- ☐ 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, CDF-C
- ☐ Dr. David Kaptain, LMFT, CADC
- ☐ Tara Kelly, LMHC
- ☐ Jayci Kuhns, LISW
- ☐ Mary Lothe, LMHC-T
- ☐ Tabitha Nicolaysen, LMFT
- ☐ Jenise Rychnovsky, LMHC
- ☐ Rich Saxton, LMFT
- ☐ Rebecca Schrock, LMFT
- ☐ Sarah Snavely, LMHC
- ☐ Jason Van Zee, LMHC
- ☐ Dr. Steve Ziebell, LISW

CONFIDENTIAL ADULT QUESTIONNAIRE

Date: _____

PERSONAL INFORMATION

First Name:	Middle:	Last Name:	
Gender: ☐ Male ☐ Female	Date of Birth (mm/dd/yy):	Age:	
Address:	City:	State:	Zip:
Cell Phone: Home Phone:	Which phone number do you prefer we use to contact you? ☐ Cell ☐ Home		
E-Mail Address:			
Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Cohabitating ☐ Widowed ☐ Dating			
Spouse's name, if married:		Number of years married:	
Children's Names, if any		Ages of Children	
Employer: ☐ Currently Unemployed		Highest Level of Education Completed:	
Occupation:			

EMERGENCY CONTACT INFORMATION

First Name:	Last Name:
Phone Number:	Relationship:

RESPONSIBLE PARTY (person who will be paying the bill, if different from client)

First Name:	Last Name:		
Phone Number:	Relationship:		
Address:	City:	State:	Zip:

PRESENTING CONCERNS

Please list the reason(s) for which you are seeking our services at this time.

1. _____
2. _____
3. _____

Please mark any of the areas you may wish to discuss during the counseling process:

- ☐ Abortion
- ☐ Abuse
- ☐ Anger
- ☐ Anxiety
- ☐ Appearance
- ☐ Childhood Hurts
- ☐ Communication
- ☐ Depression
- ☐ Finances
- ☐ Grief/Loss
- ☐ Marital Issues
- ☐ Occupation
- ☐ Parenting
- ☐ Parents/In-Laws
- ☐ Relational Conflicts
- ☐ Sexual Issues
- ☐ Spirituality
- ☐ Stress
- ☐ Substance Abuse
- ☐ Suicidal Thoughts

HEALTH INFORMATION

Rate your overall health: ☐ Very Good ☐ Good ☐ Average ☐ Poor	Are you sleeping through the night? ☐ Yes ☐ No
Have you had a recent change in weight? ☐ Yes ☐ No If yes, how much? _____ ☐ Loss ☐ Gain	Are you experiencing any fatigue or lack of energy? ☐ Yes ☐ No
Current medications and purpose:	
Primary Care Physician (PCP):	

OTHER INFORMATION

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 treatment.

_____

INFORMED CONSENT

Thank you for choosing Family Legacy Counseling (FLC) to assist you with your concerns. Our goal is that you find FLC to be a place of *hope*, *healing*, and *wholeness*. We are committed to providing a safe and confidential setting for you. Below you will find information to explain some essential details.

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 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. It can also be an ongoing process throughout many life stages. 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 to your satisfaction, he/she will assist you in finding qualified help elsewhere. This could be either another counselor at FLC or a clinician at another agency. 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 at 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. Therapy can be difficult work and progress can be slow.

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.

INSURANCE

Family Legacy Counseling 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 that you submit, the insurance company can require the disclosure of confidential information in order to process the claims. Submitting a mental health claim carries a risk to your confidentiality and privacy. In submitting insurance for you, you are authorizing payment of benefits to Family Legacy Counseling for services provided. 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 fees.

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 so that others may have the opportunity to be seen. 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.

OFFICE HOURS AND EMERGENCIES

Our phones at FLC 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 911 or pursue 24-hour assistance from a local emergency room, shelter, or police department.

CONFIDENTIALITY

All counseling is confidential, according to the Code of Ethics adhered to by your clinician. Your clinician may consult with other professionals to gain other perspectives and ideas as how to best help you reach your goals. Such consultations are discussed in a way that confidentiality is maintained. There are times when your clinician may want to consult and coordinate your treatment with another clinician at FLC. This can be due to clinicians working together with other family members where information needs to be shared or due to a temporary transfer of care. If you choose to have us share information with another individual outside of FLC, we will request that you sign a Release of Information at that time. Once information is shared, we cannot guarantee your confidentiality.

Regarding mandatory reporting, the clinicians at FLC 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 is required to contact the authorities, a family member or friend, or the person being threatened.

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 context to interpret these. If, at any time, you wish to have your clinician review your session notes with you, a consultation session will be arranged.

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.

COMMUNICATION

It is important to be aware that email, cell phone, or fax communication can be accessed by unauthorized people. Therefore, the privacy and confidentiality of such communication can be compromised. Please talk with your clinician about the best way to communicate with him/her.

HIPAA

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

WEAPONS POLICY

No weapons of any kind are allowed on Family Legacy Counseling premises.

Your signature below signifies your understanding and willingness to comply with all of the above information.

_____

Printed Name

_____ _____

Signature Date

ONLINE APPOINTMENT SCHEDULING AND APPOINTMENT REMINDERS

CREATE A LOGIN AND PASSWORD

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)	

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.

HOW WOULD YOU LIKE TO RECEIVE REMINDERS? (CHECK ONLY ONE)

☐ Via text message on my **cell phone** (normal text message rates will apply). Cell phone number: _____

☐ Via **email** message. Email address: _____

☐ Via automated telephone message to my **home phone**. Home phone number: _____

☐ None of the above. I will 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