SARAH EASTERLY, MA, LPC, CSAT

7341 Jefferson Hwy,
Suite I, Baton Rouge, LA 70806
(225)522-2612

WELCOME LETTER AND INFORMATION

Thank you for choosing me as your therapist, I am looking forward to meeting you. Below is an explanation of the things you'll need to know to be prepared for our first visit:

DIRECTIONS: See the attached map. Easterly Counseling will be located at 7341 Jefferson Highway, Suite I, Baton Rouge, Louisiana 70806. The office complex is called Jefferson Center. The driveway for Jefferson Center is between Bocage Animal Hospital and City Pork. My building is all the way in the back. Suite I is on the second floor of the building and while the stairs are covered, there is no elevator. First set of stairs, second office door. My name will be posted on the door along with my new office mate, Lauren Cooper, LPC.

You may want to allow extra time to find us for your first session, especially given Baton Rouge's traffic. Printing out these directions and/or bringing the map that is attached will help.

SCHEDULING: For your convenience, you can schedule online via https://portal.therapyappointment.com/index.cfm/public:therapistdetail?directoryId=11ecdbd406a076c6a8a50e3b532c70b5 . After your first visit, please access this portal to schedule or cancel any future appointments. To access the portal, visit www.therapyappointment.com and select my name. The first time you can only schedule one appointment, after that as many as you wish. To get a jumpstart, or because of travel, some people elect to schedule 1 1⁄2 or 2 sessions for the first visit, or later visits. This is particularly helpful for couple's counseling.

PAPERWORK: Please review, sign, and bring all the attached paperwork to your first appointment. Please do not print back to back. If you do not print out the forms, please allow 20 minutes before your session begins to complete them so you won't lose any of your therapy time. If you run late, you lose minutes. If I run late, you will always get all of your time. If you're coming as a couple then I need both of you to fill out all of the forms.

FEES: The fee per 50 minute session is $135. The first evaluative session is $145. The fee for 1 ½ sessions (75 minutes) is $202.50 and a double session of 90-100 minutes is $270.

PAYMENT: It is my policy that payment is made at the time of service. You can pay with check, cash, Visa/Master Card, or Discover -- whichever is best for you.

CREDIT CARD ON FILE: To secure your appointment, we must have your credit card number on file prior to your arrival for the first session. It is safely secured through encryption. You can call our office at (225)522-2612 with a credit card number and I will charge a penny to your account, or you can login to your account on TherapyAppointment.com and do it yourself:

1. Login and click where it says "View or pay online statement" 2. Go to "Do you want to make a payment?"
3. Go to: "Please charge a _____to a new charge card
4. Fill in the name on the card, street address, and zip code
5. Click "Submit payment to charge card"
6. Verify by clicking "Yes"
7. Put in your credit card number, expiration date and 3-4 digit security CVV code from the back 8. Then click on "Process"

Done. Your credit card information is safely stored and encrypted in my system

INSURANCE: I do not file with insurance, but I can give you a receipt with a diagnosis for you to file for reimbursement via "out of network" benefits. Please Note: am not contracted with your insurance provider and therefore cannot be held responsible for any level of reimbursement. You (the client) are ultimately responsible for any and all payments now or at any future time. Additionally, I only provide a superbill. I do not provide a 1099 to insurance companies. Should your insurance require a 1099 for reimbursement, you will not be able to use your out of network benefits with me. You can see if you have mental health benefits by calling your insurance company and asking these questions: 1) What is the address for Mental Health Claims? 2) Do I have mental out-patient benefits? (if no, then stop), 3) Do I have any "out of network" benefits? (if no then stop, if yes – write down; particularly note if you have marital counseling benefits if this is of interest to you), 4) Do I have a separate mental health deductible? If yes, how much of that have I met? 5) Is a 1099 required for an OON mental health practitioner?

