- ☐ Dr. Ed Ashby, LMHC
- ☐ Dr. Joel Ashby, PsyD
- ☐ Patricia Ashby, LMHC
- ☐ Jamie Brandon, LMFT
- ☐ Kimberly Brangoccio, LMFT, CADC
- ☐ Pamela Brown, ARNP
- ☐ Debra Gipple, LMHC
- ☐ Cliff Heckman, LMHC
- ☐ Dianne Jones, LMHC, CDWF-C
- ☐ Dr. David Kaptain, LMFT, CADC
- ☐ Tara Kelly, LMHC
- ☐ Jayci Kuhns, LISW
- ☐ Mary Lothe, MA
- ☐ Tabitha Nicolaysen, LMFT
- ☐ Jenise Rychnovsky, LMHC
- ☐ Rebecca Schrock, LMFT
- ☐ Rich Saxton, LMFT
- ☐ Sarah Snavely, LMHC
- ☐ Jason Van Zee, LHMC
- ☐ Dr. Steve Ziebell, LISW

CONFIDENTIAL CHILD/ADOLESCENT QUESTIONNAIRE

PERSONAL INFORMATION Date: _____

Minor's Name: _____
(First Name) (Last Name) (Nickname)

Date of Birth (mm/dd/yyyy): _____ **Gender:** M F **Grade:** _____ **Age:** _____

School: _____

Circle one: Biological Half Step Adopted Foster

How did you hear about Family Legacy?

- ☐ Family or Friend
- ☐ Internet/Search Engine
- ☐ Pastor - _____
- ☐ Physician - _____
- ☐ Insurance Provider Search
- ☐ Other - _____

Minor's Address: _____

City, State, ZIP: _____

Other Responsible Party (person who will be paying the bill if different from parent):

Responsible Party Name: _____

Responsible Party Address: _____

City, State, ZIP: _____

Mother's Name: _____ **Home Phone:** _____

Cell Phone: _____ **Mother's Occupation:** _____

Place of Employment: _____

Mother's Email Address: _____

Father's Name: _____ **Home Phone:** _____

Cell Phone: _____ **Father's Occupation**: _____

Place of Employment: _____

Father's Email Address: _____

Stepmother's Name: _____ *Occupation*: _____

Stepfather's Name: _____ *Occupation*: _____

Child/Teen's Physician: _____ **Phone number:** _____

SIBLING INFORMATION

First Name	Last Name	Age	Biological	Half	Step	Adopted	Foster

1. Is the child **currently** under the care of a Doctor/Psychiatrist/Counselor/Psychologist? **Yes** **No**

If yes, whom? _____ Phone #: _____

2. Has the child seen a Psychiatrist/Counselor/Psychologist **in the past**: **Yes** **No**

If yes, whom? _____ Phone #: _____

Dates of **past** counseling: _____

What was the general nature of **past** counseling? _____

3. Is the child/teen **currently** taking any medication? **Yes** **No**

If yes, what kind(s) and dosage(s): _____

Who is the prescribing physician? _____ Phone #: _____

4. Does the child/teen have any allergies? **Yes** **No** If so, what type?_____

If yes, what treatment? _____

5. Does the child/teen have any food allergies or sensitivities? **Yes** **No**

If so, what type? _____

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

_____

7. Reason(s) for seeking counseling or medication management treatment:

_____

_____

8. Please explain any special needs your child/teen has (i.e. physical, educational, speech, developmental, etc.)

_____

9. Has the child/teen had any **former** educational or mental health assessment(s) completed? **Yes** **No**

If so, who completed the assessment(s)? _____

Date(s) of assessment(s): _____

Nature of the assessment(s) completed: _____

_____

10. Church affiliation, if any: _____

TREATMENT PERMISSION FOR CHILD/ADOLESCENT

Name of child/adolescent: _____

Date: _____

It is the policy of Family Legacy Counseling to require the permission/signatures of both living custodial parents/legal guardians before treating children or adolescents. This requirement may be waived if the clinician determines such requirement to be clinically inadvisable and/or unnecessary.

I hereby give my permission to the Family Legacy mental health clinicians to provide to said child/adolescent such diagnostic and treatment services as found indicated by the professional staff.

Signature: _____

Relationship to Child/Teen: _____

Address: _____

Phone: _____

Signature: _____

Relationship to Child/Teen: _____

Address: _____

Phone: _____

Online Appointment Scheduling and Appointment Reminders

You can enjoy the convenience of online scheduling at any time. First, establish your account by creating a login name and password that will allow us to input that information into our system.

Client Name: _____

Clinician(s) Name: _____

Requested Login Name: _____
(Requires letters, **NO** characters, 15 spaces max.)

Requested Password: _____
(Requires letters **AND** numbers, **NO** characters, 8-35 spaces max.)

Go to www.familylegacycounseling.com. Click on the scheduling tab, then on the link to Therapy Appointment and follow the prompts. You may continue to schedule appointments in person or by telephone, but if you have internet access, you are sure to enjoy the convenience of this online system.

You can receive an appointment reminder to your email address, your cell phone (text message), OR your home phone (voice message) before your scheduled appointments.

Your Email Address: _____

Your Home Phone Number: _____

Your Cell Phone Number: _____

(CHECK ONLY ONE) How would you like to receive appointment reminders?

