



PROFESSIONAL DISCLOSURE STATEMENT

Covenant Counseling

212 W. Wackerly Rd. Suite 200 • Midland, MI 48640

Phone: (989) 835-8344 FAX: (989) 837-8655 • Web: CovenantCounseling.net

Thank you for the honor to serve you. The Michigan Public Health Code requires that a licensed counselor furnish a professional disclosure statement to all prospective clients before engaging in counseling services. We also want you to be well informed regarding your prospective counselor's credentials and level of experience before your first consultation. Please read the following information and sign indicating that you have read and understood the statement. You will also be furnished with a copy to keep.

Sandra Cross Lodico, M.A., NCC, LPC

Mrs. Lodico provides individual, marital, family and group counseling. She has had postgraduate training and experience in assessing and treating sexual abuse, co-dependency, addictions, and children. Sandra received a B.A. in Sociology from Malone College in Canton, OH in 1970 and a M.A. in Pastoral Psychology and Counseling from Ashland Theological Seminary in 1980. Her counseling experience includes private practice, employment with Psychological Associates of Medina, Ohio and therapist with New Source Counseling Centers of Twinsburg, Ohio. Sandra receives yearly education and training to fulfill requirements as a National Certified Counselor and an International Certified Christian Counselor. Sandra is licensed by the State of Michigan. The licensing bureau's address and phone number is:

**Department of Community Health
Complaint and Allegation Division
P.O. Box 30670 • Lansing, MI 48909
(517) 373-9196**

What to Expect:

First Session: The first session is called the diagnostic session. In this session the primary goal is to identify and evaluate the problems. If time allows, your therapist will begin to work with you to define a treatment plan outlining goals, objectives, approaches or interventions to address the reason for your coming to therapy. You are expected to play a major role in determining the treatment plan.

Continuing Sessions: Your therapist will listen, guide in processing and exploring feelings, facilitate solving of issues, structure exercises, offer suggestions, facilitate the practice and development of skills, gently challenge and explore alternative options, and give homework exercises.

Informed Consent of Therapy

We want you to be confident and informed of our therapy approach.

New research, techniques and knowledge in the psychological field continue to expand to improve therapy. As a result, it has been found that certain skills and therapy approaches are more effective with certain counseling needs than others. Because of this, we are eclectic in our approach using differing therapy skills. A main approach is Cognitive Behavioral Therapy (CBT). Research finds this model effective with most needs and it is compatible to a Christian or biblical worldview. The approach recognizes that right thinking and behavior can help one's mood, feelings and attitudes (Rom. 12:2, Eph. 4:23). At the same time, we use certain psychodynamic skills to bring subconscious emotional memories to a conscious level to allow cognitive reframing; we use Gestalt techniques to bring about awareness of what is presently happening in the client's life to gain clarity and insight. Other approaches we may use are as follows:

Interpersonal Therapy (IPT)
Interpersonal Skill Training
Process and Supportive Counseling
Marriage Communication Skills
Emotional/Behavioral Management Skills
Rational Emotive Therapy (RET)
Family System or Family Therapy
Dialectical Therapy
Educational or Insight-Oriented Therapy
In-vivo Exposure for Obsessive Compulsive Disorder

Twelve Steps for Addiction and Dysfunctional Backgrounds
Trauma Focus or Supportive Therapy for Post Traumatic Stress
Spiritual Formation
Biblical Integration
Art and Play Therapy for Children
Group Therapy
Medication Referral
Love Interventions for Substance Abuse and Conduct Disorders
Inventory Testing
Grief and Trauma Processing

Initial Data Form

Please fill in the following information:

Patient Name: _____

Address _____ City: _____

State: _____ Zip: _____

DOB*: ____/____/____ Social Security #: _____

Day Phone: _____ Home Phone: _____

Highest Educational Degree _____ Occupation: _____

Place of Work or Company Name: _____

Spouse or Parent Names: _____

Address _____ City: _____

State: _____ Zip: _____

DOB*: ____/____/____ Social Security #: _____

Day Phone: _____ Home Phone: _____

Highest Educational Degree _____ Occupation: _____

Place of Work or Company Name: _____

Purpose seeking counseling: _____

Issues and goals you would like to address: _____

Who referred you to Covenant Counseling? _____

Other counselors you or your family member has seen (Include the year and any diagnosis):

Indicate physical issues, past and present: _____

List stresses: _____

List patient medications: _____

Religious affiliation if any: _____

Circle to indicate the level of your spiritual interest: 1 2 3 4 5

Spouses spiritual interest: 1 2 3 4 5

Low Interest

High Interest

Do you use **alcohol**? Yes No Do you use uncontrolled substances? Yes No

Has either of these ever been a problem in your life? _____

Does the spouse use alcohol? Yes No Does the spouse use uncontrolled substances? Yes No