CONFIRMATION OF APPOINTMENT: On the Registration Form in your account online you can elect to have your appointments confirmed through text, email, or automated phone call. However, whether an appointment is confirmed or not, you are still responsible for remembering your appointments and will be charged if you miss. Reminders can be sent to up to 2 cell numbers or 2 email addresses – but not to both texts and emails.

CANCELLATIONS: If you ever need to cancel - I need at least 24 hours notice, preferably 48 hours. Cancellation within the remaining 24 hours will result in a charge. I appreciate your understanding so I can schedule other clients in need of counseling. If you need to cancel within the 24 hours, you may call and leave a message, text (preferred) or email.

WAIT LIST: If you now, or ever, want an earlier appointment and nothing is available – email, message through the online scheduler, or call and ask to be put on my waiting list. We'll call you if something opens up earlier. I sometimes email out notice of last-minute cancellations. If you think you'll need more sessions, you may want to not wait until your first appointment to schedule more sessions so that you can get the times you want. The system only lets you schedule your first appointment – if you want more, call.

COMING AS A COUPLE: I generally meet with a couple together first, then one session with each person individually, then back together as a couple from then on. If this isn't possible, I can be flexible. And for future sessions if one can't come it's OK to come alone.

If you have any questions, please email me or give me a call.
Please know that I'm looking forward to meeting you!
SARAH EASTERLY, MA, LPC, CSAT

7341 Jefferson Hwy., Suite I, Baton Rouge, LA 70806 (225)522-2612
https://easterlycounseling.com
sarah@easterlycounseling.com

SARAH EASTERLY, MA, LPC, CSAT

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DECLARATION OF PRACTICES AND PROCEDURES

Qualifications: I earned a Master of Arts degree in Marriage and Family Counseling from New Orleans Baptist Theological Seminary in 2013. I am licensed as a LPC# 5661 with the Licensed Professional Counselors Board of Examiners, 11410 Lake Sherwood Ave N, 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 counselor, 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. You must make your own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to establish custody and visitation. I will help you think through the possibilities and consequences on decisions, but my code of ethics prohibits me from advising you to make a specific decision. Your first session involves information gathering and becoming acquainted. I will obtain historical information from you and review the events that brought you to see me. Feel free to ask me any questions you may have. The nature of your need will be discussed, and recommendations made concerning future appointments or outside referrals if I am unable to provide the service appropriate for you.

Areas of Focus: I focus on clients with individual, marriage, and family issues. I conduct individual, couple, family and group formats for counseling sessions.

Fees and Office Procedures: The Initial Evaluation cost is $145. The fee for each fifty-minute individual, marital, or family session is $135. Fees are subject to change. Payment for services is due at the time services are rendered. Cash, personal checks, debit/credit cards are acceptable forms of payment. Please make checks payable to Sarah Easterly. There will be a $50 NSF charge on all returned checks. Payment is not accepted from insurance companies. My policy is to securely store the client's credit card number for payment purposes. It is used for the initial session, for subsequent sessions, for any "no shows", and for appointments not cancelled with at least 24 hours of notice. The time you schedule for appointments is reserved for you specifically. If you must cancel a session, the office must be notified at least 24 hours in advance, which will allow for the scheduling of another person who may benefit from this time, or you will be responsible for the full session fee of $135. If you need to cancel within the 24 hours, you may call (225)522-2622 and leave a message, text (preferred) or email sarah@easterlycounseling.com . Responsibility for remembering appointments rests with the client.

Services Offered and Clients Served: I approach counseling from an emotionally-focused theoretical framework. This experiential and person-centered perspective holds that emotions are connected to our most essential needs. As the client, emotions, and problems are explored, rapport is built, and priorities emerge. Utilized concurrent with this framework, I incorporate the cognitive-behavioral perspective in that patterns of thoughts and actions are explored in order to better understand the clients' problems and to develop solutions. I work with clients in a variety of formats, including individually, as couples, and as families. I also conduct group therapy. I see clients of all ages and backgrounds with the exception that I do not work individually with children under five years of age.

