Tracy A. Burch
Licensed Professional Counselor
7330 Fern Avenue, Suite 404
Shreveport, LA 71105
(318) 797-0084

DECLARATION OF PRACTICES AND PROCEDURES

Counseling techniques vary and each counselor employs his or her own personal methods. Therefore, this declaration is designed to inform you of my therapeutic philosophy and qualifications so that you are able to make an informed decision regarding my approach to counseling.

Qualifications: I received my Master of Science in Counseling Psychology from Louisiana State University in Shreveport in December, 2007. I am a Licensed Professional Counselor, LPC# 4085, and I am registered with the LPC Board of Examiners which is located at 8631 Summa Avenue, Baton Rouge, LA 70809, ph. (225)765-2515.

Counseling Relationship: I believe that the counseling relationship must include trust, honesty, and mutual respect between all involved parties in order to be effective. I seek to aid clients in identifying problems in their lives and setting clear goals for improvement. Through the therapeutic process, I believe that clients will be able to achieve positive changes in their lives. Clients must make their own decisions regarding life circumstances. As part of the therapy process, I will assist clients in examining the consequences of decisions, but my Code of Ethics does not allow me to advise a specific decision. Our counseling relationship will be strictly professional and will not become personal at any time.

Areas of Expertise: I work primarily with adults who are dealing with stressors in their lives, relationships, families, and workplaces. I have experience working with individuals dealing with crisis, depression and other mood disorders, marital stress, sexuality and sexual identity, grief and trauma, and recovery from addiction.

Fee Scales: The standard fee for individual services is $100 per 50-minute session, and all fees, (including co-payments or payments towards deductibles) are payable in advance of each session. I accept some private insurance, and clients must supply my office with information regarding deductibles, co-insurance and co-pays. **The fee for a missed appointment is $100, and can be avoided by cancelling the appointment 24 hours in advance**. I do not participate in litigation or other legal or court-related matters. If you believe your mental or emotional health may be at issue in such matters, please advise me immediately and I will assist you in finding another counselor.

Services Offered and Clients Served: My approach to counseling is primarily systemic, cognitive behavioral and solution-focused. I believe that thoughts underlie problems with emotions and behaviors, and that identification of problem thinking and potential solutions is crucial to making lasting positive changes. I also believe that individuals operate within larger systems, including families and workplaces, and that attention to these systems is necessary in dealing with issues of mental health. Further, I believe in a mind-body-psyche connection that allows a person to function fully as a healthy individual. I provide therapy for individuals only.

Code of Conduct: As a Licensed Professional Counselor, I am required to adhere to an ethical Code of Conduct established by the Louisiana Licensing Board. A copy of that code is available upon request.

Privileged Communications: Anything revealed in either family or individual counseling sessions will remain strictly confidential between you, the client, and me, except for the following situations in accordance with the 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 or neglect against a minor child, elderly person (age 60 or older), or dependent adult.
4) Court order directs the disclosure of such information.

Information gathered from a client can be shared with a family member or healthcare providers when an "Authorization to Release or Obtain Health Information" is signed by the client. Further questions concerning the issue of confidentiality and law may be addressed at any time the client wishes.

Emergency Situation: Should an emergency arise, you may seek help by calling Willis-Knighton Institute for Behavioral Medicine at 212-5200 for 24-hour assistance, or through the nearest emergency room or by calling 911.

Client Responsibilities: Your active participation in counseling is essential. Your honesty and commitment to the therapeutic process will determine your success in therapy. I encourage your suggestions and am committed to tailoring a treatment and continuing care plan that fits each individual. You are responsible for remaining compliant with medications and all physician orders and discussing any problems you are experiencing during our counseling relationship. You are also expected to disclose past treatment history and allow me to communicate with health care providers on your behalf. Regardless of whether you choose to accept my services as a Licensed Professional Counselor, I will make referrals for your continued care. 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 is an important factor in emotional well-being. If you have not had a physical examination in the last year, it is recommended that you do so. Also, please share any health concerns, including all medications that you are currently taking, with me.

Potential Risk in Counseling: The counseling process does contain potential risks. As the therapeutic process unfolds, additional problems and issues may arise that were not originally discussed. If this does occur, please share your new concerns with me. Counseling is a dynamic process and we can never be assured of exactly what it will entail. However, we can take steps together to handle those situations as comfortably as possible.

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I have read and understood the above information.

Client Signature:_____ Date: _____

Counselor Signature: _____ Date: _____

FOR MINOR PATIENTS, THE FOLLOWING SIGNATURES ARE REQUIRED

Client Name _____ Date:_____

Parent/Guardian Signature_____ Relationship to Client _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of your therapy evaluation and plan of treatment will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Healthcare operations. Your health information may be used or disclosed in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Abuse or Neglect. Your health information may be disclosed to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointments. Your health information will be used to schedule appointments and verify your insurance benefits.

Information about treatment. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest.

Marketing Health Related Services/Fundraising. We will not use your health information without your written consent.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information, you may submit a written revocation of authorization. However, our decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of you decision.

Individual Rights

You have rights under the federal privacy standards. These include the right:

- To receive confidential communications concerning your medical conditions and treatment
- To request restrictions on the use and disclosure of your protected health information
- To inspect and copy your protected health information
- To amend or submit corrections to your protected health information
- To receive an accounting of how and to whom your protected health information has been disclosed
- To receive a printed copy of this notice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy practices that are outlined in this notice.

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected heath information be submitted in writing. You may obtain a form request to access your records by notifying me.

Complaints

If you would like to submit a comment or complaint about these privacy practices or if you believe that your privacy rights have been violated, you should bring this matter to my attention immediately, either in person or in writing to the address above. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective on or after April 14, 2003 and will remain in effect until replaced.

Tracy A. Burch
Licensed Professional Counselor

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I HAVE RECEIVED A COPY OF the Notice of Privacy Practices for Tracy A. Burch, LPC.

_____
Name of Client/Representative

_____
Signature

_____
Date

_____
Relationship of Client to Representative
(required if client is a minor child or adult who is unable to sign)

Tracy A. Burch
Licensed Professional Counselor

MISSED APPOINTMENT POLICY

When you book an appointment with me, that time is set aside for you and only you. For this reason, if you are unable to keep your appointment, I ask that you give me at least 24 hours notice so that I may offer that time to another client.

If you do not provide me with at least 24 hours notice, you will be responsible for paying my Missed Appointment Fee **in the amount of $100.00**. Please understand that HEALTH INSURANCE DOES NOT PAY FOR MISSED APPOINTMENTS. This fee is your sole responsibility.

By your signature below, you agree to the terms of this Missed Appointment Policy.

_____ _____

Client Date