Declaration of Practices and Procedures

Qualifications: I earned a Master of Social Work degree from Southern University of New Orleans. I am a Licensed Clinical Social Worker-Board Approved Clinical Supervisor #11747 with the Louisiana State board of Social Work Examiners, 18550 Highland Road, Suite B, Baton Rouge, Louisiana 70809. (225) 756-3470

Code of Conduct: As a Licensed Clinical Social Worker, I am required by state law to adhere to a 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.

Therapeutic Relationship: Therapy is a mutual relationship in which the therapist and you, the participant, develop an understanding and trusting relationship that allows us to work together to define the reasons for therapy, discover and explore any underlying problems and define the present situations that led to seeking therapy. Together, we will develop goals to help improve your overall life and work systematically to achieve those goals.

Participant Responsibilities: You, the participant, are a full partner in counseling. Your honesty and effort are essential to success. As we work together and you have suggestions or concerns, please share those so that adjustments are made. If we determine that you would be better served by another mental health provider, I will help with the referral process. If you are currently receiving services from another mental health professional, please let me know so that services are coordinated.

Areas of Expertise: I focus on adolescents and adults who struggle with Depression, Adjustment Disorder, Trauma, Grief, Relationship Issues, Anxiety and Life Transitions. I hold certifications as a Certified clinical Trauma Professional (CCTP) and a Certified Grief Counseling Specialist (CGCS).

Face-to-Face and Teletherapy: Services are offered both in-person and virtually. In-person sessions are held at 1901B Airline Drive, Metairie, Louisiana 70001. During virtual sessions, it is the responsibility of the client to ensure confidentiality by providing a private and secure location for themselves during sessions. A 15 minute grace period is provided for both in-person and virtual sessions. If the participant does not arrive at the session before the 15 minute grace period expires, the session is counted as a no-show and the full fee will be applied to the card on file. All participants are advised to ensure that their insurance covers Telehealth sessions prior to beginning therapy. Any fees not covered by the insurance is the participants responsibility.

Emergency Situations: If an emergency should arise, you should seek immediate medical attention at your local emergency room, by call 911, Jefferson Parish Mobile Crisis Services at (504) 832-5123 or Metro Crisis Response Team at (504)826-8675

Physical Health: Physical health can be an important factor in the emotional wellbeing for an individual. If you have not had a physical examination in the last year, it is recommended that you do so. Also, please provide me with a list of medications you are currently prescribed.

Fees for Services: The fees for services are $150.00 per the initial session, which lasts 60-90 minutes and $125.00 thereafter per 50-minute session for individual therapy and $200 for 60 minutes of family therapy.

Fees are paid directly to me at the beginning of each session by Cash, Credit or Debit Card.

Appointments are confirmed at the close of each session. Evening appointments are available Monday through Thursday from 4:30pm – 7:30pm and Saturday from 8am – 12noon. A 24 hour cancellation must be given to avoid the missed appointment fee of the full fee. Failure to keep scheduled appointments may result in termination of services.

Privileged Communication: Information shared in counseling will remain strictly confidential except under the following circumstances in accordance with state law:

1. The participant signs a written release of information indicating informed consent of such release.
2. The participant expresses intent to harm themselves or someone else,
3. There is a reasonable suspicion of abuse/neglect of a minor child, elderly person or a dependent adult.
4. A court order is received directing the disclosure of information.

It is Paradise Therapeutic Services LLC policy to assert privileged communication on behalf of the participant and the right to consult with the participant if possible, except during an emergency, before mandated disclosure. Explanation of mandated disclosures will be discussed when possible.

In the event of couple and family counseling, information shared from an adult participant individually may be shared with the participant's spouse/partner or other family members only with the participant's written permission. Any information shared from a minor participant may be shared with the participant's parent/guardian.

Potential Counseling Risk:

The participant should be aware that counseling poses potential risks. While working together, additional challenges may surface of which you were not initially aware. If this occurs, feel free to share these concerns with me.

Informed Consent

I have read, understood and received a copy of the Declaration of Practices and Procedures on pages 1 and 2. My signature below indicates my full informed consent to therapy services provided by Cherlyn Cyres, LCSW-BACS of Paradise Therapeutic Services, LLC.

Participant/Parent or guardian signature Date

Cherlyn Cyres, LCSW-BACS

Cherlyn Cyres, LCSW-BACS Date

Parent/Guardian consent for Treatment of a Minor:

I, ______________________________, give my permission for Cherlyn Cyres to

Name of Parent or guardian

Conduct therapy with my ___________________, ________________________,

Relationship Name of Minor

Parent or Guardian Signature Date

Client Information

Please provide the following demographic information. The information you provide here is protected under HIPAA and treated as confidential.