Code of Conduct: As a Counselor, I am required by law to adhere to the Code of Conduct for practice that has been adopted by my licensing Board. A copy of the Code of Conduct is available to you upon request.

Confidentiality: Material revealed in counseling will remain strictly confidential except for 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 be shared with the client's spouse or other family member 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: If an emergency situation should arise, seek help through calling Our Lady of the Lake's COPE Team at (225) 765-8900 or (800) 864-9003 and proceed to Our Lady of the Lake Regional Medical Center. If you are out of town, dial 911 for your nearest emergency room.

Client Responsibilities: You are expected to follow billing, scheduling and office procedures. 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 you or 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: As a result of mental health counseling, you may realize that you have additional issues which may not have surfaced prior to the onset of the counseling relationship. If this occurs, please feel free to share these new concerns with me. Also, there is a possible risk in couple or family counseling. If one partner changes, an additional strain may be placed on the relationship(s) if the other(s) involved refuse to grow. Marital or family conflicts may intensify as feelings are expressed.

Telemental Health: When appropriate, I provide Teletherapy, an alternative form of counseling provided at a distance through confidential technology. I have completed 9 hours of live telehealth care training in addition to my professional qualifications as a clinician. This training covered the law and ethics and clinical skills specifically related to telehealth care. I continue to receive at least three hours of continuing education in the area of telemental health every two years. It is imperative that you sign my Telemental Counseling Consent Form before entering into telemental counseling; it is attached to my Declaration of Practices.

I HAVE READ THE DECLARATION OF PRACTICES AND PROCEDURES of Sarah Easterly, MA, LPC, CSAT and my signature below indicates my full informed consent to services provided by Sarah Easterly, MA, LPC, CSAT.

Client Signature

_____Date_____

Client Signature

_____Date_____

Counselor Signature

_____Date_____

Parent/Guardian Consent for Treatment of a Minor:

I _____, give my permission for Sarah Easterly, MA, LPC,

CSAT to conduct therapy with my _____,_____.

SARAH EASTERLY, MA, LPC, CSAT

7341 Jefferson Hwy,
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NO SECRETS POLICY FOR COUPLES AND FAMILIES

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. Thus, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During my work with a couple/family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions are a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We acknowledge by our individual signatures below, that each of us has read this policy, understand it, have had an opportunity to discuss its contents with __Sarah Easterly, MA, LPC, CSAT__ and we enter couple/family therapy in agreement with this policy.

Signature_____ Date:_____

Signature_____ Date:_____

Signature_____ Date:_____

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POLICY FOR CANCELLATIONS, NO SHOWS, AND CREDIT CARD AUTHROIZATION

It is my policy to securely store the client's credit card number for payment purposes. Credit card numbers will be securely locked and kept confidentially along with other client data. It will be used for the initial session, subsequent sessions (if desired) and to bill Missed Appointment/Late Cancellation fees. A $0.01 fee will be charged to store the card and credited back to you at the first session. Payment is due at the time of the session. Please initial below:

_____
Initial(s)

I/We agree to have my/our credit card charged for $.01 and kept on file for payments and agree to a charge of full fee ($120 per therapy hour) for appointments missed:

1) For any session not cancelled with at least 24 hour notice
2) For any appointment I/we neglect to appear ("no show")
3) For any balance owed 30 days past due. My card will be charged for the amount of the remaining balance due.

_____
Initial(s)

I understand that any card on file, whether listed below or encrypted in our software program, can be used

☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMERICAN EXPRESS		
CARD NUMBER:	SECURITY CODE:	ZIP CODE:
CARDHOLDER NAME:	EXP DATE:	
SIGNATURE:		

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COMMUNICATION ADDENDUM TO THE INFORMED CONSENT

Because cell phone or regular e-mail technologies cannot be fully assured, it is your right to determine whether communication by non-secure technologies may be permitted, whether initiated by you or your clinician. You should also know that any correspondence I receive from you and any responses that I send to you becomes a part of your legal record.

