseling is the successful resolution of the problems that are deemed most important by the client. Clients must make their own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to set up custody and visitation. It is my goal to assist you in the problem-solving process; however, my code of ethics does not allow me to advise you to make a specific decision, nor can I diagnose or treat you. I will guide you spiritually. As a Christian counselor, I believe God is able and eager to help facilitate emotional and spiritual growth. I seek God's guidance through the Holy Spirit and use Scripture and prayer when appropriate. It is not at all necessary that you share my view. I will respect your spiritual beliefs and am willing to explore your personal belief system as you give direction.

Qualifications: I became a Certified Medical Assistant in 2016 from Georgia Northwestern Technical College. I became a Notary Public in Georgia in 2022. In 2023 I became an Ordained Minister through ULC. As of September 2025, I got my certificate in Holistic Christian Counseling.

Areas of Expertise: My areas of specialization include depression and anxiety, trauma for both adults and children, grief and loss, couples counseling, pre-marital counseling, relational issues, communication issues, anger management, parenting, and sex education. I work with both individuals and couples. I also work with clients who present with mood and/ or personality disorders.

Session Fees: $60 per session, and each session is 1 hour.

Explanation of the types of services and client population: Individual, child, adolescent, marriage, and family counseling are available. Group counseling is offered as needed.

Code of Ethics: I am required by state law to adhere to the Georgia Code of Conduct for Georgia Pastoral Christian Counselors.

Privileged Communication/Confidentiality: I am required to abide by the professional practice standards and Georgia law. I do not disclose client confidences and information to any third party except for materials shared during supervision without clients written consent or waiver except when mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations. State law mandates that I report to the appropriate authorities suspected cases of child abuse/neglect, elder abuse/neglect, or disabled abuse/ neglect and instances of danger to self or others when reasonably necessary to protect the client or other parties from a clear and imminent threat of serious physical harm. Certain types of litigation may lead to the court-ordered release of information without your consent.

When working with individuals, couples, families, or groups I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. When working with a family or couple, information shared by individuals in sessions, when other family members are not present, must be held in confidence (except for the mandated exceptions already noted) unless all individuals involved sign written waivers at the outset of therapy. Clients may refuse to sign such a waiver but should be advised that maintaining confidentiality for individual sessions during couple or family therapy could impede or even prevent a positive outcome to therapy.

Potential Counseling Risks: As a result of mental health or couples/family counseling, the client may realize that he/she has additional issues which may not have surfaced prior to the onset of the counseling relationship. These issues may present possible risks in a couple or family in counseling. If one partner changes, additional strain may be placed on the relationship if the others involved refuse to change. Marital or family conflicts may initially intensify as feelings are expressed.

Scheduling: 3 No-Shows **or** 3 cancellations (non-emergency) within 1 calendar year will result in termination of counseling services with myself. **Cancellation: If you are unable to keep an appointment, the office must be notified at least 24 hours in advance unless it's an emergent situation. If notice is less than 24 hours (non-emergency) or you no-call no-show, you will be charged a $25.00 fee.** Please cancel online or send an email to **calledtoserve30728@rootedingracelafayette.com**, that way it will be time-stamped of when you cancel to determine if the fee will be added or not. Responsibility for remembering appointments rests with the client.

Emergency Situations: In case of emergency, call 911, The Crisis Intervention Center at 988, a psychiatric hospital, and/or go to the nearest emergency room, if warranted.

Telephone Consultations: This will be our main source of appointment meetings.

Client Responsibilities: The client is expected to follow the scheduling and office procedures. It is expected that he or she will terminate any previous counseling relation or get permission from the prior therapist. It is suggested that the client has a complete physical examination if he/she has not had one within the past year. Also, the client agrees to list on the intake form any medication he/she is taking.

I have read and understand the above information and have received a copy of it. I hereby sign in agreement and authorize my primary care provider to release any information necessary to my counselor, Amanda Wilke, to obtain assignment of health care benefits for the above services and to release information to my primary care physician, as needed.

Client Signature_____ Date _____

Counselor Signature_____ Date_____

If client is a minor, parental authorization is needed: I _____, give permission for Amanda Wilke, CMA, Min., Christian Counselor to conduct therapy with_____

Said Minor is my:

□ Son
□ Daughter
□ Niece
□ Nephew
□ Grandson
□ Granddaughter
□ Step-Son
□ Step-Daughter

TO HELP WITH YOUR FIRST SESSION, PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETELY AS YOU CAN.

