GABRIELLE E. DUFRENE

7341 Jefferson Hwy,
Suite I, Baton Rouge, LA 70806
(225) 614 – 2833

WELCOME AND IMPORTANT INFORMATION

Thank you for choosing me as your therapist, I look forward to meeting and working with you. Below is an explanation of the things that you will need to know prior to our first session together:

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: To schedule, re – schedule, or cancel appointments please leave me a voicemail at (225) 614 – 2833. I check my voicemail daily and will get back to you as soon as possible. If you must cancel or re – schedule, I ask that you give me a 24 – 48-hour notice if possible.

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're coming as a couple, then I need both of you to fill out all the forms.

FEE AND PAYMENT: The fee per one – hour session is $40. The first evaluative session is $50. It is my policy that payment must be made at the time of service. You can pay with check, cash, Visa/Master Card, or Discover (If your card is on file) -- whichever is best for you.

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.

LIMITATIONS: Due to University policy, I am only allowed to provide services while school is in session, therefore, I will only have availability from August 22nd – December 2nd with the exceptions of Monday, September 5th (Labor Day), Thursday - Friday, October 13th - 14th (Fall Break), Wednesday – Friday, November 23rd – 25th (Thanksgiving Break). While I will not be able to provide services starting December 3rd services will resume in January (Date TBA).

Adapted from Sarah Easterly, MA, LPC, CSAT
July 2022

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 Gabrielle Dufrene and we enter couple/family therapy in agreement with this policy.

Signature: _______________________________________ Date: ___________________

Signature: _______________________________________ Date: __________________

Signature: _______________________________________ Date: __________________

Adapted from Sarah Easterly, MA, LPC, CSAT
July 2022

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

________________ Voice & Text communication to and from clinician's cell phone

________________ Communication to and from client's e-mail

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July 2022

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: ____

Date: _________________ Date of Birth: _______________ Age: _____________

Address: _____________________________________ City/State __________________________

Zip: ______________

Cell Phone: ___________________________ Alternate Phone: ____________________________

Home Church, if any: ____

Breifly describe your spiritual life: ____

Highest degree of education: _______ High school diploma ______ GED _______ Some College ______ Bachelor's Degree _______ Masters _______ Doctoral Degree

Marital Status: Single _______ Engaged ______ Married ______ Separated ______ Divorced

______ Remarried ______ Widowed

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

Spouse's name ____ Spouse's Age _______

Years married (or dating if you are not married) _______

Spouse's Employment ____

Who referred you to us or how did you find us? _______________________________________

Is it okay for us to call your home/cell and leave a message: Yes _____ No ______

Emergency Contact (Name/Phone) ____

Goals for Therapy

____

____

Adapted from Sarah Easterly, MA, LPC, CSAT
July 2022

____
____

Do you have children? _____ Yes _____ No

If so, please list their names, ages, relationship to you (biological, step, adopted, or foster), and whether they live in your home or not.

____
____
____

Father's Name ___________________________ Age _______ or Deceased

Mother's Name ___________________________ Age _______ or Deceased

Any history of drug/alcohol abuse for yourself, father, mother, or siblings? ____ Yes ____ No

If yes, please describe____

____

Any history of physical or sexual abuse to you or your siblings? ____ Yes ____ No

If yes, please describe ____

____

Do you use alcohol or nonprescription drugs? _____ Yes _____ No

If yes, describe frequency and type ____

____

Have you 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, and any psychiatric hospitalizations
____
____

Describe any major changes that have occurred to you of 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?

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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

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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

GABRIELLE E. DUFRENE

7341 Jefferson Hwy,
Suite I, Baton Rouge, LA 70806
(225) 614 – 2833

DECLARATION PRACTICES AND PROCEDURES

Qualifications: I am a student intern currently earning a Master of Science degree in Marriage, Family and Couples Counseling from Southeastern Louisiana University.

Counseling Relationship: I view 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: My primary focus is on clients seeking premarital, marital, couples, or family counseling.