Initial all you permit (if couple, both initial):

_____ Voice & Text communication to and from client's cell phone
Initial(s)

_____ Voice & Text communication to and from clinician's cell phone
Initial(s)

_____ Messages left on client's cell or home land lines
Initial(s)

_____ Communication to and from client's e-mail
Initial(s)

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SOCIAL MEDIA POLICY

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

FOLLOWING: I share articles, posts and may publish blogs on my social media sites. I have no expectation that you as a client will follow my accounts. However, if you use an easily recognizable name and I happen to notice that you've followed me, we may briefly discuss it and its potential impact on our working relationship.

My primary concern is your privacy. You are welcome to use your own discretion in choosing whether to follow me. Note that I will not follow you back. I do not follow current or former clients on social media. My reasoning is that viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

MESSAGING: Please do not use messaging/commenting on Social Networking sites to contact me. These sites are not secure, and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone. Direct email at sarah@easterlycounseling.com is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

SEARCH ENGINES: It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

LOCATION-BASED SERVICES: If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

EMAIL: I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

CONCLUSION: Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

SARAH EASTERLY, MA, LPC, CSAT

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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 "Notice of Privacy Practices" available on our web site: www.easterlycounseling.com . A written copy of this policy is available upon request.

I understand that as a condition to my receiving treatment, Sarah Easterly, MA, LPC, CSAT may use or disclose my personally identified health information for treatment, to obtain payment for the treatment 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 Sarah Easterly, MA, LPC, CSAT to restrict how my health information is used or disclosed. Sarah Easterly, MA, LPC, CSAT does not have to agree to my request for the restriction, but if Sarah Easterly, MA, LPC, CSAT does agree, Sarah Easterly, MA, LPC, CSAT 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 Sarah Easterly, MA, LPC, CSAT 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.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

SARAH EASTERLY, MA, LPC, CSAT

7341 Jefferson Hwy,
Suite I, Baton Rouge, LA 70806
(225)522-2612

DX CODE: _____

To help with your first session, please provide the following information as completely as you can.
PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Name:_____(if a couple, please each fill out forms)
Date:_____ Birth Date:_____ Age: _____ Counselor_____
Address:_____ City/St_____ Zip:_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____ Email Address:_____
Your Employment/Job Title:_____
Person responsible for your bill, if different than above:
Name/Address:_____

ANY CHURCH MEMBERSHIP:_____
Briefly describe your spiritual life:_____

Last year of school completed: _____or 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 or how did you find us? _____
Is it ok to call your home/cell & leave message: Yes___ No___ At your work: Yes___ No___
Person to contact in case of an emergency (name/phone):_____
Please State Your Goals for Therapy:

1. _____
2. _____
3. _____

Do you have children? ____Yes ____No If yes:

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

Father's Name_____ Age:_____ or __ Deceased

Mother's Name_____Age:_____ or __Deceased

Number of Brothers:_____ Number of Sisters:_____ Birth Order: ____ of _____# of children

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, 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 for in the last 24 months:

_____

_____

_____

Primary Care Physician: _____ Phone:_____

Are you taking any prescription drugs at this time? _____Yes _____No

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

_____

_____

Additional Comments:

_____

_____

_____

_____

While you were growing up, during your first 18 years of life:

Yes No 1. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

Yes No 2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

Yes No 3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or have oral, anal, or vaginal sex with you?

Yes No 4. Did you often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

Yes No 5. Did you often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No 6. Were your parents ever separated or divorced?

Yes No 7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No 8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No 9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No 10. Did a household member go to prison?