Date: _____ Birth Date: _____

Name:_____(if a couple, each person will fill out forms)

Address:_____City/St_____Zip: _____

Your Phone No.: (Home) _____, (Work) _____

(Cell):

Email Address: _____

Your Employment/Job Title:

Person responsible for your bill, if different than above:
Name/Address:_____
If using Insurance, **(you also need to fill out the Insurance Questions Form**)
Name of Ins. Co.:____NOT APPLICABLE_____

ANY CHURCH MEMBERSHIP:

Briefly describe your **spiritual life**:_____

Last year of school completed:_____**GED**___ College: 1 2 3 4 Degree:_____Other:

Single_____Married_____Separated_____Divorced_____Remarried_____Widowed

Total number of prior marriages for you for your spouse/partner

Spouse's name: Age of spouse:_____#of yrs. married_____

Spouse's employment:_____

WHO REFERRED YOU TO US?

Is it ok to call your home and leave a message: Yes __No___; At your work: _____No

Yes Person to contact in case of an **emergency (name/phone):**

BRIEFLY describe your reason for seeking counseling: _____

_____

Do you have children? _____ Yes _____No

If yes:

First Name	Age	Sex	Relationship to you (biological/step/adopted/foster)	Live in your home?

Your Parents: (Father) Age:____ or ____ Deceased (Mother) Age:_____ or ____ Deceased

Number of Brothers:_____ Number of Sisters:_____

Has anyone in your family ever had **counseling** before? If so, for what?

_____

Any history of **drug/alcohol abuse** for self, father, mother, siblings?_____Yes _____No

If yes, please describe:

_____

Any history of **physical** or **sexual abuse** to you or your brothers / sisters? Yes _____No

If yes, please describe:

_____

Do you use **alcohol** or **nonprescription drugs?** Yes _____No

If yes, describe frequency and type:

_____

Have you ever experienced any **sexual difficulties:** Yes _____No

If yes, please describe:

_____

Have you ever had **counseling** before?_____Yes _____No
If yes, describe and list counselor, rough number of sessions, any psychiatric hospitalizations:

_____

_____

_____

Describe any **major changes** that have occurred to you or your family in the last few years? (moves, changes in number of family members, marital status, situation, or income)

_____

_____

_____

_____

List any **major health problems** for which you have received treatment in the last 24 months:

_____

_____

Primary Care Physician: _____ **Location:** _____
Phone:_____

Are you taking any **prescription drugs** currently?_____Yes _____No

If yes, what type, for what purpose, and who prescribed?

_____

_____

PLEASE CIRCLE or CHECK ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU:		
Nervousness	**Depression**	**Fear**
Shyness	**Sexual Problems**	**Suicidal Thoughts**
Separation	**Divorce**	**Finances**
Drug Use	**Alcohol Use**	**Friends**
Anger	**Self-Control**	**Unhappiness**
Sleep	**Stress**	**Work**
Relaxation	**Headaches**	**Tiredness**
Legal Matters	**Memory**	**Ambition**
Energy	**Insomnia**	**Making Decisions**
Loneliness	**Inferiority Feelings**	**Concentration**
Education	**Career Choices**	**Health Problems**
Temper	**Nightmares**	**Marriage**
Children	**Appetite**	**Stomach Problems**

Describe any **major changes** that have occurred to you or your family in the last few years? (moves, changes in number of family members, marital status, situation, or income)

_____

_____

_____

List any **major health problems** for which you have received treatment in the last 24 months:

_____

_____

Primary Care Physician: _____ Location: _____
Phone:_____

Are you taking any **prescription drugs** currently?_____Yes _____No

If yes, what type, for what purpose, and who prescribed?

_____

_____

PLEASE CIRCLE or CHECK ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU:		
Nervousness	**Depression**	**Fear**
Shyness	**Sexual Problems**	**Suicidal Thoughts**
Separation	**Divorce**	**Finances**
Drug Use	**Alcohol Use**	**Friends**
Anger	**Self-Control**	**Unhappiness**
Sleep	**Stress**	**Work**
Relaxation	**Headaches**	**Tiredness**
Legal Matters	**Memory**	**Ambition**
Energy	**Insomnia**	**Making Decisions**
Loneliness	**Inferiority Feelings**	**Concentration**
Education	**Career Choices**	**Health Problems**
Temper	**Nightmares**	**Marriage**
Children	**Appetite**	**Stomach Problems**

Describe any **major changes** that have occurred to you or your family in the last few years? (moves, changes in number of family members, marital status, situation, or income)

_____
_____
_____
_____

List any **major health problems** for which you have received treatment in the last 24 months:

_____
_____

Primary Care Physician: _____ **Location:** _____
Phone:_____

Are you taking any **prescription drugs** currently?_____Yes _____No

If yes, what type, for what purpose, and who prescribed?