____ Via text message on my cell phone (normal text message rates will apply).

____ Via email message to the address listed above.

____ Via automated telephone message to my home phone.

____ None of the above. I'll remember my appointments on my own. (Missed appointment fees will still apply.)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____

Signature Date

INFORMED CONSENT

Thank you for choosing Family Legacy Counseling to help you with your concerns. We are committed to providing a safe ad confidential setting for you. Our goal is that you find Family Legacy to be a place of hope, healing, and wholeness.

COUNSELING RELATIONSHIP: At Family Legacy counseling, we believe counseling is a process whereby you are seeking to resolve interpersonal, emotional, and/or spiritual difficulties with the assistance of a caring professional. Your mental health clinician will bring professional knowledge and experience to each session, but the ultimate responsibility for growth and change rests with you. Therapy can last from a few weeks to several months. The clinician will have ongoing dialogue about your needs, progress, and recommendations for the duration of therapy. You are invited to ask questions about your clinician's methods or direction at any time. If, for any reason you are dissatisfied with your clinician, please let him/her know so that an attempt can be made to resolve your concerns. If your clinician is unable to resolve your concerns, he/she will assist you in finding qualified help elsewhere. If the clinician believes that outside involvement is necessary or another clinician at Family Legacy would be helpful, it will be recommended to you. You have the right to request and receive a second opinion at any time. Occasionally, clinicians may elect to discontinue therapy. This usually happens when they feel no substantial progress is being made or other factors are interfering with their ability to help you.

SIDE EFFECTS OF COUNSELING: As you seek to create change in your life through therapy, it is possible that you may, at times, become depressed, anxious, agitated, or feel some other emotional or physical discomfort as you proceed through this process. You will always be free to move and your own pace and talk with your clinician about what you may be experiencing. It is also important for you to understand that your clinician cannot offer any promise about the results you will experience.

FEES: Sessions for counseling will last between 45-60 minutes, depending on your insurance coverage. The fees for services range from $115-$235. Group sessions are typically $40/session. Payments are expected at the time of service. If your account shows a balance of $200 or more, services will be suspended until the balance is brought up to date. Fees are subject to change without notice. **Please Initial _____**

INSURANCE: Family Legacy clinicians are covered under a variety of insurance plans and will submit to your insurance company for you. We are not providers for Medicare, Medicaid, or Hawk-i. If you have coverage under a plan for which your clinician is not a provider, we can supply you with a receipt that you can use to submit for reimbursement. Please note that once we submit to insurance or supply you with a receipt, the insurance company can require the disclosure of confidential information in order to process the claims. In submitting insurance for you, you are authorizing payment of benefits to Family Legacy for services provided. Submitting a mental health claim carries a risk to confidentiality, privacy, and/or to future eligibility to obtain health or life insurance. In some cases, your insurance company must approve all sessions in advance. If, for any reason, your insurance company does not pay the claims, you will be responsible for paying the service fee.
Please Initial _____

LATE CANCELLATIONS AND NO-SHOWS: Your clinician has reserved your appointment time expressly for you. Since there is often a wait-list, we require twenty-four hours notice prior for your scheduled appointment for cancellations. If you do not show up for your appointment or fail to give twenty-four hours notice, you may be

charged for the missed session. This fee cannot be charged to your insurance company. We understand that emergencies do arise. If this is the case, please call the office as soon as possible. **Please Initial _____**

OFFICE HOURS AND EMERGENCIES: Our phones are answered Monday through Thursday 8:00 AM to 4:00 PM and Friday 8:00 AM to 1:00 PM. Voicemail is available after hours and is confidential, so please feel free to leave a message. Voicemail will also instruct you on how to reach your clinician in case of an after-hours emergency. If you have a life-threatening emergency, please call 9-1-1 or seek 24-hour assistance from a local emergency room, shelter, or police department. **Please Initial _____**

CONFIDENTIALITY: All counseling is confidential, according to the Code of Ethics adhered to by your clinician. Your clinician may consult with other professionals regarding situations to gain other perspectives and ideas as how to best help you reach your goals. Such consultations are obtained in a way that complete confidentiality is maintained. If you choose to have us share information with another individual, we will request that you sign a release of information. Once information is shared, we cannot guarantee your confidentiality.
Regarding mandatory reporting, the clinicians at Family Legacy are required by State Law, Code Section 232 and 235, to report suspected incidences of child, dependent, or elder abuse. If your clinician believes there is a risk that you might harm yourself or someone else, he/she will be required to contact the authorities, a family member or friend, or the person being threatened. **Please Initial _____**

RELEASE OF FILES: The notes on your session are the property of your clinician and are only made available to other professionals with appropriate releases, most often in the form of a written summary. Notes of your sessions will not be directly released to you due to the lack of contextualization. If, at any time, you wish to have your clinician review your session notes with you, a consultation session will be arranged. **Please Initial _____**

LITIGATION LIMITATION: Neither I nor my attorney, nor anyone else acting on my behalf will call on my clinician to testify in court or at any other proceeding, nor will a disclosure of the therapy notes be given.
Please Initial _____

COMMUNICATION: It is important to be aware that email, cell phone, or fax communication can be accessed by unauthorized people, and therefore, the privacy and confidentiality of such communication can be compromised, and therefore, cannot be guaranteed. Please talk with your clinician about the best way to communicate with him/her. **Please Initial** _____

HIPAA: I have either read Family Legacy Counseling's Notice of Privacy Rights (HIPAA) or have chosen to decline a copy of said rights. **Please Initial** _____

WEAPONS POLICY: No weapons of any kind are allowed on Family Legacy Premises. **Please Initial** _____

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

_____ _____
Printed name Date

_____
Signature