Ann H. Abbrecht, LLC
5030 Danneel Street
New Orleans, Louisiana 70115
504 723 7844
ahabbrecht@gmail.com

Qualifications: I earned an MA degree from Loyola University in 2009. I am licensed as a LPC # 4639 with the LICENSED PROFESSIONAL COUNSELORS BOARD OF EXAMINERS, 8631 SUMMA AVENUE, BATON ROUGE, LOUISIANA 70809 TELEPHONE (225)765-2515

Counseling Relationship: I see counseling as a process in which you, the client, and I, the counselor, having come to understand and trust one another, work as a team to explore and define present problem situations, develop future goals for an improved life and work in a systematic fashion toward realizing those goals.

Areas of Expertise: I have a general practice, but focus on clients with marriage and family issues. I hold a national certification as a National Certified Counselor (NCC) and as a Certified Clinical Mental Health Counselor (CCMHC)

Fee Scales: The fee for my services is $90.00 to $120.00 per session. Payment is due at the time of service. Clients are seen by appointment only. Payment may be made by cash, check or credit card. This time is reserved for you. Missed appointments with less than 24-hour notice will be charged at the therapy session rate. Payment is not accepted from insurance companies.

Services Offered and Clients Served: I approach counseling from a cognitive-behavioral perspective in that patterns of thoughts and actions are explored in order to better understand the clients' problems and to develop solutions. I work with a variety of formats, including individually, as couples and as families. I also conduct group therapy. I see clients of all ages and backgrounds with the exception that I do not work individually with children under six years of age.

Code of Conduct: As a Counselor, I am required by state law to 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 upon request.

Privileged Communications: Materials revealed in counseling will remain strictly confidential except for:
1.) The client signs a written release of information indicating informed consent of such release.
2.) The client expresses intent to harm him/herself of someone else.
3.) There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (60 or older), or a dependent adult.
4.) A court order is received directing the disclosure of information.mt is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures as conceivable. In the event of marriage or family counseling, material obtained from an

adult client individually may be shared with the client's spouse or other family members only with the client's permission. Any material obtained from a minor client may be shared with that client's parents or guardian.

Emergency Situations: If an emergency situation should arise, you may seek help through hospital emergency room facilities or by calling 911.

Client Responsibilities: You, the client, are a full partner in counseling. Your honesty and effort is essential to success. If as we work together you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary adjustments. If it develops that you would be better served by another mental health provider, 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. Also, please provide me with a list of the medicines you are currently taking.

Potential Counseling Risk: The client should be aware that counseling poses potential risks. In the course of working together additional problems may surface of which the client was not initially aware. If this occurs, the client should feel free to share these new concerns with me.

I have read and understand the above information.

Client Signature _____ Date _____

Counselor Signature _____ Date _____

(LPC's seeing minor clients should provide a parental authorization section. See example below.)

I, signature of parent or guardian _____, give permission for Ann

Abbrecht, LPC to conduct counseling with my (relationship), _____,

(Name of minor) _____.

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Credit Card Authorization

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case (non-emergencies) where you miss or fail to cancel an appointment within 24 business hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee.

An additional $15 fee will be assessed for 1) returned checks, and 2) inaccurately disputed chargebacks.

I, _____, hereby authorize Ann H. Abbrecht, LPC to bill my credit card at the usual fee for professional services including all of the following:

- Appointments that I elect to pay for by credit card
- Missed appointments
- Telephone consultations lasting longer than fifteen minutes
- Appointments that I have cancelled (non-emergencies) with less than 24 hours' notice
- Returned checks

Credit Card/Debit Card Type (check one):
□ Visa □MasterCard □American Express

Card #_____ Expiration Date: _____

Verification/Security Code (3 digit code on back of card by signature line): _____

Name as Printed on Card: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

By signing below I am authorizing Ann H. Abbrecht, LPC to bill my credit card at the usual fee for professional services as described above.

Signature: _____ Date: _____

Print Name: _____

Client Information

(Please print information)

Client: _____ Date: _____

Home Address: _____ Suite/Apt #: _____
State: _____ Zip Code: _____

Phone Number: (Home) _____ (Cell) _____ (Work) _____

Please circle if *NOT* OK to leave a message: HOME CELL WORK

Email:_____

May contact by email: Yes No May contact by text: Yes No

Place of Employment:_____ _____

How long: _____ Occupation:_____

Relationship Status (Please Circle): single married divorced widowed committed relationship Other _____

How would you identify your sexual orientation: _____

Spouse/Significant other: (name) _____

Emergency Contact:

Name: _____

Address: _____ Suite/Apt #: _____
State: _____ Zip Code: _____

Phone Number: (Home) _____ (Cell) _____ (Work) _____

How did you find me? _____

Psychosocial Intake Form

Client: _____ Date: _____

What has brought you to the office today?