_____
_____

PLEASE CIRCLE or CHECK ANY OF THE FOLLOWING PROBLEMS WHICH PERTAIN TO YOU:		
Nervousness	**Depression**	**Fear**
Shyness	**Sexual Problems**	**Suicidal Thoughts**
Separation	**Divorce**	**Finances**
Drug Use	**Alcohol Use**	**Friends**
Anger	**Self-Control**	**Unhappiness**
Sleep	**Stress**	**Work**
Relaxation	**Headaches**	**Tiredness**
Legal Matters	**Memory**	**Ambition**
Energy	**Insomnia**	**Making Decisions**
Loneliness	**Inferiority Feelings**	**Concentration**
Education	**Career Choices**	**Health Problems**
Temper	**Nightmares**	**Marriage**
Children	**Appetite**	**Stomach Problems**

Phone (706) 954-4324 | LaFayette, GA 30728

NOTICE OF PRIVACY PRACTICES CONSENT FORM

Effective April 14, 2003, a federal regulation, commonly known as the "HIPAA Privacy Rule", requires that we must provide all of our clients with a detailed notice, in writing, of our privacy practices. We have this lengthy "*Notice of Privacy Practices*" available online.

I understand that as a condition to my receiving counseling, **Rooted in Grace La Fayette** may use or disclose my personally identified health information for outbound referrals for treatment, to obtain health records to help aid in counseling services provided, and as necessary for the operations of this office. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, and which I have had the opportunity to review. I understand that the privacy practices described in the "Notice of Privacy Practices" may change over time, and that I have a right to obtain any revised Privacy Notices, if requested.

I also understand that I have the right to request **Rooted in Grace La Fayette** to restrict how my health information is used or disclosed. **Rooted in Grace La Fayette** does not agree to my request for the restriction, but if **Rooted in Grace La Fayette** does agree, **Rooted in Grace La Fayette** is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent in writing, at any time. My revocation/withdrawal will be effective except to the extent that **Rooted in Grace La Fayette** has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

Patient Signature _____ Date _____

Counselor/Coach Signature _____ Date _____

Amanda Wilke, CMA, Min., Christian Counselor

LaFayette, GA 30728| (706) 954-4324

INFORMED CONSENT FOR TELETHERAPY (VIDEO) COUNSELING

Prior to starting video-counseling services, we discussed and agreed to the following:

- There are potential benefits and risks for video-conferencing that differ from in-person sessions (secure internet connection).
- Confidentiality still applies and no one will record the session without the permission of the other person.
- You will need a webcam or a smartphone/tablet for the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be in a quiet, private space that is free of distractions during the session.
- The same 24-hour cancellation rules apply to video counseling.
- We need a back-up plan (e.g., phone number where you can be reached) in case we have technical difficulties. If we get disconnected, I will continue to try to reach you. If we both initiate, we will miss each other.
- Back-up phone number:_____
- We need a safety plan that includes at least one emergency contact and the closest ER to your location in the event of a crisis situation.

  Emergency Contact Name:_____
  Emergency Contact Number:_____
  Closest Emergency Room :_____

- As your counselor, I may determine that due to certain circumstances, video counseling is no longer appropriate and that we should resume our sessions in-person.

PLEASE READ AND SIGN AND RETURN THE TELEMENTAL HEALTH AGREEMENT AS FOLLOWS:

As your client in teletherapy, I understand the limits of liability for Digital Communication, Telemental Health and Teletherapy. At the beginning of each session, I agree to disclose my current location and allow my therapist to assess for safety, security, and comfort in my environment. The virtual teletherapy sessions will be conducted through Spruce, a HIPAA compliant teletherapy platform, and my Patient Health Information (PHI) will be protected within the limitations of Spruce and the environment in which the services are utilized.

Email and Text Messaging: The client should be aware that they have the right to refuse digital communications with the therapist; however, this could limit communication channels and immediacy of access to reach each other in the counseling relationship. The client understands that the use of digital technology, email, text messages, online video conferencing services, software, and/or platforms may not meet HIPAA compliance standards; therefore, I understand that my therapist will protect my information to the best of their ability within the limitations of the digital and physical environment.

There is confidentiality risk involved for both parties in utilizing digital technology

Communication. I understand the risk involved in digital communication and I hereby authorize my therapist to communicate with me utilizing digital technology on the internet.

Please initial here if you agree to the teletherapy policy outlined above: _____

Client's Signature: _____ Date: _____

Print Name: _____ Date: _____

Counselor's Signature: _____ Date: _____

Print Counselor's Name: Amanda Wilke, CMA, Min., Christian Counselor Date: _____