

# DECLARATION OF PRACTICES AND PROCEDURES

## **James M. McGinn, Ph.D., LPC, NCC**

New Orleans Counseling and Hypnosis Center

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### **QUALIFICATIONS**

I earned a Master of Arts degree in Mental Health Counseling with an emphasis in School Counseling from Fairfield University in 2011 and a Doctor of Philosophy degree in Counselor Education and Supervision from the University of Holy Cross in 2020. I am a Licensed Professional Counselor (LPC) in the states of Connecticut – license number 002833; State of Connecticut Department of Public Health: 410 Capitol Avenue | Hartford, CT 06134 | (860) 509 – 7603 – and Louisiana – license number 7729; State of Louisiana Licensed Professional Counselors Board of Examiners: 8631 Summa Avenue, Suite A | Baton Rouge, LA 70809 | (225) 765 – 2515. I additionally hold certification as a National Certified Counselor (NCC) – certificate number 275349 – through the National Board for Certified Counselors: 3 Terrace Way | Greensboro, NC 27403 | (336) 547 – 0607.

### **THE COUNSELING RELATIONSHIP**

I believe that counseling is a process wherein the client and counselor come to a level of understanding, trust, and respect that enables them to work as a team to explore the client’s history and present state in order to: (a) Define problems; (b) identify realistic goals to improve those problems and/or the overall quality of life; and (c) systematically actualize those goals through concrete, active changes and ongoing assessment of those changes.

### **AREAS OF FOCUS**

Although I have worked with clients experiencing a variety of challenges in both the school and outpatient clinic settings, I have predominantly worked with those experiencing anxiety and/or depression; LGBTQ+-related issues; familial conflict or divorce; loss and grief; trauma; and school performance issues or academic decline.

### **SERVICES OFFERED AND CLIENTS SERVED**

I predominantly approach counseling from a cognitive-behavioral perspective in that thought patterns and subsequent feelings and behaviors are explored in order to understand how the client’s problems were created and are perpetuated as well as to develop alternative ways of thinking and more effective means of behaving. I am specifically trained and certified in the State of Connecticut to use cognitive-behavioral therapy (CBT) to treat trauma. I additionally draw from reality therapy, which asserts that behaviors are purposeful but changeable, and I therefore help the client to distinguish between needs and wants as well as identify all possible options before settling on a course of action. I also operate from solution-focused and strengths-based approaches, in which specific questioning helps the client to identify his/her goals and existing abilities, from which he/she can draw and on which he/she can expand in order to achieve those goals.

I work with clients in a variety of formats, including individual, family, and group counseling. I meet with clients of all ages and from all backgrounds with two exceptions: (a) I do not work with clients who are

chronically mental ill, such as those diagnosed with schizophrenia, as I believe they require a higher level of care than I can provide; and (b) I do not work with clients who present substance misuse or dependency as the primary issue as I believe these individuals require specialized treatment outside of my training or expertise.

## **CODE OF CONDUCT**

As a professional counselor, I am required to adhere to the legal and ethical codes for practice set forth by the Connecticut Department of Public Health and State of Louisiana Licensed Professional Counselors (LPC) Board of Examiners as well as by such counseling governing bodies as the American Counseling Association (ACA) and the National Board for Certified Counselors (NBCC). A copy of any or all of these codes is/are available to the client upon request.

## **CONFIDENTIALITY AND PRIVILEGED COMMUNICATION**

All information disclosed or revealed during the counseling session will remain strictly confidential between the client and myself except under the following circumstances, in accordance with legal and ethical obligations:

1. The client signs a written release of information to a designated third party indicating informed consent of such release.
2. The client expresses intent to harm themselves or another person.
3. There is reasonable suspicion of abuse or neglect against a minor, an elderly person (age 60 or older), or a dependent adult.
4. A court order is received requesting the disclosure or release of information.

It 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 the client of all mandated disclosures as conceivable.

In the event of marriage or family counseling, information individually obtained from an adult client may be shared with the client's spouse or other family member with the client's signed permission. Any information individually obtained from a minor client – other than that which regards potential harm to the minor, which is automatically disclosed – may be shared with the client's parent or guardian in conjunction with the client's awareness and/or participation.

To maintain my clinical effectiveness, there may be instances where I share client information with a supervisor or colleague to verify and plan appropriate treatment services that best respect and meet the needs of the client. The information that is shared/disclosed in these instances will be as minimal as possible and further protected by the third party providing supervision or consultation.

## **FEES AND OFFICE PROCEDURES**

Payments are typically processed through a client's health insurance provider, but they are expected to pay the predetermined co-pay – which can vary depending on a client's insurance provider and/or the chosen plan – following each session, if applicable. For those clients who either choose not to pay through their insurance provider or do not have one, a preset session fee of \$100.00 is charged following each session. If there is financial constraint and ability to pay is a concern in or obstacle to counseling, a sliding scale is available and session fees are determined based on a client's income and monthly expenditures.