Put a number next to any item which you experience. 1=mildly, 2=moderately, 3=severely

Emotional Concerns

____feeling anxious or uptight
____excessive worrying
____not being able to relax
____feeling panicky
____unable to calm yourself down
____dwelling on certain thoughts or images
____fearing something terrible about to happen
____avoiding certain thoughts or feelings
____having strong fears
____worrying about a nervous breakdown
____feeling out of control
____avoiding being with people
____fears of being alone or abandoned
____feeling guilty
____having nightmares
____flashbacks
____troubling or painful memories
____missing periods of time - can't remember
____trouble remembering things
____feeling numb instead of upset
____feeling detached from all or part of body
____feeling unreal, strange or foggy
____feeling depressed or sad
____being tired or lacking energy
____feeling unmotivated
____loss of interest in many things
____having trouble concentrating
____having trouble making decisions
____feeling the future looks hopeless
____feeling worthless or a failure
____being unhappy all the time
____dissatisfied with physical appearance
____feeling self critical or blaming yourself
____having negative thoughts
____crying often
____feeling empty
____withdrawing inside yourself
____thinking too much about death
____thoughts of hurting yourself
____thoughts of killing yourself
____frequent mood swings
____feeling resentful or angry
____feeling irritable or frustrated
____feeling rage
____feeling like hurting someone

Behavioral and Physical Concerns

____not having an appetite
____eating in binges
____self induced vomiting for weight control
____using laxatives for weight control
____eating too much
____eating too little
____losing weight - how much?_____
____gaining weight - how much?____
____trouble sleeping
____trouble falling asleep
____early morning awakening
____sleeping too much
____sleeping too little
____# of hours I usually sleep: _____
____lack of exercise
____not having leisure activities
____smoking cigarettes
____often spending in binges
____temper outbursts
____aggressive toward others
____impulsive reactions
____trouble finishing things
____working too hard
____using alcohol too much
____being alcoholic
____using drugs
____driving under the influence
____blackouts - after drinking
____excessive internet/phone/tv usage
___Yes ___No Have you ever felt you ought to cut down on your drinking or drug use?
___Yes ___No Have people annoyed you by criticizing your drinking or drug use?
___Yes ___No Have you ever felt bad or guilty about your drinking or drug use?
___Yes ___No Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover

Intimate Relationship Concerns

____feeling misunderstood in relationship
____not feeling close to partner
____trouble communicating with partner
____not trusting partner
____lack of respect by partner
____partner being secretive
____lack of fairness in relationship
____problems with dividing household tasks
____disagreeing about children
____lack of affection
____unsatisfactory sexual relationship
____lack of time together
____lack of shared interests
____lack of positive interaction
____lack of time with other couples
____jealousy in relationship
____frequent arguments
____trouble resolving conflict
____partner being demanding and controlling
____partner putting you down
____violent arguments
____emotional abuse in relationship
____physical abuse in relationship
____sexual abuse in relationship
____partner having alcohol or drug problem
____self or partner having an affair
____feeling uncommitted to relationship
____wanting to separate
____discussing separating or divorce
____problems with in-laws
____problems with ex-partner
____problems with step parents
____children having special problems

Sexual Concerns

____worrying about getting pregnant
____having miscarriage(s)
____choice of birth control
____having an abortion
____not able to become pregnant
____not enjoying sexual affection
____too tired to have sex
____too anxious to have sex
____feeling a lack of sexual desire
____wanting to have sex more often
____feeling neglected sexually
____feeling used sexually
____feeling unable to have orgasm
____being unable to sustain an erection
____feeling negatively about sex
____porn usage
____I think I may be a sex addict
____I think my partner may be a sex addict

When Growing Up to Present Time:

____being physically abused - by whom?
____being emotionally abused - by whom?
____being sexually abused - by whom?
____having an alcoholic parent - which?
____having a drug abusing parent - which?
____having a depressed parent - which?
____having a parent with emotional problems
____having parents separate or divorce
____close family member dying - who?
____felt neglected or unloved - by whom
____having an unhappy childhood
____having serious medical problems - what?
____having drug or alcohol problem
____frequent moves
____having learning problems - what?
____having emotional problems
____having attempted suicide - when?

