

Declaration of Practices and Procedures

Walter Camos, MS, LPC, NBCCH
Licensed Professional Counselor
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- 1. Qualifications**
- Education: University of Louisiana at Lafayette
M.S. Counseling Psychology 2005
M.S. Experimental Psychology 2004
B.S. General Psychology 2001
- Licenses: Licensed Professional Counselor (LPC) #3535
LPC Board of Examiners, Baton Rouge, Louisiana
- Affiliations: American Counseling Association (ACA)
American Psychological Association (APA)
Association of Family and Conciliation Courts (AFCC)
National Board for Certified Clinical Hypnotherapists (NBCCH)

2. Therapeutic Relationship

Therapy is a process where a trusting relationship is formed between Client and Therapist. Presenting problems are to be defined and explored, goals formulated, and a plan for achieving these goals shall be established.

In the event client brings a partner, spouse, family member or others, into sessions, client hereby agrees that material obtained individually may be shared with others brought into therapy by client.

I record all of my sessions with a digital recorder. Audio recordings of sessions are very useful for review of material covered and also provide ideas for new directions to move in. All recordings shall be treated as confidential, private, client information.

3. Services Offered and Clients Served:

I offer counseling, psychotherapy, hypnotherapy services and some evaluations, for children age six and above, adolescents, adults and the elderly. Sessions can be individual, couples, families or groups. For evaluations, multiple family members may be involved along with others.

My orientation to therapy/counseling is eclectic, drawing from evidence based practices such as Cognitive-Behavioral, Ericksonian, and Existential, along with Clinical Hypnosis and Energy Psychology, such as Meridian Tapping Techniques (MTT).

My practice is general in nature, but I do specialize in mood disturbances (bipolar disorder/major depression), anxiety/panic, sexual assault, posttraumatic stress (PTSD), and also reconciliation/reunification/family/couples therapy, court ordered or not. I am registered with the Board for Certified Clinical Hypnotherapists and I do utilize clinical hypnosis, if beneficial.

4. Professional Fees, Charges and Payments

Professional fees for any service provided, such as intake interview, counseling, psychotherapy, hypnotherapy, reports, or any other one-hour type session or service shall be \$150.00 per service-hour and shall be due at time of service. Services beyond one hour shall be charged on a prorated basis. In order to establish an intake appointment, half of the fee shall be paid in advance by credit card or other means. Should client not present for the intake at the time scheduled, the \$75.00 intake deposit shall be forfeited and considered payment for the missed appointment, unless client experiences hardship which prevents appearing for the scheduled intake. A fee of \$150.00 shall be charged for all missed appointments that are scheduled, missed, but not cancelled at least 24 hours in

advance. Therefore; please call and cancel your appointment 24 hours in advance if you cannot make it.

As services are provided, payments shall be made in the form of cash, check or credit card. I do accept Blue Cross Blue Shield of Louisiana, and you hereby, with your signature below, assign and transfer any benefits payable for services rendered to Walter Camos, MS, LPC; but you are ultimately responsible for payment of all charges incurred, should your insurance provider not pay said charges. You also hereby authorize refund to your insurance company of any overpaid insurance benefits, although you agree that any overpayment due will first be applied to any unpaid balance on your account. Should your account become in arrears, it will be then forwarded to collections and you hereby agree to pay all attorney, court, and collection costs. You also hereby agree to pay a \$25.00 service charge for any NSF checks or denied credit/debit card charges. A 1.5% per month finance charge shall be applied to all accounts that are sixty days overdue or more.

We will do our best to use the following to notify you of appointments but whether or not you receive an email, text or phone call, you are ultimately responsible for canceling any appointment that you cannot keep, or you will be billed \$150.00 for a missed appointment.

Email address _____ Cell phone number _____

5. Code of Conduct

As a Therapist/Counselor, I adhere to the Code of Conduct for practice that has been adopted by my licensing board. A copy of this Code of Conduct is available to you upon request.

6. Emergency Situations

In private practice I offer therapy services during normal working hours. Should there be an emergency of any kind, or any thoughts of hurting self or others, you hereby agree to call 911 or go to the nearest emergency room. I refer all emergency needs to the nearest hospital emergency room.

7. Client Responsibilities

You are a partner in the therapeutic relationship and as we work together please express any concerns or suggestions you might have. If necessary, adjustments or adaptations will be made. Should it become necessary, I will help you with a referral. If you are currently receiving services from another mental health professional, or choose to begin other mental health services after we begin, please inform me of this so that sharing of information may be coordinated if necessary.

8. Diagnoses

Have you ever been diagnosed with any of the following?

