Hilary Shaw, MA MS LDN RD
Counselor Intern/Nutrition Therapist
Woman's Center for Wellness
9637 Jefferson Highway
Baton Rouge, LA 70809
225-924-3292

Declaration of Practices and Procedures

I am pleased that we will be working together and am committed to helping you reach your goals in counseling. This statement is designed to inform you of my background and to ensure that you understand our professional relationship.

After reading this document, please sign and date the signature page.

1. **Counseling Relationship:** It is my desire to provide a warm and trusting environment where you feel free to examine patterns of behavior, thoughts, or emotions that are causing your concern. I see the counseling relationship as one that must be based on mutual trust, respect, and honesty. Goals are established through collaboration with you. I will help you think through possibilities and consequences of decisions, but my role is not to make decisions for you. Assignments may be given to continue the therapeutic process between sessions. It is my hope that you will complete the assignments and view them as a vital part of your therapy.

   I use a variety of theoretical approaches in attempt to match your needs, the issue, and the counseling method to achieve your goals. I primarily use techniques based in Cognitive-Behavioral Theory. Intervention strategies are utilized which help to modify patterns of thought and actions to promote mental health, wellness, and personal growth.

   Our first session involves information gathering and becoming acquainted. I will obtain historical information and review the events that brought you in to see me. Feel free to ask any questions you may have. The nature of your need will be discussed and recommendations made concerning future appointments or outside referrals if I am unable to provide the service appropriate for you.

2. **Qualifications:** I hold a Master of Arts degree in Community Counseling from Louisiana State University. I am Counselor Intern #:CI 4203 registered with the Licensed Professional Counselors Board of Examiners, 8631 Summa Avenue, Suite A, Baton Rouge, Louisiana 70809, (225) 765-2515. My supervisor is Diane Marabella, LPC, LMFT.

   I also have a Master of Science degree in nutrition from Louisiana State University and a BSED degree in Exercise Physiology from the University of Georgia. I am a licensed dietitian/nutritionist (LDN) # 1340

with the Louisiana Board of Examiners in Dietetics and Nutrition, 11930 Perkins Rd., Suite B, Baton Rouge, LA 70809, (225) 763- 5490.

3. **Areas of Expertise:** I am a counselor intern working towards licensure as a professional counselor. Areas of interest include disordered eating, women's issues, adjustment to major life transitions, anxiety, depression, relationships and health and wellness.

4. **Session Fees:**

Initial Evaluation:	1 hour	$100
Follow up:	50 min	$70

Payment can be made by cash or check and is due at the time of service. Fees are payable to my supervisor, Diane Marabella, LPC.

Cancellation: If you are unable to keep an appointment, the office must be notified at least 24 hours in advance or a fee of $35 will be assessed for the first cancellation, then the full session fee will be assessed thereafter.

5. **Code of Conduct:** I am required by state law to adhere to codes of conduct for practice that have been adopted by my licensing boards. Copies of these codes of conduct are available upon request.

6. **Privileged Communications:** Information shared by you in the counseling relationship is confidential. I do not disclose client confidences and information to any third party except for materials shared during supervision without your written consent or waiver. State law mandates that I report to the appropriate authorities suspected cases of child abuse/neglect, elder abuse/neglect (60 years or older), or disabled abuse/neglect and instances of danger to self or others when reasonably necessary to protect the client or others from a clear and imminent threat of serious physical harm. Additionally, I am required to disclose information if there is a court order to do so.

7. **Emergency Situations:** In life-threatening emergencies call 911 or go to the nearest hospital emergency room. You may also call the Crisis Intervention Center ('The Phone') at 225-924-3900, seek assistance through the nearest hospital emergency room, or if you are under the care of a psychiatrist, contact his/her office.

8. **Client Responsibilities:** You are responsible for keeping appointments, paying your bill, and following office procedures. In order to receive the most benefit from the counseling relationship it is essential that you are honest and put forth effort in the counseling process. If you have concerns about the goals and process, it is your responsibility to discuss this with me so that any necessary adjustments can be made. I should be informed if you are receiving treatment from another mental health professional. If permission is allowed I would ask that you grant me authorization to share information with this professional so that we may coordinate services. If it

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

9. **Physical Health:** There is a strong connection between physical and emotional health. As part of the initial evaluation you will be asked to give the name of your primary are physician, describe your medical history and list all medications you are currently taking. It is recommended that you have a physical examination if you have not had one in the last year.

10. **Potential Counseling Risk:** Your participation in outpatient therapy is strictly voluntary and can pose some risk to you. Therapy can involve a wide range of emotions, which may be experienced as both positive and negative. In addition, because of the growth process, you could experience changes in relationships with others that may be a source of strain or difficulty. During the course of treatment, additional problems may surface that you were not aware. If this occurs, please discuss any new concerns with me.

ADULT CLIENT

I have read and understand the Practices and Procedures for the counseling agreement as described above.

I am aware of the counseling relationship and responsibilities, and my rights of confidentiality. I realize there is a benefit and risk involved in counseling. I accept the stated fees. I have a copy of the phone numbers I may call in the event of an emergency.

Client Signature _____ Date_____

Counselor Intern Signature_____ Date_____

Counselor Supervisor Signature _____Date_____

CONSENT FOR A MINOR

I, (parent or legal guardian) _____ give permission for

Hilary Shaw to conduct counseling with my _____,
(relationship),

_____.
(name of minor).

_____ Date_____
Signature Parent/Guardian