

Michelle Coon, LISW
Licensed Independent Social Worker

OFFICE POLICIES

At Family Legacy we believe counseling is a process whereby a client seeks resolution of emotional, relational, and/or spiritual difficulties with the assistance of another caring individual. Your counselor, Michelle Coon, will bring to the session her professional knowledge and expertise, but the ultimate responsibility for growth and change rests with you, the client. You are invited at any time to ask questions of Michelle regarding your counseling and your progress.

OFFICE HOURS: Michelle's office hours vary. Appointments can be made or messages left by calling the Family Legacy office at (515) 727-1338. Family Legacy's receptionist office hours are Monday through Friday 8:00 AM until 4:00 PM. Voice mail is available after office hours and is confidential, so please feel free to leave a message.

AFTER HOURS EMERGENCY: Please pursue 24-hour assistance from a local hospital emergency room, shelter, or police department.

INSURANCE: Michelle is able to submit to Wellmark BC/BS, United Health Care, and Midlands Choice. We do not submit claims for other insurance, however we can provide you with a receipt. You authorize the release of any information necessary to process claims and you authorize the payment of benefits to Family Legacy. **Please initial** _____

CHARGES: Sessions will last between 45-60 minutes depending on the service provided. Michelle's fees are \$155.00 for an initial session and \$115.00-\$145.00 (depending on the service provided) for each additional session. Payment is due upon arrival. If your account ever reaches a balance of \$200.00, services will be suspended until the balance is brought up to date. **Please initial** _____ Michelle has reserved your appointment time expressly for you. Since there is often a waiting list, we require twenty-four hours notice prior to your scheduled appointment for cancellations. If you do not show up for your appointment or fail to give 24 hours notice, you will be charged half the session fee, or \$57.50, for the missed session. We understand that emergencies do arise. If this is the case, please call the office as soon as possible. **Please initial** _____

CONFIDENTIALITY: All counseling is confidential, according to the Code of Ethics adhered to by your counselor. The counselors at Family Legacy are required by State Law, Code Section 232 and 235, to report suspected incidences of child, or dependent, or elder abuse.

NOTICE OF PRIVACY PRACTICES: I have read Family Legacy's Notice of Privacy Practices (HIPPA).

WEAPONS POLICY: No weapons of any kind are allowed on Family Legacy premises.

Your signature below signifies your understanding and willingness to comply with these policies.

Client(s)

Date

INFORMED CONSENT

Michelle Coon, LISW

Phone: (515) 727-1338

Fax: (515) 727-1340

E-Mail: legacyforyou@aol.com

Web Site: www.familylegacycounseling.com

Professional Information: I hold a Masters Degree in Clinical Social Work from a regionally accredited institution. I am independently licensed in the State of Iowa and have experience working with children, teens, adults and families with a variety of concerns. I draw on a variety of theories, all of which I find to be biblically sound, in order to take into account your spiritual, psychological, social and dialogical dimensions.

Counseling Relationship: I believe counseling is a process whereby you are seeking to resolve interpersonal, emotional, and/or spiritual difficulties with the assistance of a caring professional. As your counselor I will bring to the sessions my professional knowledge and experience, but the ultimate responsibility for growth and change rests with you. Therapy can last from a few weeks to several months. We will be in ongoing dialogue about your needs, progress, and recommended duration of therapy. You are invited at any time to ask questions about my methods or the direction of your counseling.

If for any reason you are dissatisfied with my services, please let me know and I will try to resolve your concerns. If we are unable to resolve your concerns, I will be available to assist you in finding qualified help elsewhere. Occasionally, I may elect to discontinue therapy if I feel no substantial progress is being made or other factors are interfering with my ability to help you.

Side Effects of Counseling: You should know that counseling is not always easy. You may find yourself discussing very personal information, and you may find these conversations difficult. I may suggest changes for you that at first may make you feel awkward or uncomfortable. As you learn more about yourself, you may encounter changes, some pleasant and some unpleasant in your relationships with family members, friends, co-workers, etc.

Counseling can be a disruptive process as you seek to create the change in your life that you desire, and it is possible that you may at times become depressed, anxious, agitated, or feel some other emotional/physical discomfort as you proceed through this process. You will always be free to move at your own pace, and talk with me about any of these kinds of things that you may experience. It is also important for you to understand that I cannot offer any promise about the results you will experience. Your outcome will depend upon many things...some that are beyond my control.

If at any time I believe that your situation requires knowledge that I do not have, I may refer you for a consultation with someone with specific training or experience in that given area. I will discuss any such referral with you before we act.

Confidentiality: Under normal circumstances everything you discuss with me will be held in strict confidence. However, you should be aware that there are some exceptions in which I may be required to report information to proper authorities and/or an appropriate family member or friend without your permission. If I believe there is a risk that you might harm yourself or someone else, I will be required to contact the authorities, a family member or friend, or the person being threatened to give them the opportunity to protect you and/or him/herself.

I am also mandated by the state of Iowa (State Law, Code Section 232 & 235) to report suspected incidents of child and/or dependent adult abuse.

If you become involved in any legal issues in which your mental health is an issue (for example child custody disputes or an injury lawsuit resulting in emotional pain/suffering) then the courts may insist upon, and obtain your counseling information from me.

