DECLARATION OF PRACTICES AND PROCEDURES STATEMENT

Kathryn Stephenson, M.S., LPC, ATR
NOLA Art Therapy and Counseling, LLC
1000 Veterans Memorial Boulevard Suite 310
Metairie, LA 70005
Phone: (504) 220-1483
Fax: (888) 248-7189

Qualifications: I earned a Master of Science degree in Art Therapy from Florida State University in 2016. I am a Licensed Professional Counselor (LPC) # 6856 with the Louisiana LPC Board of Examiners, which is located at 11410 Lake Sherwood Avenue North, Suite A, Baton Rouge, LA 70816 (Phone: 225-295-8444). I am a Registered Art Therapist #19-339 with the Art Therapy Credentials Board, which is located at 7 Terrace Way, Greensboro, NC 27403 (Phone: 336-482-2858).

Counseling Relationship: I view counseling as a partnership in which you, the client, and I, the counselor, focus on identifying strengths and needs, working together to facilitate your achievement of personal goals, in order to live with a higher quality of life.

Although our work may feel emotionally close, it is essential for you to realize that our relationship is a professional rather than personal one. I believe that you will be best served if our relationship remains focused on your concerns; therefore, our time together will be limited to the counseling services provided each week.

Area of Focus: My focus at NOLA Art Therapy and Counseling is to provide counseling with children, adolescents, and adults, experiencing interpersonal issues or emotional/behavioral disorders. In addition to being registered as a LPC in Louisiana, I hold a national registration as an Art Therapist (ATR# 19-339).

Fees and Office Procedures: I accept insurance plans and self-paying clients. All co-pays and service fees must be paid in full at the time of service. The payment can be made using cash, check, debit or credit cards (Visa, MasterCard, American Express, and Discover). The fee for counseling services will be discussed upon initial contact. Failure to give notice for any appointment not cancelled 24 hours in advance may result in a charge for the time reserved for you.

Services Offered and Clients Served: I approach counseling from an eclectic perspective by drawing on various aspects of cognitive-behavioral and solution-focused methods to create a custom approach. This perspective is based on the notion that patterns of thoughts and feelings can be examined and better understood in order to better address the issues a client is experiencing, and come up with better solutions for coping with stressful situations moving forward. Art therapy is incorporated in the mental health services to enhance the therapeutic process. My counseling services are offered on an individual basis, couple, family,

and group.

Code of Conduct: As a Counselor, I am required by law to adhere to the Code of Conduct for Practice that has been adopted by my licensing Board. A copy of the code of conduct is available to you upon request. The ATCB oversees the ethical practice of art therapists and may be contacted with client concerns.

Confidentiality: Material revealed in counseling will remain strictly confidential except for material shared with my staffing 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 him/herself or someone else.
3. There is reasonable suspicion of abuse/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 or family counseling, material obtained from an adult client individually may be shared with the client's spouse/partner or other family member only with the client's permission. Any material obtained from a minor client may be shared with the client's parent or guardian.

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 an emergency, before mandated disclosure. I will endeavor to let clients know of all mandated disclosures as conceivable.

Emergency Situations: In the event the client requires emergency mental health care between counseling sessions, he or she is advised to call 911 or report to the emergency room of a local hospital. For individuals in crisis in Jefferson Parish, please call Jefferson Parish Human Services Authority at (504) 832-5123. For individuals in Orleans, Plaquemines, and St. Bernard Parishes, please call the Metropolitan Crisis Response Team at (504) 826 2675.

Client Responsibilities: Honesty and effort are essential components to a successful therapeutic relationship; therefore, you, the client, are a full partner within the counseling/art therapy process. Clients are expected to follow NOLA Art Therapy and Counseling's policy for keeping appointments. In order for me to make any necessary adjustments toward your counseling experience, I ask you to indicate any suggestions or concerns. If at any time you feel that you would be better served by another mental health professional, I will help you with the referral process. 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 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. As a routine part of the initial session, you will be asked the name of your physician and to list any medications that you are now taking.

Potential Counseling Risk: You should be aware that counseling poses potential risks. In the course of working together additional problems may surface of which you were not initially aware. Sometimes you may experience unwanted feelings such as sadness, anger, fear, guilt, and/or anxiety through the therapeutic process. If this occurs, please feel free to share the new concerns with me.

ACKNOWLEDGMENT OF READING
THE DECLARATION OF PRACTICES AND PROCEDURES

I have read the Declaration of Practices and Procedures of Kathryn Stephenson, M.S., LPC, ATR and my signature below indicates my full informed consent to the services provided by Kathryn Stephenson M.S., LPC, ATR.

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

Client Signature _____ Date _____

Kathryn Stephenson, M.S., LPC, ATR _____ Date _____

Parent/Guardian Consent for Treatment of a Minor:

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

Kathryn Stephenson, M.S., LPC, ATR to conduct counseling with my _____

(relationship), _____(name of minor).

Signature of parent or legal guardian _____ Date _____