Stresses During the Past Several Years:

____death of family member or friend - who?
____birth or adoption of child
____self or family member hospitalized - who?
____moved
____being harassed or assaulted
____frequent family or couple arguments
____separation/divorce
____an important relationship ending - who?
____losing or changing job
____financial trouble
____legal problems
____natural disaster
____serious or chronic illness -what:_____
____other

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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.
- 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.
- Session fees are handled in an identical fashion for teletherapy as in-person counseling.
- We need a back-up plan (eg, 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 ER:_____**
- 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.
- **Consultation:** I may deem it appropriate to consult with or coordinate your care with other professionals, but only with your written agreement.
- **Louisiana License:** I can only counsel in the state I am licensed, Louisiana. Except in an emergency, i.e. COVID-19, counseling services cannot be delivered across state lines. I must know where you are when I am performing counseling services.
- **Ethics Code:** I follow the same Louisiana Code of Conduct and adhere to its ethics as outlined in my Declaration of Practices as an LPC.

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

Limits of Liability: 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 Doxy, a HIPAA compliant teletherapy platform, and provides a Business Associate Agreement and my Patient Health Information (PHI) will be protected within the limitations of Doxy and the environment in which the services are utilized. Your PHI is stored via our EHR system, Therapy Appointment, which is an electronic healthcare system. It is designed specifically for healthcare and provides a Business Associate Agreement for HIPAA compliance. Therapy Appointment uses encryption which is point to point and federally approved. Any paper with your personal information s kept in a locked cabinet behind at least one locked door.

Records: In the event that your clinician is no longer available due to untimely death or incapacity, the Julie Alleman with Psychological Wellness Institute or Michele Louvier at Refuge 182 will be glad to assist you in providing appropriate referrals for further treatment and access to your records. They will also be responsible for destroying records after the legal time frame of storage.

Verify Identity: Anyone receiving teletherapy via videoconferencing is required to verify their identity by showing his/her picture ID during the first session. If Teletherapy is being conducted over the phone, a passphrase or number will be chosen which will be used for all future sessions. This process is in place to protect you from another person posing as you.

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.

Risk: 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.

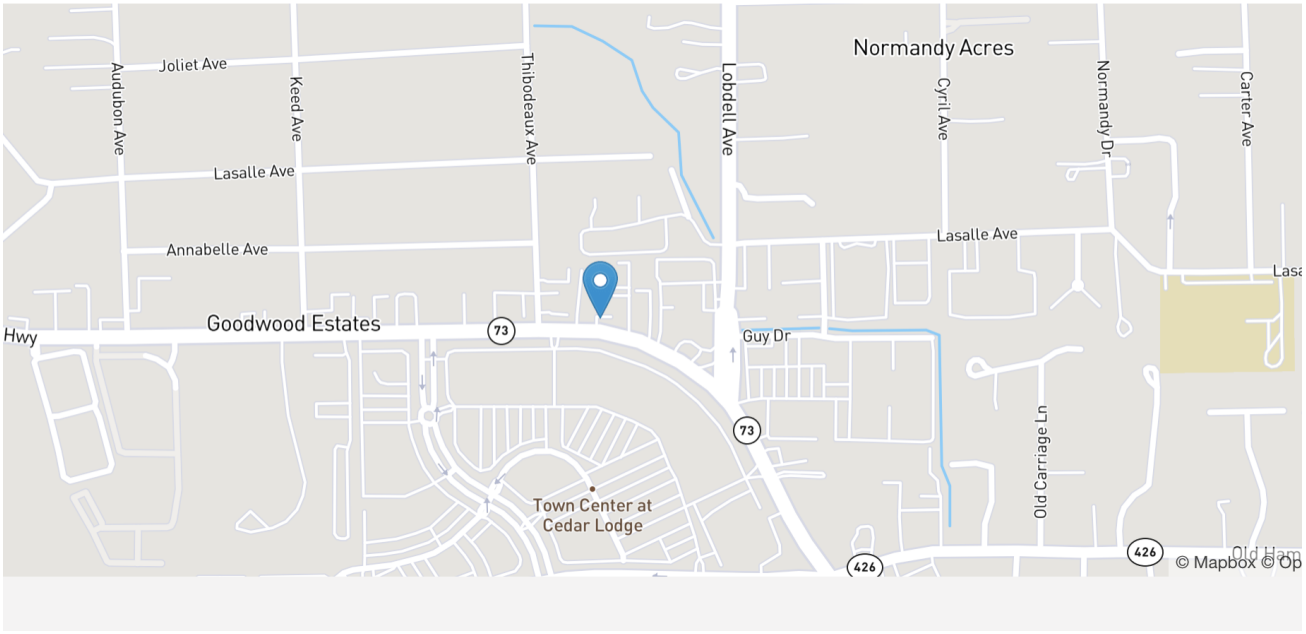
Client's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Print Name(s): _____

