



614 Esplanade Street
Lake Charles, LA 70607
Office (337) 478-1411 • Fax (337) 562-1489

Declaration of Practices and Procedures Statement

Julie Christman, M.A., PLPC

The Counseling Relationship

The counseling relationship is a unique one. Though not a personal or social relationship, it is a meaningful relationship that can and should facilitate growth and self-understanding through openness and honesty in a safe and trusting environment. As a result of mental health counseling, the client may realize that he/she has issues which may not have surfaced prior to the onset of the counseling relationship. Counseling does not ensure that all personal issues will be resolved and at times, may elicit uncomfortable emotions, especially regarding interpersonal relationships. I use a variety of counseling theories and techniques, but I mainly adhere to cognitive and behavioral therapies. Clients must make their own decisions regarding life events, for example, such things as deciding to marry, separate, divorce, reconcile, etc. I will help you through identifying and exploring the possibilities and consequences of decisions, but my Code of Conduct/Ethics prohibits me from advising you to make specific decisions.

Professional Qualifications

S.S. degree, Psychology, University of New Orleans, 1999

B.A degree , General Business, University of New Orleans, 1992

M.A. degree, Counseling Psychology, McNeese State University, 2015

I am currently a Provisional Licensed Professional Counselor (#6495), completing my hours requirements for a License to practice counseling in the state of Louisiana. I have experience in a wide range of issues with clients of all ages. If any concerns questions, or problems arise and you do not feel that I can adequately resolve them, please feel free to contact my Site supervisor, Brenda Roberts, EdD, LPG, LMFT at 337-562-1411.

Confidentiality

I will keep confidential anything you say to me in counseling except under the following circumstances in accordance with state law:

- A. As a PLPC, I am required to discuss my clients with my supervisor. Additionally, I participate in group clinical staff meetings with my counseling colleagues in order to best serve the needs of my clients.
- B. If I determine that you are a danger to yourself or others.

- C. If abuse or neglect of any sort is suspected against a child, dependent adult, or an elderly adult (60 years or older).
- D. If I am ordered by a court of law to disclose information.
- E. If you direct me (by written consent) to release information concerning your sessions to someone else.
- F. Child custody cases may lead to court-ordered release of information without your consent.
- G. In the event of Marriage/Family counseling, material discussed with one individual in the private session will not be disclosed to other couple/family members without prior written consent from the individual client. In the event of counseling minors, any information obtained can be released to the parent/guardian until that minor reaches the age of 18.

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.

Code of Conduct

I am required by law to adhere to the Code of Conduct for practice that has been adopted by the Licensed Professional Counselor (L.P.C.) Board of Examiners. A copy of this code is available to you upon request or can be found at www.lpcboard.org. Should you wish to file a disciplinary complaint regarding my practice as a PLPC, you may contact the Louisiana LPC Board of Examiners.

Office Hours and Emergencies

Appointments are usually scheduled between 8:00 a.m. and 6:00 p.m. Monday through Friday, at an agreed upon time convenient to the client and counselor. Each appointment lasts approximately fifty (50) minutes. If you are unable to keep your scheduled appointment, please notify me at least twenty-four (24) hours in advance. Messages can be left with the front office. There is a \$60 charge for a missed appointment that is not canceled 24 hours in advance.

In the event of an emergency, please contact your local hospital emergency room facility (such as Lake Charles Memorial 337-475-3036) or by calling 911. If you feel that an emergency situation may arise, please let me know as soon as possible.

Fee Policy

The fee is \$75 per session. No insurances are accepted at this time. As a PLPC, I may not accept payment for services directly.

Client Responsibilities:

- Follow the appointment scheduling procedures.
- Make an invested effort into the counseling process.
- Work toward establishing goals, including completion of assignments. My effectiveness in assisting you is dependent on your level of honesty and effort.
- Terminate one counseling relationship before beginning another. If you are seeing another mental health professional, permission must be granted from the first counselor for the second counselor to see the same client. If it develops that you

Client Name: _____

would be better served by another mental health provider, I will help you with the referral process.

Physical Health

It is suggested that you have a complete physical examination within the past year. As intake data is collected you will be asked to identify your physician, any medications you are currently taking, and any side effects you may be experiencing.

Potential Counseling Risks

The client should be aware that therapy poses potential risks. In the course of working together additional problems may surface to which the client was initially unaware. If this occurs the client should feel free to share these new concerns with me. As a result of therapy, there may be changes in relationship patterns that produce unpredicted or adverse responses from other people in the client's social system. Studies suggest that therapy involving only one spouse can lead to the dissolution of the marriage instead of improving it. Please feel free to address these concerns.

Agreement

Please sign and date this form to indicate that you have read and understand Julie Christman's Declaration Statement and that you have been offered the opportunity to discuss and clarify any questions you have relating to the policy and/or the counseling relationship.

Client Signature _____ Date _____ Print Name _____

Julie Christman, M.A., PLPC Signature _____ Date _____ Print Name _____

Brenda Roberts, EdD, LPC, LMFT, Site Supervisor Signature _____ Date _____ Print Name _____

Parental Authorization Section for Minor Clients

I, _____, give permission for Julie Christman to conduct counseling with my _____ (relationship).

Name of minor client. _____

Signature _____ Date _____

Client Name: _____