Request for service is directly made to myself, who will schedule the client's initial/intake session based on my availability. Ongoing appointments are scheduled between the client and myself at the end of each session based on the availability of both. Appointments may be scheduled between the office hours of 9:00 AM and

7:00 PM Monday through Friday based on my availability. Failure to cancel or reschedule an appointment at least 24-hours in advance will result in a direct charge to the client of \$100.00 for the time reserved for them regardless of the existing session payment arrangement.

### **TELE-MENTAL HEALTH OR DISTANCE COUNSELING**

I am trained in the use of technology to provide tele-mental health or distance counseling – as per the requirements of the Louisiana LPC Board of Examiners – and can therefore provide this form of treatment to clients. This does not include the use of text or email messaging, both of which are only used for the purposes of scheduling or the brief exchange of non-personal information. The technology that I use to provide this form of counseling is the telephone and/or video-conferencing via the tele-medicine Doxy.me platform, which is HIPPA-compliant.

Protection of a client’s confidentiality is more difficult to ensure via this form of counseling. I will make every effort to ensure a client’s confidentiality is protected on my end of the tele-session. I cannot, however, guarantee it on the client’s end of the tele-session and it is therefore his/her responsibility to establish and maintain privacy in the physical space in which he/she chooses to conduct the tele-session.

There may be instances in which technology fails. In the event of technology failure during a video-conferencing counseling session, I and/or the client will attempt to reconnect using the same technology. If this technology failure persists, I will attempt to finish the session – with the client’s permission – via the telephone. If the client chooses not to use the telephone to complete the session, then a phone call, text message, or email will be sent to reschedule the session. In the event of technology failure during a telephone counseling session, I and/or the client will attempt to reconnect using the same technology but will agree to reschedule the session if this technology failure persists.

All other standards and protocols for traditional face-to-face counseling practice and treatment as outlined in this document apply to this form of counseling.

### **EMERGENCY SITUATIONS**

If I am unavailable to take a phone call during my office hours or when I am otherwise out of the office, the client may leave a message on my confidential voicemail and I will return the call as soon as possible. In a situation where an immediate response is required, the client may request to speak to another clinician within the office during office hours or contact the 24-hour crisis helpline by dialing 2-1-1 outside of office hours. The client should seek immediate help by going to the local hospital emergency department or dialing 9-1-1 if physical safety is at all a concern.

### **CLIENT RESPONSIBILITIES**

The client is a full, active partner in the counseling process, and both their honesty and effort are essential to its success. Consistency is a key factor in a client’s improvement and I therefore expect regular attendance for all scheduled sessions. As the client and I work together, all of the client’s suggestions or concerns pertaining to the counseling process should be shared so that adjustments can be made to it to improve efficacy. If I determine that the client would be better served by another mental health provider or service, I will help the client with the referral and transfer processes. If the client is presently receiving services from another mental health or health care provider, I expect that the client informs me of this and grants me permission to share information with this professional so that we may coordinate services for the benefit of the client.

### **PHYSICAL HEALTH**

Physical health is intricately connected to mental and emotional well-being and is therefore a factor to be addressed in the counseling process. If the client has not had a physical examination in the past year, it is recommended that they do so or obstacles to this be discussed with me to create a plan to have one completed. Also, a list of current medications – including name, dosage, and prescribed use – are to be provided at the start of treatment, and the client must notify me of any medication additions or changes that occur during treatment.

**POTENTIAL COUNSELING RISK**

The client should be aware that counseling poses potential risk. This includes the experiencing of uncomfortable or unwanted feelings – such as sadness, anger, guilt, or fear – and the surfacing of additional issues or concerns of which the client was not initially aware. If either occurs, please share this information with me in order to address it and prevent harm.

## ACKNOWLEDGMENT OF THE DECLARATION OF PRACTICES AND PROCEDURES

I have read the *Declaration of Practices and Procedures* of James M. McGinn, Ph.D., LPC, NCC and my signature below indicates my full informed consent of services provided by him.

\_\_\_\_\_  
**Client Signature** \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**James M. McGinn, Ph.D., LPC, NCC** \_\_\_\_\_  
**Date**

## PARENTAL/GUARDIAN CONSENT FOR TREATMENT OF A MINOR

I, \_\_\_\_\_, give my permission for James M. McGinn, Ph.D.,  
LPC,  
(Name of Parent/Guardian)  
NCC to conduct counseling with my \_\_\_\_\_,  
\_\_\_\_\_  
(Relationship) (Name of Minor)

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**Parent/Guardian Signature**

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**Date**