- | | |
|---|-----------------------------------|
| (a) Schizophrenia or schizoaffective disorder | (b) Bipolar disorder |
| (c) Panic disorder | (d) Obsessive-compulsive disorder |
| (e) Major depressive disorder | (f) Anorexia/bulimia |
| (g) Intermittent explosive disorder | (h) Autism |
| (i) Psychosis or Psychotic disorder | (j) Rett's disorder |
| (k) Tourette's disorder | (l) Dementia |
| (m) None | |

Please be aware that per State of Louisiana you should see a physician who is licensed by the State Board of Medical Examiners for assessment and continued treatment for any of the above listed diagnoses, and continued treatment by your physician is considered a requirement during therapeutic treatment herein. Please explain any diagnosis if necessary below, or list anything that you feel might be a problem now.

Have you ever been diagnosed with any of the following?

(a) Seizure Disorder

(b) Epilepsy

(c) Developmental Disorder

(d) None

Please explain any diagnosis if necessary.

9. Substance / Alcohol Abuse

In the event that you are here for substance abuse or alcohol abuse counseling, please list abused substance(s): _____.
Please be aware that continued treatment is contingent upon sobriety and your commitment to being clean. Presenting for sessions intoxicated or while using will not be allowed. The use of hypnotherapy for any substance abuse or alcohol abuse problem may only be considered once sobriety is under way.

10. Potential Risks

You should be aware that any of the services offered (Therapy, Counseling, Hypnotherapy, Energy Psychology, Meridian Tapping, etc.) may involve potential risks. For example, issues/problems/emotions may arise that were not previously problematic. These issues/problems/emotions may result in positive effects in well-being but there is a possibility that negative effects could be experienced as well. Should questions, concerns or issues arise during any part of intake or ensuing sessions, please feel free to bring these into discussion so that they may be addressed promptly.

11. Physical Health

A major factor of psychological well-being is physical health. You are encouraged to get regular examinations by your own personal care physicians and, if necessary, psychiatrists. Any current medications that you may be taking should remain part of your regular prescribed medication regimen. Any changes to your personal medication regimen should be done only in consultation with your prescribing physician. Also, any increased activity, exercise, or the implementation of an exercise program should also be done in complete consultation with your physicians.

Treatment herein is not intended to supersede, change, or substitute for any treatment that you receive from your own physicians. Any ideas discussed or mentioned during sessions are merely presented for your own consideration, and as food for thought. Your physical and mental health is very important and the only way for you to maintain it is through direct supervision by your own physicians. Prior to implementing anything that may have been mentioned or implied during the course of any form of treatment received herein, always consult your physicians.

12. Privileged communication

In accordance with state law, material revealed in therapy/counseling/sessions, will remain confidential except for the following circumstances: 1) When client signs a consent to release information, 2) When there is a reasonable suspicion of intent to harm self or others, or a party hereto presents as gravely disabled, 3) When there is a reasonable suspicion of abuse or neglect to anyone concerned, 4) When a court order is received directing the disclosure of information, or 5) When the client is a minor and information is formally requested by a parent or legal guardian, 6) For billing purposes especially to insurance where diagnoses and other information may be required by your insurance provider, 7.) When requested by your insurance company for any reason, 8) All of our work is done on a secure web service especially for therapists and your information will be visible to this secure service which maintains all HIPAA practices. Our office retains any paper records for up to six years, after which, when able, it is destroyed in a confidential manner.

In the case of **Potential Court Involved Therapy/Counseling/Evaluation/Etc.**, you hereby consent to treatment, and to the release of information to others, and also to my receipt of any pertinent information. This may consist of communications and or transfer/exchange of confidential

personal information, etc., with the courts, judges, attorneys, prosecutors, healthcare professionals, consultants, and others involved in your case. You hereby consent to any communication, transfer, or exchange of information, whether for consultation on your case or otherwise, whether verbal, written, electronic, or otherwise.

13. Questionnaire

I sometimes send out questionnaires to follow up on any treatment that you may have received in order gather information that could be useful in bettering the services that I offer. Your input would be greatly appreciated. Would you be agreeable to filling out and returning a questionnaire that is mailed to you? _____

14. Consent to Treatment

I _____, DOB _____

I _____, DOB _____

I _____, DOB _____

hereby acknowledge that I have reviewed and understand the above declaration and agree to willingly enter into a therapeutic relationship, or present for evaluation, with Walter Camos, MS, LPC, NBCCH, and consent to the release of personal information as necessary. I also agree to pay all charges in full. If, at any time in the future, I change my mind about this consent or treatment received herein, I understand that I may terminate my consent, but it must be in writing, dated and signed by me. Any material or information that has already changed hands cannot be undone, should you decide to terminate. All future treatment is contingent upon signed consent below.

Treatment Plan shall be as follows:

Client Signature: _____ Date: _____

_____ Date: _____

_____ Date: _____

(If Client is a minor)

Parent or Legal Guardian: _____ Date: _____

Relationship: _____

Walter Camos, MS, LPC, NBCCH: _____

Licensed Professional Counselor #3535