Has either of these ever been a problem in your life? _____

See Back

If applicable:

Present status (Circle One): single, married, separated or divorced

Your Present Marriage is you're: 1st, 2nd, 3rd, _____

Your Spouse's Present Marriage is the: 1st, 2nd, 3rd, _____

Your Children:

Name	DOB*	BAP [♦] Indicate to which marriage the children were born or adopted.	Indicate A for adopted, B for biological parent.
—	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Spouse's Children:

Name	DOB*	BAP Indicate to which marriage the children were born or adopted.	Indicate A for adopted, B for biological parent.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Primary Insurance: _____

Billing Address: _____

Secondary Insurance: _____

Billing Address: _____

I understand that if my insurance fails to pay Covenant Counseling for any reason I am responsible for full payment of my account.

Signed: _____ Date: _____

Signed: _____ Date: _____

* Date of Birth

* Date of Birth

[♦]**Biological or Adopting Parent:** Identify biological spouse by indicating the spouse is of which marriage using **1st, 2nd, 3rd**, etc., **P** = present, or **BSP** = Born of single parent.

Confidentiality and Consent to Use or Disclose Information for Treatment, Payment, and Health Care Operations

Patient Name _____

Organization Granted this Consent: *Covenant Counseling, 212 W. Wackerly, Suite 200, Midland, MI 48640*

Confidentiality:

We want you to know that we regard confidentiality an important component of effective therapy and privileged communication a right of all clients according to the law. Exceptions to this confidentiality are as follows:

- If the client requests that we bill their insurance company or a third party, diagnosis and dates of service are shared to collect payments when required.
- When the client signs a release of information.
- Mandated reporting of physical or sexual abuse of children, threats of suicide or homicide and those required by law. As a mental health practitioner, I will under no circumstances inform such individuals without first sharing that intention with the client, unless it is not possible to do so. Every effort will be made to resolve the issue before such a breach of confidentiality takes place.
- Information necessary for supervision or consultation of therapy.
- Information handled as outlined in the HIPAA Notice of Privacy Practice.

Records: Records are kept concerning your therapy. If you prefer your therapist keep no records, you must give a written request to this effect for your file. If this is done, the only record kept will be the date of your attendance. Without a record, requests from third party payers such as insurance companies cannot be made.

Couple Counseling Policy:

If you and your partner decide to have some individual sessions along with your joint therapy sessions, what you say in individual sessions is considered to be part of the couple's therapy and the information maybe discussed in joint sessions.

HIPAA Regulations:

In our effort to keep privileged information confidential and at the same time provide treatment, federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example, quality improvement activities).

With this consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.

These uses and disclosures are described more fully in our **Notice of Privacy Practices**. You have the right to review that Notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the waiting room. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

Phone Contact:

We, at times, phone to remind our clients of their appointment or to be in contact for various reasons. **Please indicate below the ways you would like to be contacted by writing your initials in the corresponding boxes:**

Home	<input type="checkbox"/>
Work	<input type="checkbox"/>
Cell phone	<input type="checkbox"/>

Give us any contact instructions: _____

I hereby consent to the use or disclosure of my protected health information as specified above.

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____

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Counseling Problem Checklist

Name: _____

Age: _____ Date filled out: _____

Check any of the following problems that you experience:

Depression	Feeling that you are not real
Low energy	Feeling that things around you are not real
Low self-esteem	Lose track of time
Poor concentration	Unpleasant thoughts won't go away
Hopelessness	Anger management/frustration
Worthlessness	Easily agitated/annoyed
Guilt	Difficulty with rules/submitting to authority
Sleep disturbance (more/less)	Habit blaming others
Appetite disturbance (more/less)	Tend to argue & be defensive
Thoughts of hurting yourself	Excessive use of drugs and/or alcohol
Thoughts of hurting someone	Excessive use of prescription medications
Isolation/social withdrawal	Blackouts
Sadness/loss	Physical abuse issues
Stress	Sexual abuse issues
Anxiety/panic	Spousal abuse issues
Heart pounding/racing	Loneliness
Chest pain	Nightmares
Trembling/shaking	Intrusive thoughts
Sweating	Headaches
Chills/hot flashes	Sexual problems
Tingling/numbness	Suicidal thoughts
Fear of dying	Relationship problems
Nausea/Stomach Problems	Difficult relaxing
Phobias	Compulsive behaviors
Obsessive thoughts	Marital/family problems
Thoughts racing	Poor impulse control
Can't hold onto an idea	Confusion
Easily agitated	Difficulty trusting
Excessive behaviors (spending, gambling)	Not thinking clearly/confusion
Delusions/hallucinations	Spiritual Issues:
Other problems/symptoms:	Pain (where):