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**Qualifications:** Licensed Professional Counselor # 2654 (2001)

LICENSED PROFESSIONAL COUNSELORS BOARD OF EXAMINERS

8631 SUMMA AVENUE, BATON ROUGE, LOUISIANA 70809 TELEPHONE (225)765-2515

Master of Arts in Counseling - Louisiana Tech University - 1994.

Bachelor of Science in Psychology – Louisiana State University in Shreveport - 1991

**The Counseling Relationship:** The counseling relationship involves a process in which you and I come to an understanding of and trust our roles. We will need to work together to explore and define the issues that you believe will be the focus of our work. You will also need to be open to the possibility that what you are currently concerned with, may be symptoms of other issue(s) and be willing to work toward understanding and working through these issues as well.

**Areas of Expertise:** Since 1983, I have worked with adolescents, adults, and families experiencing a wide range of issues, from mental health, substance abuse, and other relationship/individual concerns. My career has afforded me the opportunity to have worked in a variety of settings, including group homes, residential treatment, outpatient substance abuse and mental health counseling as well as private practice mental health counseling. I have worked in coordination with the local court systems, as well as other community agencies/organizations as necessary to effectively support those served. Over the past several years, I’ve also had the opportunity to work with individuals serving cross-culturally, from over 40 different countries representing 12 different Nationalities.

**Member Fees and Length of Counseling:** Members of Broadmoor Baptist Church will receive 6 free counseling sessions per calendar year. Members will be charged $20 per session for each additional session for the remainder of the calendar year. \*Ministers and those working Cross-Culturally are not charged for services.

**Non-Member Fees and/or Insurance**

**Fees** applicable to non-members are to be paid at the time of service. Check or cash only. Fees are based on total gross household income:

Up to 20k – $35 per session

20k – 30k – $45 per session

30k – 40k – $55 per session

40k – 55k – $65 per session

55k – 70k – $75 per session

Over 70k - $85 per session

**Insurance.** I am also on several insurance panels as an “In-Network” provider. You would be responsible for checking with your insurance provider to determine if I am “in-network” as a provider under your specific insurance plan. If it is determined that I am in network, and you have met your deductible or annual out of pocket requirements, then we will accept your co-pay (per your health plan) and assignment of payment through your insurance provider.

My services are by appointment only. Because the appointment is reserved for you, failure to provide 24 hour notice of cancellation generally means that some other person is not able to use that appointment time.

The length of the counseling session is approximately 45 – 50 minutes. We will mutually agree on the number of sessions to be provided in counseling following a thorough assessment to determine the extent of the issues presented and the goal(s) to be achieved in counseling.

I will strive to ensure that my availability for your counseling needs is consistent, continuous, and meets your needs.

**Services Offered and Clients Served:** My primary counseling approach is Cognitive-Behavioral, meaning essentially that we will explore patterns of thoughts, beliefs and actions in order to better understand your concerns and to develop effective solutions. For those individuals professing specific Christian religious conviction / belief as a foundation for their relationships, lives, day to day decisions / interactions, I will explore these beliefs’ impact, influence not only as they relate to the presenting concerns but also possible solutions. For individuals who do not share a Christian worldview or perspective, I will abide by the LPC Code of Conduct, being aware of my own values, attitudes, beliefs, and behaviors and will avoid imposing values that are inconsistent with the client’s counseling goals.

**Teletherapy**

I am required by the Louisiana LPC board to provide you, the client, with certain basic information regarding teletherapy. Please review the attached Teletherapy Addendum to this Declaration of Practices and Procedures. This Teletherapy Declaration & Informed Consent addendum describes certain important aspects of therapy unique to Teletherapy. I am providing you this information for your review and agreement. Please read it carefully and discuss any questions you have before signing below.

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

**Privileged Communications:**

Information revealed in counseling will remain strictly confidential except under the following circumstances:

1.) The client signs a written release of information indicating informed consent for such release.

2.) The client expresses intent to harm him/herself of someone else.

3.) There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (65 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 at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprize clients of all mandated disclosures as conceivable. 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 members only with the client’s permission. Any material obtained from a minor client may be shared with that client’s parents or guardian.

The Thomas C. Pennell Christian Counseling Center is a part of Broadmoor Baptist Church and while we provide a private entrance to the center, there may be times when you need to enter the center through the main entrance of the church. On those occasions, you do not need to sign in at the front reception desk.