Fees and Office Procedures: The fee for each one-hour individual, marital, or family session is $40. Payment for services is due at the time services are rendered. Acceptable forms of payment are cash, personal checks, and debit/credit cards. 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. If you must cancel a session, I must be notified at least 24 hours in advance, failure to do so will result in your payment of the full session $40 fee. To schedule, re – schedule, or cancel, you may leave me a voicemail at (225) 614 – 2833.

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 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.

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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: Matters discussed in counseling will remain strictly confidential excluding matters shared with my supervisor. Confidentiality may also be broken under these circumstances, in compliance with State law:

1. If the client discloses intent to harm themselves or someone else
2. If the client signs a written release of information indicating informed consent of such release
3. If there is suspicion of abuse/neglect against a minor child, elderly person (60 or older), or dependent adult
4. A court order is received demanding 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 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 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: As the client, your success is dependent on your honesty, efforts, and vulnerability. As we walk together through your counseling journey, I encourage you to speak openly to me about any suggestions or concerns that you may have throughout the therapeutic process so that I may make the appropriate changes. In the event that I feel you will be better served by another mental health professional I will aid you in the process of referral. I expect you to inform me if you are receiving services from another mental health professional. If you are receiving services from another mental health professional, I need you to grant me permission to share information with that professional for collaboration purposes.

Physical Health: I believe that physical health is just as important as mental and emotional health. If you have not already done so within the year, it is recommended that you have a physical examination performed by your primary care physician. Also, please provide me with a list of medications that you are currently taking.

Potential Counseling Risk: Please be mindful that counseling poses potential risks. Over the course of our work together, additional problems of which you were not initially aware of may surface. If you find yourself in this position, you should feel free to address any 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.

Adapted from Sarah Easterly, MA, LPC, CSAT
July 2022

I have read the Declaration of Practices and Procedures of Gabrielle Dufrene and my signature below indicates my full informed consent to services provided by Gabrielle Dufrene. I am aware that Ms. Dufrene may share information with Sarah Easterly, M.A., LPC, CSAT and Dr. Michael Leeman, Ph.D., LPC other student interns for the sole purpose of supervision toward licensure and information shared in supervision may not be used for any other purposes. I am also aware that my sessions with Gabrielle Dufrene may be audio or videotaped for the purpose of supervision.

___

Client Signature Date

___

Client Signature Date

___

Gabrielle Dufrene Date

Parent/Guardian Consent for Treatment of a Minor:

I____, give my permission for Gabrielle

Dufrene to conduct therapy with my __________________________________,

____.

Adapted from Sarah Easterly, MA, LPC, CSAT
July 2022

SOUTHEASTERN
LOUISIANA UNIVERSITY | Department of Health & Human Sciences

Permission to Audio or Video Record Form

Graduate Program in Counseling Southeastern Louisiana University

Date _____________

Counseling Student (print) ______________________________

I understand that the above-named counselor is in training in a counseling graduate program at Southeastern Louisiana University. I further understand that counseling sessions will be subject to video or audio recording and reviewed for supervisory and teaching purposes only. I understand that the university supervisor will view the sessions both in a live and recorded format in order to provide feedback for the counselor's growth. Confidentiality will be observed, and care taken to protect the identity of the counselee. Following supervisory feedback, each recording will be immediately erased.