_____

_____

Have you ever seen a counselor, psychiatrist or mental health professional before? _____

Social History

Marital status: _____

Do you have children? If yes, what are their names and ages?

_____ _____

_____ _____

Do you have brothers and/or sisters? _____

Occupation: _____

Highest grade completed: _____

Current/past legal involvement: _____

_____

Symptoms

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				

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Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself more than half the days				

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

Check the line next to the one statement in each group that best describes the way you have been feeling for the past week.

Question 1

___I do not feel happier or more cheerful than usual.
___I occasionally feel happier or more cheerful than usual.
___I often feel happier or more cheerful than usual.
___I feel happier or more cheerful than usual most of the time. ___I feel happier or more cheerful than usual all of the time.

Question 2

___I do not feel more self-confident than usual.
___I occasionally feel more self-confident than usual.
___I often feel more self-confident than usual.
___I feel more self-confident than usual.
___I feel extremely self-confident all of the time.

Question 3

___I do not need less sleep than usual.
___I occasionally need less sleep than usual.
___I often need less sleep than usual.
___I frequently need less sleep than usual.
___I can go all day and night without any sleep and still not feel tired.

Question 4

___I do not talk more than usual
___I occasionally talk more than usual.
___I often talk more than usual.
___I frequently talk more than usual.
___I talk constantly and cannot be interrupted

Question 5

___I have not been more active (either socially, sexually, at work, home or school) than usual.
___I have occasionally been more active than usual. ___I have often been more active than usual
___I have frequently been more active than usual.
___I am constantly active or on the go all the time.

During the past week how often did you:

1. Have thoughts race through your head?

___Never ___Rarely ___Sometimes ___Often ___Always 2.

Think you had special powers?

___Never ___Rarely ___Sometimes ___Often ___Always

3. Hear voices or see things?

___Never ___Rarely ___Sometimes ___Often ___Always 4.

Think people were watching you?

___Never ___Rarely ___Sometimes ___Often ___Always 5.

Think people were against you?

___Never ___Rarely ___Sometimes ___Often ___Always

Please answer the following questions in relation to how you have been over the past <u>six months</u>:

	Never	Sometimes	Often	Very often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?				
How often do you have difficulty getting things in order when you have to do a task that requires organization?				
How often do you have problems remembering appointments or obligations?				
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?				
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?				
How often do you feel overly active and compelled to do things, like you were driven by a motor?				

Substance use:

1. Have you used drugs other than those required for medical reasons? Yes___ No___
2. Have you abused prescription drugs? Yes___ No___
3. Do you abuse more than one drug at a time? Yes___ No___
4. Can you get through the week without using drugs? Yes___ No___
5. Are you always able to stop using drugs when you want to? Yes___ No___
6. Have you had "blackouts" or "flashbacks" as a result of drug use? Yes___ No___
7. Do you ever feel bad or guilty about your drug use? Yes___ No___
8. Does your spouse (or parents) ever complain about your involvement with drugs? Yes___ No___
9. Has drug abuse created problems between you and your spouse or between you and your parents? Yes___ No___
10. Have you lost friends because of your use of drugs? Yes___ No___
11. Have you neglected your family because of your use of drugs? Yes___ No___
12. Have you been in trouble at work because of your use of drugs? Yes___ No___
13. Have you lost a job because of drug abuse? Yes___ No___
14. Have you gotten into fights when under the influence of drugs? Yes___ No___
15. Have you engaged in illegal activities in order to obtain drugs? Yes___ No___
16. Have you been arrested for possession of illegal drugs? Yes___ No___
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? Yes___ No___
18. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? Yes___ No___
19. Have you gone to anyone for help for a drug problem? Yes___ No___
20. Have you been involved in a treatment program especially related to drug use? Yes___ No___

Alcohol use:

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Have you ever felt the need to cut down on drinking? Yes___ No___

Have you ever felt annoyed by criticism of your drinking? Yes___ No___

Have you ever had guilty feelings about your drinking? Yes___ No___

Do you ever take a morning eye opener (a drink first thing in the morning to steady your nerves or get rid of a hangover)? Yes___ No___

General Health:

Do you have any medical problems?

Please list:

_____
_____
_____
_____

Do you have any allergies?

_____
_____
_____
_____

Are you taking any medication currently?

Please list:

_____
_____
_____
_____

Have you taken psychiatric medication in the past?

Please list:

_____
_____
_____
_____

Please list any additional questions or concerns you would like for me to know about:

_____
_____
_____
_____

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