Declaration of Practice

Walter Camos, MS, LPC
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 11410 Lake Sherwood Ave. North Suite A, Baton Rouge, Louisiana; 225.295.8444

Affiliations: American Counseling Association (ACA)

2. Therapeutic and Service Relationship

Therapy is a process where a trusting relationship is formed between Client and Therapist. The focus is to identify problems and formulate a plan for improvement. Should client bring a partner, spouse, family member or others, into sessions, client hereby agrees that material obtained in one session may be shared with others brought into therapy by client. Client hereby agrees that recordings of any kind regarding sessions, phone calls or otherwise, shall not be permitted. Should a complaint arise during the course of service, client hereby agrees to report this directly to me, or my professional associations or boards, and specifically, client shall not display complaints in any public form, even after termination of service.

3. Services Offered and Clients Served:

I offer counseling, psychotherapy, and hypnotherapy services, for children, adolescents and adults. Sessions can be individual, couples, families or groups. Sometimes 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, Clinical Hypnotherapy and Energy Psychology. My practice is general in nature, but I do specialize in mood disturbances (bipolar disorder/major depression), anxiety/panic, posttraumatic stress (PTSD), and also family / couples therapy.

4. Professional Fees, Charges and Payments

Professional fees for any service provided 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 prevented appearance 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. Please call and cancel your appointment 24 hours in advance if you cannot make it and there will be no charge.

As services are provided, payments shall be made in the form of cash, check or credit card. Should your account become in arears, 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 overdue.

Most individuals coming in for therapy find improvement within 3 to 6 sessions although some may continue for additional sessions. This is my good faith estimate of what to expect, regarding costs. Whether you continue beyond the 6 sessions will depend on you and your decision to continue. Should you feel that you would like to inquire with another therapist, please advise and referrals could be made at that time.

Client hereby provides contact information for appointments that may be electronically sent out. Client is ultimately responsible for canceling any appointment that cannot be kept, or client will be billed $150.00 for a missed appointment.

Email address _____Cell phone number_____

5. Code of Conduct

I adhere to the Code of Conduct adopted by my licensing board as a Louisiana Licensed Professional Counselor. A copy of this Code of Conduct is available online (LPC Board and ACA).

6. Emergency Situations

I offer 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. Whether after hours or not, you may also contact a hotline for assistance at 1.800.273.8255 or go to their website at, "https://suicidepreventionlifeline.org/ ."

7. Client Responsibilities

You are a partner in the therapeutic relationship and agree to express any concerns or suggestions you might have. If necessary, adjustments or adaptations will be made. Should consultation with another professional concerning your case become necessary, you hereby consent to such a professional consultation. Should it become necessary, I will help you with a referral if services are terminated. 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 a seizure disorder, mental health diagnosis, or do you feel that you have something of concern to report that has not been diagnosed, e.g. anxiety or depressed mood?

_____

_____

9. Substance / Alcohol Abuse

In the event there has been or may still be substance abuse or alcohol abuse issues, please list abused substance(s): _____. Please be aware that continued treatment is contingent upon maintaining sobriety. Presenting for sessions intoxicated or while using will be cause for referral to a more appropriate treatment source. The use of hypnotherapy for any substance abuse or alcohol abuse problem may only be considered once sobriety is under way and client can present for sessions not under the influence.

10. Potential Risks

Client should be aware that any of the services offered (Therapy, Counseling, Hypnotherapy, Energy Psychology, Meridian Tapping, etc.) may involve potential risks. Sometimes clients may become emotional as a result of sessions, and client should make such thoughts or feelings known. Any emotional reactivity shall be processed, and assistance towards issue resolution will be provided.

11. Physical Health

Client is encouraged to get regular examinations by a personal care physician. Prescribed medications should remain a part of client's regular medication regimen and any changes should be only in consultation with your physician. Any increased activity or exercise should be in consultation with your physician. Treatment herein is not intended to supersede, change, or substitute for any treatment that you receive from your own physician. Any ideas mentioned during sessions are merely presented for your own consideration and should be cleared by your physician.

12. Privileged communication

In accordance with HIPAA and 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/subpoena is received directing the disclosure of information, 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.) Client information is entered on a secure web service especially for therapists, Therapynotes.com, where this web service complies with 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 Court Involved Therapy/Counseling/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, as deemed professionally necessary by me to properly manage your case.

13. Teletherapy

I do offer Teletherapy services, should this be an option of interest for your treatment. Please let me know and I will provide you with more information. This form of treatment is HIPAA compliant yet there are limitations regarding the extent of confidentiality that the worldwide web can provide. As long as you understand the limitations and agree to provide necessary information at the beginning of each session for your own safety, this form of treatment is available, provided a Teletherapy consent form is signed.

14. Treatment Plan

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15. Pilgrimages

I do participate in yearly pilgrimages abroad and am away sometimes for 4 to 6 weeks. I do provide therapist referrals for these periods, so as to provide you with continuity of care. I will begin therapy again with you upon return, should you choose to continue with me.

16. Consent to Treatment

I _____, DOB _____

I _____, DOB _____

I _____, DOB _____

have reviewed and understand the above declaration and agree to willingly enter into a therapeutic relationship with Walter Camos, MS, LPC, 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 treatment received herein, I understand that I may terminate this consent in writing, but any outstanding payments shall remain due and no complaint shall be made through public or social media platforms or on the web, e.g., Google, Facebook, etc. Complaints should be made only to associations or licensing boards, or to me directly. 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.

Client Signature: _____ Date: _____

_____ Date: _____

_____ Date: _____

(If Client is a minor)

Parent or Legal Guardian: _____ Date: _____

Relationship: _____

Walter Camos, MS, LPC: _____

Licensed Professional Counselor #3535