

Declaration of Practices and Procedures
Kayley Armstrong, M.S., LPC, LMFT
Granberry Counseling Center
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Phone 318-953-6939

Qualifications: I earned a Master of Science degree in Marriage and Family Counseling/Therapy from Harding University in 2022. I am a Licensed Professional Counselor (LPC) #9521 and Licensed Marriage and Family Therapist (LMFT) #MFT1497 by the Louisiana LPC Board of Examiners located at 11410 Lake Sherwood Ave. North, Suite A, Baton Rouge, LA 70816 (phone 225-295-8444).

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). The length of counseling varies from person-to-person and from situation-to-situation. If you are benefiting from counseling, I encourage you to continue attending sessions. Counseling is voluntary and you may stop at any time. If you feel that you are no longer benefiting from counseling or would like to stop our sessions, please feel free to discuss this with me so we can ensure that you have any referrals or resources you need. Although counseling is an extremely personal experience, it is important to realize that our relationship is a professional rather than a personal one. That means that our time together will be limited to the scheduled sessions that you have with me.

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 completed Eye Movement Desensitization and Reprocessing (EMDR) therapy basic training, and I utilize Trust-Based Relational Intervention (TBRI) concepts. I have experience in substance abuse counseling and experience helping children and adults with exceptionalities or special needs.

Confidentiality: Material revealed in counseling will remain strictly confidential except for material shared 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. To be an ethically responsible LPC/LMFT, it is important for me to consult with other professionals from time to time. 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 LPC/LMFT, I am required by law to adhere to the Codes 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.

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

Physical Health: Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. Also, please provide me with a list of any medications that you are currently taking.

Fees and Insurance: Granberry Counseling Centers accepts some private insurances. Any fees not covered by the client's insurance are the client's responsibility and are paid on-line directly to Granberry Counseling Centers at granberrycounseling.org. The fee for service is \$90.00 per 60 minute session. When applicable, services are provided on a sliding scale basis. Payment is due at time of session.

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, please 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., LPC, LMFT and my signature below indicates my full informed consent to services provided by Kayley Armstrong, M.S., LPC, LMFT.

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

Spouse Signature Date

Kayley Armstrong, M.S., LPC, LMFT Date

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

Signature of parent or legal guardian Date