Date:___________________________ Referral Source:____

Participant Name:____________________________________ Gender:_________ Race:__________

Name of parent/guardian if minor:________________________________ Relationship:________________

Date of Birth:___________________ Age:_______ Social Security #:___________________________

Marital Status: __ Never Married __Married __Domestic Partnership __Separated __Divorced __Widowed

Address:____

Street City State Zip Code

Home Phone Number: _____________________________ May we leave a message? ___Yes ___No

Home Phone Number: _____________________________ May we leave a message? ___Yes ___No

E-mail:____ May we email you? ___Yes ___No

*Please note: E-mail correspondence is not considered to be a confidential medium of communication.

Emergency Contact Information:

Name Number Relationship

Name Number Relationship

Medical History

Please provide the following information for Participant's Primary Care Provider (PCP)

PCP Name: ____

PCP Phone Number: ________________________ PCP Fax Number: _____________________

Circle all symptoms experienced by participants.

Mood Swings	Sadness	Insomnia	Panic Attacks
Guilt	Grief	Obsessions/Compulsions	Chronic Pain
Hopelessness	Racing Thoughts	Personality Changes	Hallucinations
Anxiety	Fatigue	Isolate/Decreased Socialization	
Irritability/Easily Angered	Aggression	Behavioral Problems	Mania
Impulsivity	Grief/Loss	Uncontrollable Fear/Phobia	Overwhelmed
Nightmares	Trauma	Worthlessness	Stress
Homicidal Thoughts	Suicidal Thoughts	Active plan to hurt myself	Unmotivated
Eating/Disorder	Poor Concentration	Memory Impairment	

How did you hear about these services?____

What are your reasons for seeking services?

Are you seeking Virtual (Telehealth) or in-person therapy? ___Virtual ___In-Person

****In-Person session are health at 1901B Airline Drive, Metairie, LA 70001**

Insurance Information

***If you have private insurance in addition to Medicaid, you must provide the information and insurance card for both insurances. Failure to do so can result in additional fees being acquired.**

Insurance: ____

Policy Holder Name: ____

Policy Holder Address: ____

Policyholder Employer: ____

Date of Birth: __________________________ Social Security #: ______________________

Member #: ____________________________ Policy/Group#:________________________

Secondary Insurance: ____

Policy Holder Name: ____

Policy Holder Address: ____

Policyholder Employer: ____

Date of Birth: __________________________ Social Security #: ______________________

Member #: ____________________________ Policy/Group#:________________________

If services are not covered by the insurance company or you do not have insurance, please provide information for the responsible party – the person who will be responsible for paying the per-session fee for services.

Responsible Party's Name: ____

Social Security #: ______________________________ Relationship to Client: _______________

Address: ____

Home #: __________________ Work#: __________________ Cell#: ___________________

Financial and Appointment Adherence Agreement

1. Fees for services:
   a. Initial Assessment: $150.00
   b. Psychotherapy: $125.00
   c. Family therapy: $200.00
2. All patients are required to pay in full for the service rendered at the time of the appointment. Refunds will not be issued under any circumstances.
3. Cancellation Policy: Appointments must be canceled 48 hours in advance of your scheduled appointment or you will be charged the full amount for the scheduled services. We can be notified of your intent to cancel by calling (504) 656-6440 or email at paradisetherapeuticservices@gmail.com. Reminder calls, text and or emails are not guaranteed and are offered as a courtesy only.
4. We have the right to discharge participants at any time. However, participants who miss 2 or more appointments without a 48 hour notice or are 15 minutes or more late for their scheduled appointment on 2 or more occasions will be discharged automatically and mailed a written letter of notification.
5. Questions: You are encouraged to call our office if there are any questions about this information. If financial problems arise at any time while under the care of Paradise Therapeutic Services LLC, you are encouraged to speak with our office.
6. Payments for services can be made by cash, credit or debit card.
7. Delinquent Accounts: All fees and costs associated with collections and prosecution will be the sole responsibility of the participant.
8. If billing insurance, I authorize payment of insurance benefits to Cherlyn Cyres, LCSW and Paradise Therapeutic Services LLC.

By signing below, you acknowledge that you have read, understood and agreed with the above policy and information.

Signature: ____

Print Name: ____

Date: ____

Relationship to Participant: _____________________________

Credit Card Consent Policy Form

I, __________________________, authorize Cherlyn Cyres of Paradise Therapeutic Services, LLC to keep my signature on file and charge my credit/debit card account as indicated below.

1. Missed appointments*
2. Cancellations made less than 48 hours before the scheduled appointment*
3. Payments/copayments made with credit/debit card at the time service is rendered

*Missed appointment/late cancellation fee: Appointments must be canceled at least 48 hours in advance of your scheduled appointment or you will be charged the full amount for the scheduled services. We can be notified of your intent to cancel an appointment by office voicemail (504) 656-6440, or email paradisetherapeuticservices@gmail.com. Reminder calls, text or emails to our participants are not guaranteed and are offered as a courtesy only.

I, the undersigned, understand that this form will be valid for the duration of my enrollment with Cherlyn Cyres, LCSW of Paradise Therapeutic Services LLC. Unless I provide written notice to cancel.