**Emergency Situations:** If a life-threatening emergency should arise, you will be instructed to obtain assistance through the nearest hospital emergency room and/or call for assistance via 911. I will secure and notify you of the assistance of a backup board approved counselor or supervisor to assist you in the event of my unavailability.

**Client Responsibilities:** You will be a full partner in the counseling process. Your honesty and effort are essential to success. If as we work together you have suggestions or concerns about the progress you are making, I expect you to share these with me so that we can work together to determine what, if any, adjustments need to be made. If during the course of this counseling experience, we determine that you would be better served by another mental health provider, I will assist you with the transition. If you are currently receiving services from another mental health professional, you will need to inform me of this prior to our beginning this professional relationship and grant me permission to share information with this professional so that we may coordinate our services on your behalf.

**Homework.** Implementing what you’ve learned during our counseling sessions, is an important component of the counseling process. You will be expected to complete activities between counseling sessions that allow for greater benefit and opportunity for change discussed during our counseling sessions.

**Physical Health:** Physical health is an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, I will recommend that you do so. I will also require that you provide me with a list of all medications that you are currently taking or have been prescribed in the past year.

**Potential Counseling Risks:** You need to be aware that your involvement in the counseling process poses potential risks. As we work together defining the issues and working to resolve them, additional problems may surface, some of which you were not initially aware. Changes you make as a result of counseling can result in changes in your relationship patterns and possibly produce unpredicted / unanticipated and possibly adverse reactions from other people in your family /social network. If this occurs, please feel free to let me know so that we can determine how best to proceed.

**Professional Services Contract:**

(Print Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ herein referred to as the “Client”, has this day retained Russell Semon, LPC-S, of the Thomas C. Pennell Christian Counseling Center to provide counseling. I have read and understand the above information.

It is expressly understood that Russell Semon, LPC-S, has not issued and will not issue any guarantee of cure, treatment effects, or number of sessions necessary.

If is further understood that Russell Semon, LPC-S, shall be obligated to maintain a reasonable standard of care for practicing Licensed Professional Counselors. Neither Russell Semon, LPC-S, nor the Thomas C. Pennell Christian Counseling Center shall be held to any special or elevated standard of care.

We the undersigned LPC and Client, have read, discussed together, and fully understand this agreement and the stated policies. We agree to honor these policies and will respect one another’s views and differences during the counseling process. This agreement is entered into voluntarily by the Client with competency. Understanding, and knowledge of consequence.

Client’s Signature: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor’s Signature: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Russell Semon, MA, LPC-S

**For Minor(s) Only:**

I,(Parent / Guardian)\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_ , give permission for Russell Semon, MA, LPC-S to conduct counseling with my (relationship to minor) \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

Name of Minor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Minor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_

Parent / Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_

**TELETHERAPY DECLARATION AND INFORMED CONSENT ADDENDUM**

Please read the following carefully and discuss any questions you have before signing below.

By signing this form, you are not making a commitment to continue teletherapy therapy as a

permanent modality, but you will continue to have that option should you and Russell Semon, MA LPC-S

both agree that it is in your best interest.

**QUALIFICATIONS OF CLINICIAN**

I have completed 12.5 Continuing Education Hours of 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 will continue to receive at least three hours of continuing

education in the area of tele-mental health care every two years. All teletherapy sessions will be

conducted through an online video / audio platform which is encrypted to the federal standard.

**Scheduling and Structure of Teletherapy**

Counseling sessions will be scheduled in 50 minute increments, unless you and I agree

on a different time schedule. Each subsequent session will scheduled at the end of the current session,

unless otherwise agreed upon. The structure of sessions will be dependent on the treatment

plan and interventions being used.

**Ethical and Legal Rights Related to Teletherapy**

I will not be conducting Teletherapy in any other state than Louisiana unless I specifically seek and

obtain licensure in the other state. It is important for you, as a client, to realize if you should relocate to

another state, my ability to continue to conduct teletherapy would be dependent on my decision

whether or not to seek licensure in the state to which you are relocated.

**RESPONSIBILITIES OF THE CLIENT**

All clients should:

• Be appropriately dressed during sessions.

• Avoid using alcohol, drugs, or other mind-altering substances prior to session.

• Be located in a safe and private area appropriate for a teletherapy sessions.

• Make every attempt to be in a location with stable internet capability.

Clients should NOT:

• Record sessions unless first obtaining my permission.

• Have anyone else in the room unless you first discuss it with me.

• Conduct other activities while in session (such as texting, driving, etc.).

\* If the client is a minor, a parent or guardian must be present at the location/building of the

teletherapy session (unless otherwise agreed upon with the therapist).

