Granberry Counseling Centers
Orlando Madrid, M.A., MDIV

Location # 1 - 5011 Jackson Street
Alexandria, LA 71303
Location # 2 - 620 South 3rd Street
Leesville, LA 71446
(318) 355-1067

Declaration of Practices and Procedures

Qualifications:
Masters of Arts in Clinical Mental Health Counseling from Liberty University
Master of Divinity with Biblical Languages

Provisional Licensed Professional Counselor (PLPC) PLC9598
LPC Board of Examiners
11410 Lake Sherwood Ave. North Suite A
Baton Rouge, LA 70816
(225) 295-8444.
LPC Board of Examiners approved Supervisor, Kathy Eichelberger, D. Min, LPC-S, #4310

Counseling Relationship: I view the counseling relationship as a process and as a collaborative effort between you, the Client, and me, the counselor, where respect and mutual trust are formed and founded. You and I will jointly work to define and understand the present problem, identify the goals of counseling, and work together to realize those goals.

Areas of Focus: My counseling training plus experience provide me with abilities to counsel individuals and couples dealing with marital issues, family issues, stress, depression, anxiety, and trauma. I am a licensed minister since 2001 with pastoral experience (pastoral and chaplaincy) which enables me to counsel clients with spiritual issues.

Fees and Office Procedures: Sessions are by appointment only (60 minute session). Appointments are available on Tuesday (Leesville), Wednesday (Alexandria) and Thursday (Alexandria). Appointments may be scheduled, rescheduled or cancelled by calling 318-355-1067. Failure to provide 24-hour notice of cancellation generally means that some other person is not able to use that appointment time. We charge for no-show and late cancellations, except in the case of an emergency.

The standard fee for services is $90.00 per session. We offer a sliding scale of fees based on client's income when needed. Payment for services is due at the close of each session and can be made online at Granberrycounseling.org.

Services Offered and Clients Served: My counseling orientation will be tailored to the client, based upon the nature of the defined problem. I draw from the following therapeutic approaches: Cognitive, Behavioral, family counseling, Solution-Focused, Eye Movement Desensitization and Reprocessing (EMDR), Emotionally Focused Therapy, Reality, and Reconciliation focused therapies. I provide counseling for individuals , older adolescents and couples via in person and through telehealth therapy I approach counseling from a Christian worldview. I will not demand that you accept my Christian worldview to continue counseling.

Code of Conduct: As a PLPC, I am required by law to adhere to the Code of Conduct that has been adopted by the Louisiana LPC Board of Examiners and the National Board of Certified Counselors (NBCC). A copy of the Code of Conduct is available to you upon request

Confidentiality: The Client/counselor relationship is one of mutual trust and respect. Information discussed in our sessions will remain confidential. However, I may be required to disclose confidential information discussed in sessions in 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 him/herself or someone else. 3)There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (60 or older), or a dependent adult. 4) A court order is received directing the disclosure of information.

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 written permission. Any material obtained from a minor client may be shared with the client's parent or guardian.

Granberry will store, safeguard, and dispose of client records in such a way as to maintain confidentiality and in accordance with applicable laws and professional standards.

Privileged Communication: It is my policy to assert privileged communication on behalf of the client and the right to consult with the client, if possible, except during emergency, before mandated disclosure. I will seek to apprise clients of all mandated disclosures as conceivable.

Emergency Situations:
I do not provide 24-hour emergency services. If an emergency should arise, you may leave a message for me at (318) 355-1067. If you are unable to reach me in an emergency situation, you may seek help by calling 911, going to the nearest hospital emergency room, or calling the Crisis Line is 988 which is a suicide/mental health crisis hotline.

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 expect you to share these with me so that we can make the necessary adjustments. If 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.

Part of the counseling process involves the Client putting into practice ideas that we mutually agree will be beneficial for helping the client improve their situation. I expect the client to faithfully attempt to implement and follow through with any outside work assigned during counseling sessions. Success in counseling will be greatly diminished unless the client is willing to practice what is discussed in counseling in their everyday environment.

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. It is also important to report any physical conditions and/or regular medications as they may relate to mental health and well-being.

Potential Counseling Risk: The client should be aware that counseling poses potential risks. While working together, additional problems may surface of which the client was not initially aware. If this occurs, the client should feel free to share these concerns with me. Changes in relationship patterns that may result from family counseling may produce unpredicted and/or possibly adverse responses from other people in the client's social system.

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 Orlando 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 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 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 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.

Professional Services Contract: (*Print name*)_____, herein referred to as the "client", has this day retained Orlando Madrid, M.A., M.Div., PLPC, to provide individual counseling and/or family counseling. I have read and understand the above information and my signature below indicates my full informed consent to the services provided by Orlando Madrid, PLPC, M.A.

It is expressly understood that Orlando Madrid, M.A., M.Div., PLPC, has not issued and will not issue any guarantee of cure, treatment effects, or number of sessions necessary.

It is further understood that Orlando Madrid, M.A., M.Div., PLPC, shall be obligated to maintain a reasonable standard of care for practicing Licensed Professional Counselors. Neither, Orlando Madrid, PLPC, M.A., M.Div., nor the Louisiana Baptist Children's Home & Family Ministries, shall be held to any special or elevated standard of care.

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

Client's Signature(s) _____ Date _____

_____ Date _____

Counselor's Signature _____ Date _____

Orlando Madrid, PLPC, M.A., M.Div (PLPC #PLC9598)

Parental Authorization for Minors: As a parent, I understand that I have the right to information concerning my minor child in counseling, except where otherwise stated by law. I also understand that Orlando Madrid, M.A., M.Div., PLPC believes in providing a minor child with a private environment to facilitate counseling. I, _____, therefore, give permission for Orlando Madrid, M.A., M.Div., PLPC, to use his discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me and to conduct counseling with my

(relationship) _____,

(name of minor) _____.

Parent/Guardian Signature _____ Date _____