Counselor's Signature: _____ Date: _____

Sarah Easterly, MA, LPC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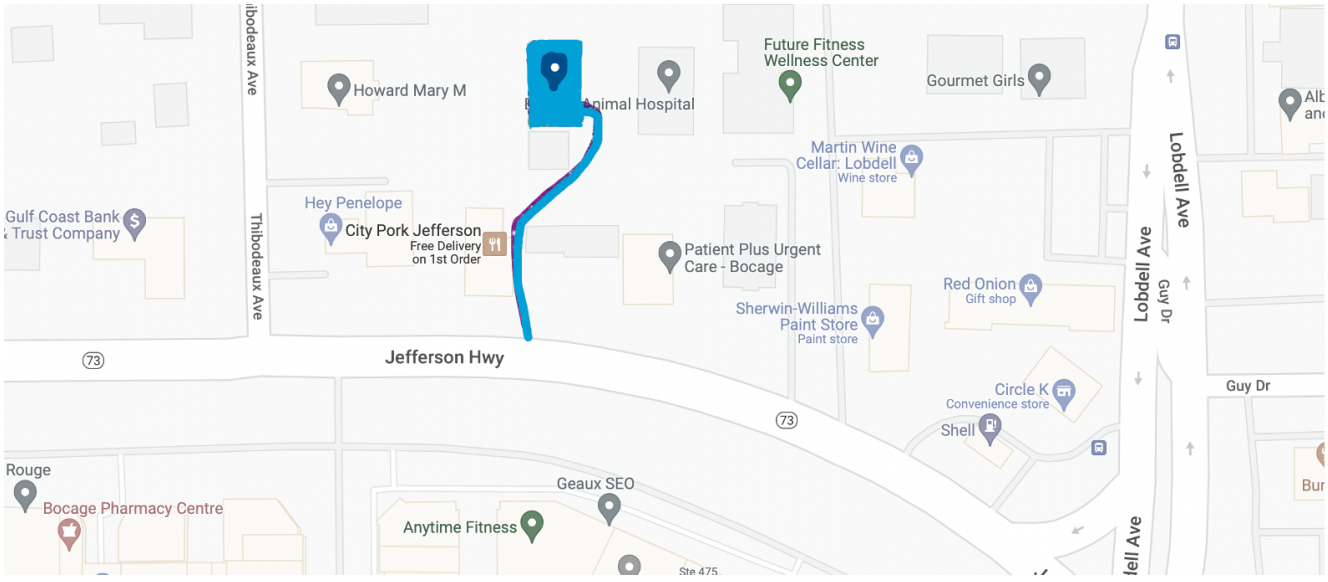
Howard Mary M
Animal Hospital
Future Fitness
Wellness Center
Gourmet Girls
Martin Wine
Cellar: Lobdell
Wine store
Hey Penelope
City Pork Jefferson
Free Delivery
on 1st Order
Gulf Coast Bank
& Trust Company
Patient Plus Urgent
Care - Bocage
Red Onion
Gift shop
Sherwin-Williams
Paint Store
Paint store
Lobdell Ave
Guy Dr
Thibodeaux Ave
73
Jefferson Hwy
Circle K
Convenience store
Shell
Guy Dr
73
Rouge
Bocage Pharmacy Centre
Geaux SEO
Anytime Fitness
Ste 475