**POTENTIAL COUNSELING RISKS**

When using technology to communicate on any level, there are some important risk factors of

which to be aware. It is possible that information might be intercepted, forwarded, stored, sent

out, or even changed from its original state. It is also possible that the security of the device

used may be compromised. Best practice efforts are made to protect the security and overall

privacy of all electronic communications with you. However, complete security of this

information is not possible. Using methods of electronic communication with us outside of our

recommendations creates a reasonable possibility that a third party may be able to intercept

that communication. It is your responsibility to review the privacy sections and agreement forms

of any application and technology you use. Please remember that depending on the device

being used, others within your circle (i.e. family, friends, employers, & co-workers) and those not

in your circle (i.e. criminals, scam artists) may have access to your device. Reviewing the

privacy sections for your devices is essential. Please contact me with any questions that you

may have on privacy measures.

**POTENTIAL LIMITATIONS OF TELETHERAPY**

Teletherapy is an alternate form of counseling and should not be viewed as a substitution for

taking medication that has previously been prescribed by a medical doctor.

It has possible benefits and limitations. By signing this document, you agree that you

understand that:

• Teletherapy may not be appropriate if you are having a crisis, acute psychosis, or

suicidal/homicidal thoughts.

• Misunderstandings may occur due to a lack of visual and/or audio cues.

• Disruptions in the service and quality of the technology used may occur.

• Fees charged will be consistent with your insurance carrier requirements for Teletherapy

* Insurance. Fees charged will be consistent with your insurance carrier policies. (Check with your insurance carrier) Please check with them ahead of time to be sure your policy covers tele-mental health counseling.

**EMERGENCY SITUATIONS**

The following items are important and necessary for your safety. I will need this information in order to

get you help in the case of an emergency. By signing this consent to treatment form you are

acknowledging that you have read, understand, and agree to the

following:

• The client will inform Russell Semon, MA, LPC-S of the physical location where he/she is, and

will utilize consistently while participating in sessions and will inform Dr. Doe if this location

changes.

• In the first teletherapy session, your will provide the name of a person Russell Semon, MA,

LPC-S is allowed to contact in the case she believes you are at risk. You will be asked to sign a

release of information for this contact.

• In the first teletherapy session, you will provide information about the make, model, color,

And tag number of your automobile.

• In each session you will provide information about the nearest emergency room or

emergency services (such as fire station, police station, if there is not an emergency room

nearby.)

• Depending on the assessment of risk and in the event of an emergency, you or Russell Semon,

MA, LPC-S may be required to verify that the emergency contact person is able and willing to go

to the client’s location and, if that person deems necessary, call 911 and/or transport the client

to a hospital. In addition to this, Russell Semon, MA., LPC-S may assess, and therefore require

that you, the client create a safe environment at your location during the entire time of

treatment. If an assessment is made for the need of a “safe environment” a plan for this safe

environment will be developed at the time of need and made clear by

Russell Semon, MA, LPC-S.

• In the case of a need to speak to me between sessions, please call, or text, and leave a

message. I do not provide emergency services on a 24-hour basis. If your emergency is after

hours, please contact your nearest emergency room. Typically contact between sessions is

limited to arranging for appointments.

• If you are in need of the services of other professionals, I am happy to consult and coordinate

with them. Clients should not routinely be meeting with more than one counselor, unless the

two counselors have agreed to coordinate your care.

**BACKUP PLAN IN CASE OF TECHNOLOGY FAILURE**

A phone is the most reliable backup option in case of technological failure. It is, therefore, highly

recommended that you always have a phone at your disposal and that I know your phone number. If

disconnection from a video conference occurs, end the session and I will attempt to restart the session.

If reconnection does not occur within five minutes, call me at the contact number I have provided. If,

within 5 minutes, I do not hear from you, you agree (unless otherwise requested) that I can call the

provided phone number.

**CONSENT TO TELETHERAPY TREATMENT**

I have read this Declaration of Telehealth Policies and Procedures and my signature below indicates my

full informed consent to services provided by Russell Semon, MA, LPC via teletherapy treatment.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Clinician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Parental Authorization for Minors I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission for

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (clinician’s name) to conduct counseling with my (relationship),

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (name of minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Options for recording your signature:

● You may sign this document while I am watching via video; or

● You may scan the signature page and send it via text to me; or

● You may snap a picture and send it via text to me;

● You may mail your signed document, sending it to me at the address at the top of this

document.)