Declaration of Practices and Procedures
Kayley Armstrong, M.S., PLPC, PLMFT
Granberry Counseling Center
7200 Desiard Street Monroe, LA 71203
Phone 318-953-6939

Qualifications:

Master of Science degree in Marriage and Family Counseling/Therapy from Harding University in 2022

Provisional Licensed Professional Counselor (PLPC) #PLC9521
Provisional Licensed Marriage and Family Therapist (PLMFT) #PLM1497
Louisiana LPC Board of Examiners
11410 Lake Sherwood Ave. North Suite A
Baton Rouge, LA 70816
(225) 295-8444

LPC Board of Examiners has approved Kathy Eichelberger, D.Min, LPC-S (#4310) as my LPC Board Approved Supervisor
LPC Board of Examiners has approved Emily Jones, Ph.D., LMFT-S, LPC-S (#5327, #1207) as my LMFT Board Approved Supervisor.

Counseling Relationship/Therapeutic Process: Individual, marriage, or family therapy, is a learning process that seeks for the persons involved to better understand themselves and others, as well as the interactions that occur among the participants and significant others. Additional goals include achieving enhanced functioning as an individual, couple, or family, so that healthy interactions are established, and greater satisfaction is attained. 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. Goals for therapy are always established through collaboration with the client(s).

Areas of Focus: I provide therapy for individuals, couples, and families. I work with children, teenagers, and adults. I work with problems of childhood and parenthood, marital difficulties, trauma and life difficulties that may relate to disturbances in family relationships. I have experience in substance abuse counseling, treating clients with co-occurring mental health disorders, working with clients with antisocial personality disorder, and experience helping children and adults with exceptionalities or special needs.

Confidentiality: Material revealed in counseling will remain strictly confidential except for material shared with my LPC Board-Approved Supervisor and 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 themselves or someone else. 3. There is reasonable suspicion of abuse or 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, couple, or family counseling, material obtained from an adult client individually may be shared with the client's spouse/partner or other family members only with the client's written permission. Any material obtained from a minor client may be shared with the client's parent or guardian. As a PLPC, I may be required to audio or videotape our sessions. These will only be shared with my LPC Board-Approved Supervisor or other PLPCs and may only be used for the purpose of supervision towards licensure. To be an ethically responsible PLPC, it is important for me to consult with other professionals from time to time. As such, it is my practice to meet with a "peer consultation" group. This practice is encouraged by my Code of Conduct. No identifying information is given during peer consultations.

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.

Code of Conduct: As a PLPC, I am required by law to adhere to the Code of Conduct that has been adopted by my licensing board, the Louisiana LPC Board of Examiners. A copy of the Code of Conduct is available to you upon request. A copy of this code is available upon request.

Client Responsibilities: You 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 ask you to share these with me so that we can make the necessary adjustments. If you are currently receiving services from another mental health professional, I ask 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. Clients must make their own decisions regarding such things as marriage, separation, divorce, reconciliation, and how to set up custody and visitation. That is, I will help you think through the possibilities and consequences of decisions, but my Code of Ethics does not allow me to advise you to make a specific decision. Clients who may wish to terminate the counseling relationship agree to first meet with this therapist before making a final decision.

Fees and Length of Therapy: It is difficult to predict how many sessions will be required for therapy to be maximally effective. I will better be able to discuss the probable number of sessions after we have explored and gained insight into your situation. The fee for services is $90 for a 60 minute session but is adjustable based on the client's income. Payment for services is due at the time of visit. Payments can be made on-line directly to Granberry Counseling Centers at granberrycounseling.org

Potential Counseling Risks: The client should be aware that counseling poses potential risks. While working together, additional problems may surface of which you were not initially aware. If this occurs, you should feel free to share these new concerns with me. The risks may include the experience of intense and unwanted feelings. Please remember that these feelings may be natural and normal and are an important part of the therapy process. Changes in relationship patterns that may result from family therapy may produce unpredicted and/or possibly adverse responses from other people in the client's social system. Often, as a result of therapy, major life decisions are made including: choices to reconcile or separate from other family members, changes in employment settings, etc. As your therapist, I will be happy and available to discuss any of your concerns, problems, or possible negative side effects of our work together.

Teletherapy: 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 Kayley Armstrong both agree that it is in your best interest. I have completed teletherapy training required by the LA Board of Examiners. All teletherapy sessions will be conducted through Doxy.me which is encrypted to the federal standard. I will not be conducting Teletherapy in any state other than Louisiana. It is important for you, as a client, to realize if you should relocate to another state, I will not be able to continue teletherapy with you.

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).

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.

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.

The following items are important and necessary for your safety. The clinician will need this information in order to get you help in 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 me of the physical location where he/she is and will utilize consistently while participating in sessions and will inform me if this location changes.
• In the first teletherapy session, you will provide the name of a person I am allowed to contact in case I believe 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 I 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, I 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 me.
• 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 need 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.

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.

After-Hours/Emergency Situations: When I or the receptionist (318-345-8200) is unavailable to answer calls after normal office hours, you may leave a message at 318-953-6939, and I will return your call as soon as possible. In an emergency, when an immediate response is necessary you may seek help through hospital emergency facilities or by calling 9-1-1. The suicide prevention hotline number is 988. Glenwood Regional Medical Center can be reached at (318) 329-4525 for any mental health or psychiatric emergencies.

Please Ask Questions: You may have questions about me, my qualifications, or anything not addressed in the previous paragraphs. It is your right to have a complete explanation for any of your questions at any time. Please exercise this right.

Professional Services Contract

I have read the Statement of Practices and Procedures of Kayley Armstrong, M.S., PLPC, PLMFT and my signature below indicates my full informed consent to services provided by Kayley Armstrong, M.S., PLPC, PLMFT. I am aware that Mrs. Armstrong may share information with Kathy Eichelberger, D.Min, LPC-S or Emily Jones, Ph.D., LMFT-S, LPC-S and other PLPCs/PLMFTs for the sole purpose of supervision toward LPC/LMFT licensure and information shared in supervision may not be used for any other purposes. I am also aware that my sessions with Kayley Armstrong, M.S., PLPC, PLMFT may be audio or videotaped for the purpose of supervision.

The Client agrees that all fees shall be due and paid at the time of treatment and the payments in arrears over two sessions will result in the cessation of therapy until the balance is made current. We, the undersigned therapist and client, have read, discussed together, and fully understand this agreement and the stated policies. We agree to honor these policies, including the commitment to negotiate and mediate as stated above, and will respect one another's views and differences in their outworking. This agreement is entered into voluntarily by the Client with competency and understanding and knowledge of the consequence.

_____

Client Signature Date

_____

Kayley Armstrong, M.S., PLPC, PLMFT

Date

Parent/Guardian Consent for Treatment of a Minor: I, _____, give my permission for Kayley Armstrong, M.S., PLPC, PLMFT to conduct therapy with my _____, _____. (Relationship, Name of minor)

_____

Signature of parent or legal guardian Date

_____

Board Approved Supervisor