Participant Name: ___________________________________

Cardholder Name: ___________________________________

Billing Address____

Card Type: ___Visa ___MasterCard ___Discover ___American Express

Card Number: _______________________ Exp Date: _____________ CVC______

Cardholder Signature: _______________________________ Date: ______________

Notice Of Privacy Practices.

This notice describes how medication information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Paradise Therapeutic Services, LLC is required to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about the privacy practices of Paradise Therapeutic Services, LLC, please contact: Cherlyn Cyres, LCSW-BACS, 1901B Airline Drive, Metairie, LA 70001.

Effective date of this notice is January 1, 2022

I. MY PLEDGE REGARDING HEALTH INFORMATION:

Health information is collected from you and stored in a chart and/or computer. This is your medical record. The medical record is the property of Paradise Therapeutic Services, LLC, but the information in the medical record belongs to you. Paradise Therapeutic Services, LLC, protects the privacy of your health information. The law permits Paradise Therapeutic Services LLC to use or disclose your health information for the following purposes:

1. Treatment. Medical information about you may be given to doctors, nurses, technicians and medical personnel who are involved in providing your care.
2. Payment. Medical information about you concerning the treatment and service received will be billed either to the patient or the patient's insurer. Your health plan or third-party payer may request information from your medical record to authorize prior approval or certification for service.
3. Regular healthcare care operations. Information about you may be used in order to review treatment and services and in order to evaluate the performance of the staff.
4. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable to agree or object, our health professionals will use their best judgment in communication with your family and others.
5. Required by law. As required by law, we may use and disclose your health information.

6. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling injury or disability, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.
7. Health oversight activities We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
8. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.
9. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
10. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

II. Paradise therapeutic Services, LLC may not use or disclose your health information except as described in this Notice of Privacy Practices without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your health information Rights.

1. You have the right to request restrictions on certain uses and disclosures of your health information.
2. You have the right to receive your health information through a reasonable alternative means.
3. You have the right to inspect and copy your health information
4. You have the right to request an amendment of your health record that is incorrect or incomplete. We are not required to change your health information and will provide you with information about our denial and how you can disagree with the denial
5. You have the right to receive an accounting of disclosures of your health information, except for the uses of the disclosures listed in section I of the Notice of Privacy Practices
6. You have the right to a paper copy of the Notice of Privacy Practices.

IV. Changes to this Notice of Privacy Practices

Paradise Therapeutic Services, LLC reserves the right to amend Privacy Practices at any time in the future and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment.

V. Complaints

Complaints about this Notice of Privacy Practices or how Paradise Therapeutic Services LLC handles your health information should be directed to Cherlyn Cyres, LCSW-BACS.

ACKNOWLEDGEMENT OR RECEIPT OF PRIVACY NOTICE.

Under the health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Name Date

Patient Rights and Responsibilities

As a patient of Paradise Therapeutic Services, you have the right to privacy and confidentiality regarding your health care. Thank you for giving us the opportunity to best serve your needs and allowing us to provide your mental health services.

As a patient, you have the following rights:

1. The Right to Privacy and Confidentiality: All records and communication regarding your health information will be kept secure and confidential in compliance with state and federal laws. Under state and federal law, there may be times when confidentiality may have to be broken and health information disclosed to certain parties. This includes cases in which someone is a danger to themselves or others, is involved in domestic violence, or there is suspicion of abuse or neglect. We may also be mandated to report your health information by court order or when it is necessary to prevent or lessen an imminent threat to the health or safety of a person or the public. With your authorization, we may also disclose your health information to an insurance company for payment of services.
2. The Right to Medical Records: You may request a copy of your medical records pertaining to your treatment. A reasonable copy fee may be applied.
3. The Right to Account Information: You may request an accounting of certain disclosures that are made of your health information. A reasonable fee may be applied.
4. The Right to Clear Instructions and Up-to-Date Information: We will make it a priority to clearly explain your diagnosis, prognosis, treatment options, the risks and benefits of treatment.
5. The Right to Accept or Refuse Treatment Recommendations
6. The Right to Seek Additional Professional Opinions.
7. The Right to a Safe Environment
8. The Right to Professionalism and Courtesy.
9. The Right to Continuation of Care – Please note that we will refer you to another practicing mental health provider in the event that we are not available or able to treat you.

As a patient, you have the following responsibilities:

1. Contact your treatment provider for any serious situation that arises regarding your mental health.
2. Provide correct and complete information about your health.
3. Follow the treatment plan to achieve your treatment goals.
4. Advise your treatment provider of any changes in your health condition.
5. Be respectful of the rights of other patients and building/office personnel.
6. Arrive for your scheduled appointment on time and notify the office if you are unable to make your appointment.
7. Meet the financial obligations for your care.

By signing below, you acknowledge that you have read, understood, and agreed with the above policies and information.

Patient name: ____**DOB:** ______________________

Signature: ____ **Date:** ______________________