Client's name (print) ____________________________________

Client's signature ______________________________________

Parent's signature if client is under age 17 ______________________

Graduate student counselor's signature ________________________

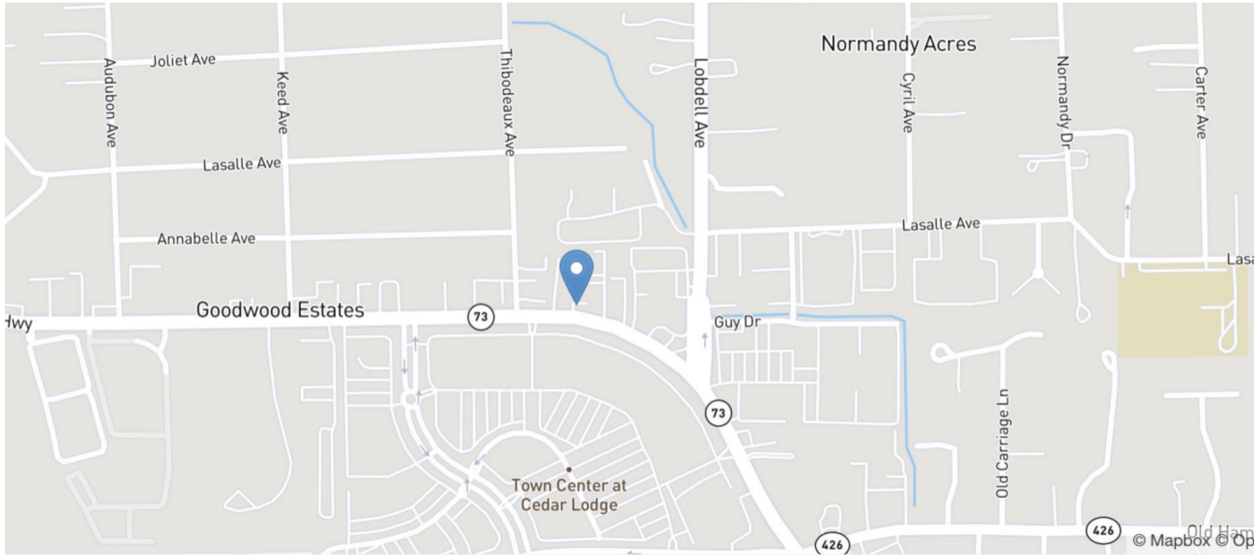
Site Supervisor's signature _________________________________

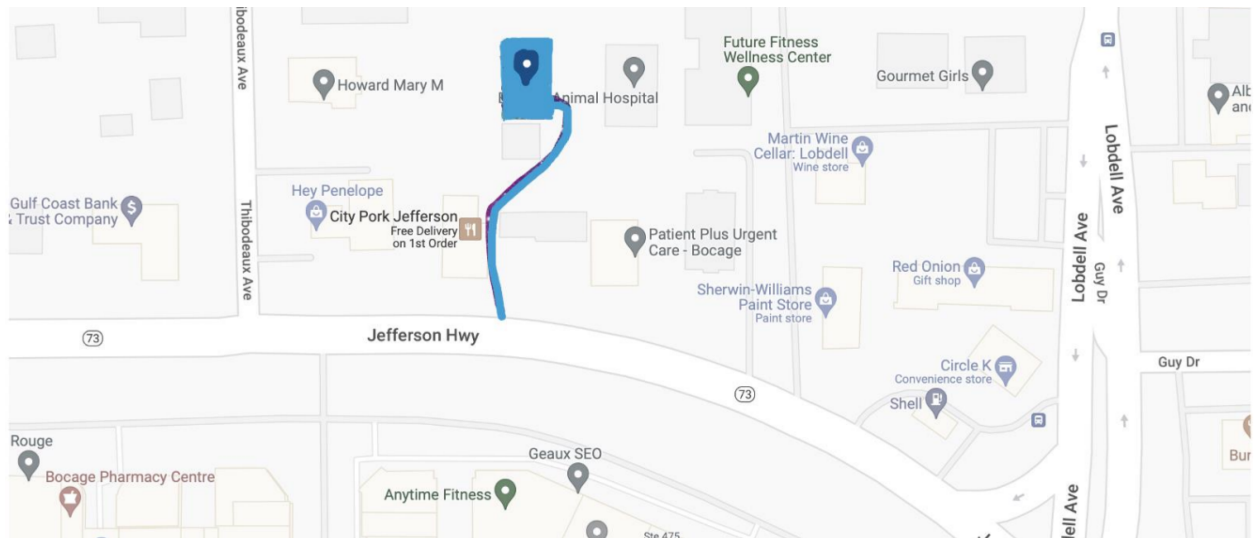
*** This form is to be filed with the client's records. ***

Revised 12/2021

Adapted from Sarah Easterly, MA, LPC, CSAT
July 2022

MAP





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