Finally, if you are utilizing third party payment, then your insurance company will need access to certain information, including (but not always limited to) your diagnosis and dates of your visits. I will use my best judgment in both discussing these circumstances with you if they arise, and in disclosing only essential information when required.

You should also know that I consult regularly with other professionals regarding clients with whom I am working. This allows me to gain other perspectives and ideas as how to best help you reach your goals. Such consultations are obtained in a way that your complete confidentiality is maintained.

Office Policies: Counseling sessions normally last 50 minutes. To best utilize your time, please come prepared with your ideas about how you can best use each session to your fullest benefit, and please share the responsibility with me in watching the clock so that we can bring each session to good closure in a timely manner.

If you need to reach me by phone, you may call Family Legacy at 515-727-1338, follow the prompts, and leave me a confidential voice message. I will do my best to return your call that day or the following business day. I do not work on Fridays, so messages left on Thursday afternoons or Fridays will not be returned until the following Monday. If you have not heard back from me after a reasonable amount of time, please try again as your message may have somehow been missed. If you have an emergency, follow the instructions given on my voice mail, or promptly contact 911, your local emergency room, or crisis center.

Electronic Communications: You are welcome to communicate with our office via e-mail regarding scheduling and other administrative concerns. It is important to be aware that any electronic communication can be vulnerable to unauthorized access, and I cannot guarantee the confidentiality of any electronic communication. Like phone messages, if your electronic communication is not responded to in a reasonable amount of time, please follow up with a phone call to ensure that your communication was received.

Notice of Privacy Rights: I have read and understand my privacy rights at Family Legacy.

Your signature indicates that you understand and agree to the above information and policies, and that any questions you have about this information has been answered to your satisfaction.

Signature_____Date_____

Signature_____Date_____

CONFIDENTIAL QUESTIONNAIRE

Michelle Coon, LISW

Licensed Independent Social Worker

PERSONAL INFORMATION

Date: _____

Name: _____ Home Phone: _____ Cell _____

Address: _____

City, State, Zip: _____

Birth Date: _____ Age: _____ Education (last year completed): _____

Occupation: _____ Business Phone: _____

May we leave a message at your home? ____yes ____no Business? ____yes ____no

Circle One: Single Married Separated Divorced Widowed

If married, how long? _____

Spouse's name and occupation: _____

Names and ages of children: _____

In case of emergency, please contact the following: _____

Relationship: _____ Phone: _____

Referred to Family Legacy by: _____

HEALTH INFORMATION

Rate your overall health (check one)

____Very Good ____Good ____Average ____Poor

Are you sleeping through the night? ____yes ____no

Have you had a change in weight recently? ____yes ____no

If yes, about how much? _____loss _____gain

Are you experiencing fatigue or lack of energy? ____yes ____no

Present medications and purpose: _____

(Please turn over and complete the other side)

OTHER INFORMATION

Have you recently suffered loss from a significant social, business, or family relationship? _____Yes _____No If yes, please explain:_____

Have you had previous counseling? _____Yes _____No
If yes, please list the dates, name of therapist and reason for counseling:_____

What religious organization do you attend, if any?

Briefly describe your belief about God and if/how you see your faith being part of the change process in your counseling:

What has brought you here today and what would you like the counseling process to accomplish?

Please circle the areas you may wish to discuss during the counseling process:

abortion	childhood hurts	marital issues	sexual issues
abuse	communication	occupation	spirituality
anger	depression	parenting	stress
anxiety	finances	parents/in-laws	substance abuse
appearance	grief/loss	relational conflicts	suicidal thoughts

CONFIDENTIAL CHILD/TEEN QUESTIONNAIRE

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CHILD/TEEN PERSONAL INFORMATION

Date: _____

Name: _____ Home Phone: _____

Address: _____ City, State, Zip: _____

Birth Date: _____ Age: _____ Grade: _____

School: _____

May we leave a message at your home? ___yes ___no

Email Address (optional): _____

(We cannot guarantee the confidentiality of electric communication.)

Circle One: Biological Half Step Adopted Foster

Mother's name and occupation: _____

Work Phone number _____ Cell _____ May we leave a message? Yes No

Stepmother's name and occupation: _____

Father's name and occupation: _____

Work phone number _____ Cell _____ May we leave a message? Yes No

Stepfather's name and occupation: _____

Referred to Family Legacy by: _____

SIBLING INFORMATION

First Name, Last Name Age Biological Half Step Adopted Foster

1. Is the child/teen **currently** seeing any Doctor/Psychiatrist/Counselor/Psychologist?

Yes No

If Yes, Whom? _____

General nature of counseling sessions _____

2. Has the child/teen seen a Doctor/Psychiatrist/Counselor/Psychologist in the past?

Yes No

If yes, Whom and When? _____

General nature of past counseling sessions _____

3. Is the child/teen **currently** taking any medication? Yes No If, so what kind and dosage?

4. What are the child/teen's interests, hobbies, or activities? _____

5. Reason(s) for seeking counseling? _____

6. Please explain any special needs your child/teen has (i.e. physical, educational, speech,

etc.) _____

7. Church affiliation if any _____